Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	29 July 2021
TEITL YR ADRODDIAD: TITLE OF REPORT:	Corporate Risk Register
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Steve Moore, Chief Executive
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Wilson, Board Secretary Charlotte Beare, Head of Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Corporate Risk Register (CRR) is presented to the Board to advise of the corporate risks of Hywel Dda University Health Board (HDdUHB) and provide assurance that these risks are being assessed, reviewed and managed appropriately/effectively.

Cefndir / Background

Risk management is a key component of the governance framework, and should underpin organisational strategy, decision-making and the allocation of resources; as such the organisation is required to have effective risk management arrangements in place. The Board should receive sufficient and timely assurance information on the management of risk to enable it to exercise good oversight.

The Board agreed the approach, format and content of the Corporate Risk Register (CRR) and Board Assurance Framework (BAF) at its meeting on 27th September 2018, and that it should receive the CRR and the BAF twice a year. The in-depth scrutiny and monitoring of corporate risks was delegated to Board Committees in order that they could provide assurance to the Board, through their Committee Update Reports, on the management of its principal risks.

The Health Board is operating in unprecedented times, and its primary focus at present is responding to the COVID-19 global pandemic and recovery planning with a focus on delivering the Quarterly Operating Framework. At its Board Meeting in Public on 16th April 2020, the Board agreed that there needed to be a proportionate response to risk balanced with the current capacity pressures and challenges presented by COVID-19.

The Executive Directors are responsible for reviewing and discussing their corporate risks, and agreeing any new risks and the escalation/de-escalation of operational risks that are on directorate risk registers. It is the role of the Executive Directors to review controls and ensure appropriate action plans are in place, which might include the development of corporate risk management strategies to manage risk(s). Effective management of these risks enables the organisation to improve its chances of success and reduce the likelihood of failure.

Asesiad / Assessment

Since the CRR was previously presented to the Board in March 2021, the risks have been discussed in detail at its Board Committees, and therefore reported to the Board via the Committee Update Reports. Where assurance has not been received that principal risks are being managed effectively, the Committees can request a more in-depth report at a subsequent meeting. Recent examples of this have taken place at the Quality, Safety and Experience Assurance Committee where a deep dive was undertaken in to risk 1032. The risks have also been reviewed on a monthly basis at the Executive Risk meetings.

Work is currently underway to align the Board Assurance Framework (BAF) to our 6 strategic objectives. An outline of work was reported to the previous Board meeting on 24th June 2021. Whilst the BAF will identify the Health Board's principal risks to achieving its strategic objectives, and these will be long term in nature, the Corporate Risk Register will need to include significant risks associated with delivering the 'here and now'.

The following changes have taken place since the CRR was previously presented to the Board in March 2021.

Total Number of Risks	21	
New risks	1	*See note 1*
De-escalated/Closed	2	*See note 2*
Increase in risk score ↑	1	*See note 3*
Reduction in risk score ↓	1	*See note 3*
No change in risk score →	18	

The 21 corporate risks are detailed on the below heat map:

HYWEL DDA RISK HEAT MAP

	LIKELIHOOD →				
IMPACT ↓	**RARE 1**	**UNLIKELY 2**	**POSSIBLE 3**	**LIKELY 4**	**ALMOST CERTAIN 5**
CATASTROPHIC 5	853	634 1016	813	117(↑)	
MAJOR 4		1030	291 628 633 451 855(↓) 1063 (NEW)	624 646 750 1027 1032 1048	684
MODERATE 3	854			129	
MINOR 2					
NEGLIGIBLE 1					

Attached to this report to provide the Board with assurance on the management of its principal risks are:

Appendix 1 - CRR Summary
Appendix 2 - Each risk detailing the strategic objective, controls, assurances, performance indicators and action plans to address any gaps in controls and assurances.

Note 1 – New Risks
Since the previous report in March 2021, 1 new risk has been added to the CRR:

Risk	Lead Director	Close/De-escalated	Date	Reason
Risk 1063 – Risk to the delivery of the Health Board's draft interim Financial Plan for 2021/22 of a £25.0m deficit	Director of Finance	New	07/07/21	This risk has been closed as the level of risk has been reduced to 5, reflecting the increased level of confidence in the system, which has been working well over a number of months. It is anticipated that previous issues are very unlikely to reoccur. The current risk score of 5 is within the tolerance level of 6 for a risk in the safety domain.

Note 2 - De-escalated/Closed Risks
Since the previous report to Board in March 2021, the following 2 corporate risks have been closed/de-escalated:

Risk	Lead Director	Close/De-escalated	Date	Reason
Risk 1017 – Delivery of Q3/4 Operating Plan – Test, Trace and Protect Programme being able to quickly identify and contain local outbreaks	Director of Therapies and Health Science	Closed	21/05/21	This risk has been closed as the level of risk has been reduced to 5, reflecting the increased level of confidence in the system, which has been working well over a number of months. It is anticipated that previous issues are very unlikely to reoccur. The current risk score of 5 is within the tolerance level of 6 for a risk in the safety domain.
1018 - Delivery of Q3/4 Operating Plan - Insufficient workforce to support delivery of essential services	Director of Workforce and OD	Closed	07/07/21	This risk has been closed as it relates to the Q3/4 Operating Plan. A new corporate level risk has been assessed in respect of workforce availability to deliver the services required for the continued response to COVID-19, as outlined in the Health Board's Annual Recovery Plan for 2021/22, which will be considered at the next Executive Risk Session.

Note 3 – Increase/decreases in Current Risk Score
Since the previous report to Board in March 2021, there have been changes to the following 2 risks.

Risk	Risk Owner	Previous risk Score	Risk Score Jul-20	Date	Reason
117 - Delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery	Director of Operations	**2x5=10**	**4x5=20** ↑	17/05/21	This risk has increased to reflect the increasing numbers of patients waiting for transfer from all 4 acute hospital sites due to the cessation of the 'treat and repatriate' service in 2020. This is further compounded by acute site pressures at Morriston Hospital – the risk likelihood has consequently been increased from 2 to 4 to reflect the current waiting times averaging 7.7 days. The Acute Coronary Syndrome (ACS)/ Non-ST Segment Elevation Myocardial Infarction (NSTEMI) 'treat and repatriate' service was established in January 2019 and provided 6 ring-fenced beds at Prince Phillip Hospital (PPH) and improved transfer times for Bronglais General Hospital (BGH) and Withybush General Hospital (WGH) patients in particular to address the historical delays experienced by HDdUHB in transferring patients to Swansea Bay University Health Board's (SBUHB) tertiary cardiac service for a range of cardiac investigations, treatments and surgery, in particular transfer delays for ACS/NSTEMI patients requiring tertiary centre angiography/coronary revascularisation within 72 hours of presentation to local secondary care hospital (NICE).
855 risk that the UHB will be unable to address the issues that arise in non-covid related services and support functions.	Chief Executive Officer	**4x4=16**	**3x4=12** ↓	17/05/21	This risk has been reduced to 12 to reflect that levels of COVID-19 patients are at very low levels, and there has been a limited restart of some planned care services since April 2021. Work has also commenced on the waiting list support (Single Point of Contact) programme to support patients waiting for services. This has reduced the likelihood to a 3, giving a rating of 3 x 4 = 12. The likelihood will reduce further once the first tranche of recovery funding is deployed to overcome the UHB's capacity in all planned care services.

Argymhelliad / Recommendation

The Board is asked to consider whether it has sufficient assurance that principal risks are being assessed, managed and reviewed appropriately/effectively through the risk management arrangements in place, noting that these have been reviewed by Board level Committees.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Corporate Risk Register
Rhestr Termau: Glossary of Terms:	Current risk score – Existing level of risk taking into account controls in place. Target risk score - The ultimate level of risk that is desired by the organisation when planned controls (or actions) have been implemented. Risk appetite can be defined as '*the amount of risk that an organisation is willing to pursue or retain*' (ISO Guide 73, 2009). ISO (2009) define risk tolerance as '*the organisation's readiness to bear a risk after risk treatment in order to achieve its objectives*', however it can be simpler to see it as a series of limits such as lines in the sand beyond which the organisation does not wish to proceed.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Gweithlu: **Workforce:**	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Risg: **Risk:**	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Cyfreithiol: **Legal:**	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Enw Da: **Reputational:**	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Gyfrinachedd: **Privacy:**	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Cydraddoldeb: **Equality:**	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.

CORPORATE RISK REGISTER SUMMARY JULY 2021

Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Jul-21	Trend	Target Risk Score	Risk on page no...
684	Lack of agreed replacement programme for radiology equipment across UHB	Carruthers, Andrew	Service/Business interruption/disruption	6	5x4=20	5x4=20	→	3x4=12	3
117	Delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery	Carruthers, Andrew	Safety - Patient, Staff or Public	6	2x5=10	4x5=20	↑	2x5=10	6
624	Ability to maintain and address backlog maintenance and develop infrastructure to support long term strategic objectives	Davies, Lee	Business objectives/projects	6	4x4=16	4x4=16	→	4x4=16 Accepted	9
1027	Delivery of the Plan in Quarter 1- Delivery of integrated community and acute unscheduled care services	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4x4=16	4x4=16	→	3x4=12	14
1032	2021/22 Operating Plan Delivery - Timely access to assessment and diagnosis for Mental Health and Learning Disabilities clients	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4x4=16	4x4=16	→	3x4=12	18
1048	Risk to the delivery of planned care services set out in the Annual Recovery Plan 2021/22	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4x4=16	4x4=16	→	3x4=12	22
750	Lack of substantive middle grade doctors affecting Emergency Department in WGH.	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4x4=16	4x4=16	→	2x4=8	26
646	Ability to achieve financial sustainability over medium term.	Thomas, Huw	Finance inc. claims	6	4x4=16	4x4=16	→	2x4=8	29
813	Failure to fully comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO)	Carruthers, Andrew	Statutory duty/inspections	8	3x5=15	3x5=15	→	1x5=5	32
451	Cyber Security Breach	Thomas, Huw	Service/Business interruption/disruption	6	3x4=12	3x4=12	→	3x4=12 Accepted	37
129	Ability to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda patients	Carruthers, Andrew	Service/Business interruption/disruption	6	4x3=12	4x3=12	→	4x3=12 Accepted	42
628	Fragility of therapy provision across acute, community and primary care services	Shakeshaft, Alison	Safety - Patient, Staff or Public	8	3x4=12	3x4=12	→	3x4=12	47
855	Risk that the UHB will be unable to address the issues that arise in non-covid related services and support functions	Moore, Steve	Quality/Complaints/Audit	8	4x4=16	3x4=12	↓	2x4=8	51
1163	Risk to the delivery of the Health Board's draft interim Financial Plan for 2021/22 of a £25.0m deficit	Thomas, Huw	Statutory duty/inspections	6	N/A	3x4=12	NEW	2x4=8	54
633	Ability to meet the 75% target for waiting times for 2020/21 for the new Single Cancer Pathway (SCP)	Carruthers, Andrew	Quality/Complaints/Audit	8	3x4=12	3x4=12	→	3x2=6	57
291	Lack of 24 hour access to Thrombectomy services	Carruthers, Andrew	Quality/Complaints/Audit	8	3x4=12	3x4=12	→	2x2=4	61
1016	Delivery of Q3/4 Operating Plan - Increased COVID-19 infections from poor adherence to Social Distancing	Rayani, Mandy	Safety - Patient, Staff or Public	6	2x5=10	2x5=10	→	2x5=10	64
634	Overnight theatre provision in Bronglais General Hospital	Carruthers, Andrew	Safety - Patient, Staff or Public	6	2x5=10	2x5=10	→	1x5=5	67
1030	Reputational risk if the Health Board is perceived to not deliver the mass vaccination programme	Jervis, Ros	Adverse publicity/reputation	8	2x4=8	2x4=8	→	2x4=8	70
853	Risk that Hywel Dda's response to COVID-19 will be insufficient to manage demand.	Moore, Steve	Safety - Patient, Staff or Public	6	1x5=5	1x5=5	→	1x5=5	73
854	Risk that Hywel Dda's Response to COVID-19 will be larger than required for actual demand	Moore, Steve	Adverse publicity/reputation	8	1x3=3	1x3=3	→	1x3=3	76

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Management	Tends to be detailed assurance but lack independence
2nd Line	Corporate Oversight	Less detailed but slightly more independent
3rd Line	Independent Assurance	Often less detail but truly independent

Key - Assurance Required	
	Detailed review of relevant information
	Medium level review
	Cursory or narrow scope of review

NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you

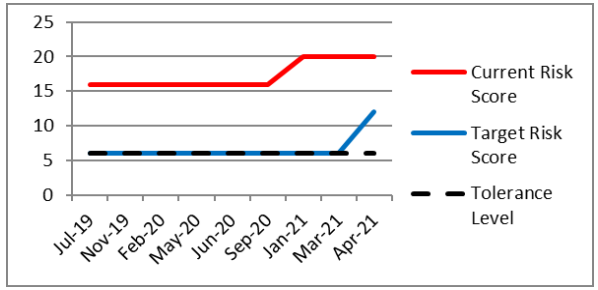
Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective and in proportion to the risk
INSUFFICIENT	Insufficient information at present to judge the adequacy/effectiveness of the controls

Appendix 2

Date Risk Identified:	Jan-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Apr-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	May-21

Risk ID:	**684**	**Principal Risk Description:**	There is a risk radiology service provision from breakdown of key radiology imaging equipment (specifically insufficient CT capacity UHB-wide, and the general rooms and fluroscopy room in Bronglais). This is caused by equipment not being replaced in line with RCR (Royal College of Radiographers) and other guidelines. This could lead to an impact/affect on patient flows resulting from delays in diagnosis and treatments, delays in discharges, increased waiting times on cancer pathways, increased staffing costs to minimise the impact on patients when breakdowns occur and increased number of breaches over 8 weeks due to increased downtime.
Does this risk link to any Directorate (operational) risks?	644		

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	5×4=20
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:

The UHB's stock of imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites which has a significant impact on the UHB's ability to meet its RTT target and impact to patients can include delays in diagnosis and treatment. Presently equipment downtime is frequently up to a week which can put significant pressures on all diagnostic services. Whilst activity has decreased due to COVID, scanning of COVID patients requires more time than non-COVID patients, which will become an issue as requests for diagnostics for non-COVID patients increase as other services resume. Commissioning of agreed equipment has also been delayed as a result of COVID and this remains dependent external factors. Radiology has been asked to increase its service provision to other Directorates which it is currently unable to provide due to limitations on current equipment, however the demountable CT-scanner will provide much needed resilience at GGH. The risk score remains at 20 as a funding has been agreed for 2 out 5 required CT scanners for Hywel Dda, however these will not be commissioned until end of Q3 and Q4 therefore the benefits will not be realised and the likelihood will not decrease until these are in place. Whilst some contingency has been provided by a scanner in a demountable unit this does not provide full cover for acute care (not suitable for complex care).

Rationale for TARGET Risk Score:

Until a formal replacement programme in place, it will not be possible to bring this risk within tolerance and therefore the target score has increased to 15 as it should be possible that when the new equipment is commissioned, this will slightly reduce the risk.

With more modern equipment, breakdowns will be less likely and less significant in terms of downtime together with a reduced impact on the diagnostic services at the remaining hospital sites. Improved business continuity plans will also help reduce the impact of equipment breakdown across the UHB.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports.Some funding has been secured from AWCP for some replacements but does not cover all outdated equipment nor the future requirements. # Escalation process in place for service disruptions/breakdowns. # WG Funding agreed for 2 x CT scanners (GGH & WGH) - to be commissioned by Dec21 and Mar22. # Additional CT secured in the form of a mobile van in December 2020.	Limitation of spare parts for some older equipment leading to extended outages. This issue may be compounded by Brexit. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Reliance on AWCP for replacement of equipment.	Work with planning colleagues about sourcing capital funding through DCP and AWCP.	Evans, Amanda	~~30/06/2019~~ 01/04/2020 31/12/2020 31/03/2021 31/03/2023	Two business cases have been funded by WG. Further Business Cases for the further 3 CT scanners and or General Rooms (depending on priority) to be submitted in 2022/23.Submit updated paper to CEIMTSC to outline current priorities and funding requirements from DCP and AWCP.
		Monthly project meeting to discuss commissioning of agreed equipment with estates, planning and manufacturers.	Evans, Amanda	~~31/12/2020~~ 30/08/2021 31/03/2022	Commissioning equipment is dependent on lockdown measures in and outside of UK and contractor availability to undertake work. Some equipment has already been commissioned, however still awaiting completion of project on MRI in WGH. The commissioning of the 2 CT scanner has been added to project meeting.

Appendix 2

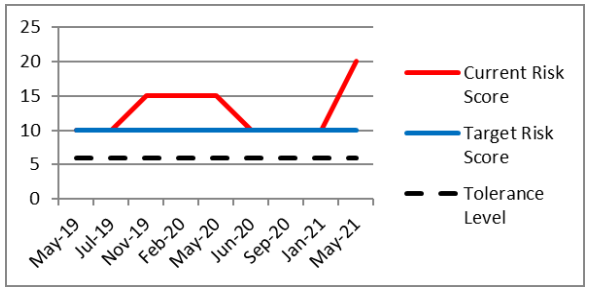
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Reduction of waiting times to under 6 weeks by Mar22. Reduction in overtime costs to nil by Mar22.	Monthly reports on equipment downtime and overtime costs	1st			Radiology Equipment SBAR - Executive Team - Mar19 Further updates CEIMT February 2020 Further updates CEIMT September2020	Lack of process of formal post breakdown review.				
	IPAR report overseen by PPPAC and Board bi-monthly	2nd								
	Internal Review of Radiology Service Report (Reasonable Rating	3rd								
	WAO Review of Radiology - Apr17	3rd								
	External Review of Radiology - Jul18	3rd								

Date Risk Identified:	Feb-11
Strategic Objective:	N/A - Operational Risk

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	May-21
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Jun-21

Risk ID:	**117**	**Principal Risk Description:**	There is a risk avoidable patient harm or death and serious deterioration in clinical condition, with patients having poorer outcomes. This is caused by the delay in transfers to tertiary centre for those requiring urgent cardiac investigations, treatment and surgery. This could lead to an impact/affect on delayed treatments leading to significant adverse clinical outcomes for patients, increased length of stay, increased risk of exposure hospital acquired infection/risks, impaired patient flow into appropriate tertiary cardiac pathways with secondary care CCU and cardiology beds exceeding capacity and inhibiting flow from A&E/Acute Assessment wards.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	↑



Rationale for CURRENT Risk Score:
The UHB has historically experienced delays in transferring patients to Swansea Bay UHB (SBUHB) tertiary cardiac service for a range of cardiac investigations, treatments and surgery, in particular transfer delays for ACS/NSTEMI patients requiring tertiary centre angiography/coronary revascularisation within 72 hours of presentation to local secondary care hospital (NICE). The ACS/NSTEMI Treat & Repatriate service established in January 2019 provided 6 ring-fenced beds at PPH and improved transfer times for BGH and WGH patients in particular. Cessation of the Treat & Repatriate service due to COVID acute site pressures at PPH in 2020 has seen a return to increased numbers of patients awaiting prolonged periods for transfer from all 4 acute hospital sites, which is further compounded by acute sites pressures at Morriston Hospital - the risk likelihood has consequently been increased from 2 to 4 to reflect current waiting times averaging 7.7 days.

Rationale for TARGET Risk Score:
The target score was reduced to 10 in March 2019 on account of the anticipated benefits of the Regional N-STEMI 'Treat & Repat' arrangement. The service initiated in January 2019 saw a reduction in transfer wait from an average of 10.7 to 4 days by April 2019. Whilst the PPH 'Treat & Repat' service is currently suspended, it is anticipated that resumption of this approach would yield the same improvement.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# All patients are risk-scored by cardiac team at SBUHB on receipt of patient referral from HDUHB and discussed at weekly Regional MDT. # Weekday telephone call between SBUHB Cardiology Coordinator and all 4 hospital Coronary Care Units (CCUs) to review patients awaiting transfer, in particular the progress on identified work-up actions. # Medical and nursing staff review patients daily and update the Sharepoint referral database as appropriate to communicate and escalate changes in level of risk/priority for patients awaiting transfer. # Bi-monthly operational meeting with Swansea Bay UHB (SBUHB) to monitor activity/patient flow and address associated risks/issues. # Increased numbers of patients waiting / prolonged transfer delays are identified on daily Sitrep Calls and escalated by HDUHB Cardiology Clinical Lead / SDM to SBUHB Cardiology Clinical Lead / Cardiology Manager. # Reporting arrangements in place to monitor emergency and elective waiting times.	Lack of capacity in tertiary centre to manage a range of specialised cardiac investigations, treatments and surgery. Lack of cardiac catheter capacity in HDUHB to reduce reliance on tertiary centre angiography. Lack of theatre / pacing workforce capacity in HDUHB to reduce reliance on tertiary centre pacing. Lack of CT Coronary Angiography capacity in HDUHB to reduce reliance on in-house and SBUHB angiography. Suspension of PPH ACS/N-STEMI 'Treat & Repat' pathway in 2020.	Increase in-house CT Coronary Angiography (CTCA) capacity. As a less invasive/lower risk diagnostic, this will release and prioritize in-house and tertiary Percutaneous Coronary Angiography capacity for those patients who require it and thereby reduce transfer delays.	Smith, Paul	~~31/01/2019~~ 31/12/2021	SBAR development delayed due to COVID pressures. Cardiology Clinical Lead and SDM currently working with in-house CTCA Steering Group to support SBAR development.
		Develop long term Regional Cardiology Plan.	Carruthers, Andrew	~~30/09/2019~~ 31/12/2022	Decision taken not to establish a regional Cardiac Network/Collaborative in 2019. Development of long term regional plan for cardiology historically overseen by Joint Regional Planning and Delivery Forum and Committee and ARCH workstreams, but progress delayed/activity suspended during COVID. Cardiology Clinical Lead and SDM will engage with the ARCH Regional Cardiology Project' which resumes in June '21.
		Increase in-house cardiac pacing capacity as part of a broader plan to repatriate the pacing LTA from SBUHB.	Smith, Paul	~~31/10/2019~~ 31/12/2021	Pacing SBAR approved by Execs in Sept '19 supporting repatriating Simple Bradycardia Pacing (LTA)from SBUHB. Initial plan to phase repatriation from Spring 2020 impeded by COVID. Cardiology Clinical Lead / SDM to oversee refresh of SBAR/review of feasibility in support of repatriating this activity/pathway.

Re-establish HDUHB ACS/N-STEMI Treat & Repatriate Pathway	Smith, Paul	07/01/2021	Cardiology Clinical Lead/SDM currently drafting SBAR outlining a plan to support restoration of ACS Treat & Repatriate pathway to address current delays/immediate risks in the short-term.
Review ACS/NSTEMI Pathway and longer term plans/requirements to achieve NICE NG185 ACS recommendations.	Smith, Paul	12/03/2021	Cardiology Pathway Transformation Project commencing June '21 to prioritise ACS pathway review in conjunction with current focus on ACS by Clinical Effectiveness Team and Value Based Healthcare Team.
Increase in-house diagnostic Percutaneous Coronary Angiography. This will address current in-house capacity deficit due to patient social distancing as well as reduce reliance on tertiary pathway and thereby reduce transfer delays.	Smith, Paul	31/12/2021	SBAR development delayed due to COVID pressures. Cardiology Clinical Lead and SDM currently reviewing options to support SBAR development.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**		
Performance indicators for Tier 1 targets.	Daily/weekly/monthly/ monitoring arrangements by management	1st			
	Audit of N-STEMI referral undertaken by Cardiology Clinical Lead/SDM on quarterly basis	1st			
	IPAR Performance Report to BPPAC & Board	2nd			
	Monthly oversight by WG	3rd			

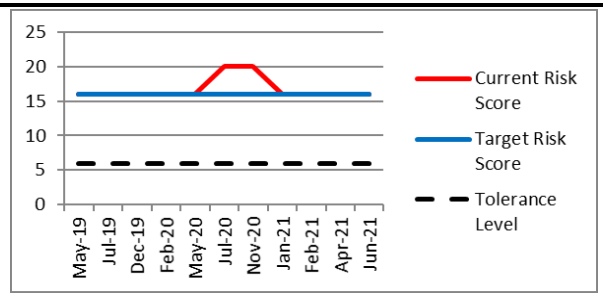
Gaps in ASSURANCES				
Identified Gaps in Assurance:	**How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
Lack of oversight at the Board and Committees.				

Date Risk Identified:	Sep-18
Strategic Objective:	6. Sustainable use of resources

Executive Director Owner:	Davies, Lee	**Date of Review:**	Jun-21
Lead Committee:	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Jul-21

Risk ID:	**624**	**Principal Risk Description:**	There is a risk the UHB will not be able to maintain and address either the backlog maintenance or development of its estate, medical equipment and digital infrastructure, that it is safe and fit for purpose. This is caused by insufficient capital, both from the All Wales Capital Programme and Discretionary Capital allocation. This could lead to an impact/affect on delivery of strategic objectives, service improvement/development and delivery of day to day patient care.
Does this risk link to any Directorate (operational) risks?		Yes	

Risk Rating:(Likelihood x Impact)	
Domain:	Business objectives/projects
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	4×4=16
30/05/2019 - Board 'Accept' Target Risk	
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
Based on knowledge of Welsh Government Capital Fund for imaging priorities, the Welsh Targeted Improvement Programme for Estates Infrastructure, capital receipts during 2021 and the Fire and Major Infrastructure business cases, this risk narrative has been reviewed and the risk score reduced from 20 to 16.

Rationale for TARGET Risk Score:
The target risk score of 16 reflects the actions and processes planned and controls in place to help mitigate the risk.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
* There is an annual programme of replacement in place for equipment, IT and Estates which follows a prioritisation process. * The People, Planning & Performance Committee (PPPAC) and Capital Estates & IM&T Sub Committee (CEIM&T) (to date with IM membership and wide stakeholder engagement in prioritisation process), receive reports and recommendations on the prioritisation and allocation of available capital. *Development of Programme Business Case (PBC) for the implementation of Health and Care Strategy which includes the development of business cases for a new build and repurposing of GGH and WGH sites, this is aligned to the Major Infrastructure Programme Business Case for business continuity on existing sites. * When possible, aligning replacement equipment to large All Wales Capital schemes to minimise the impact on discretionary capital within the UHB. * Completion of the medical devices inventory by the operational management team which helps in the prioritisation of available funds. * Retention of a medical equipment capital contingency to manage urgent issues of repair or replacement. * Review of regulatory reports which have a capital component ie. HIW, WAO, CHC. * Investigating the potential for 'Charitable' funding rather than Discretionary Capital Programme as appropriate. * Communication with Welsh Government via Planning Framework and IMTP (Infrastructure & Investment Enabling Plans) and regular dialogue through Capital Review meetings. * The impact of Covid19 recovery plans on capital requirements for 2021/22 need to be understood for their impact on All Wales Capital and it's impact on the 2021/22 DCP. * Preparation of priority lists for equipment, Estates and IM&T in the event of notification of additional capital funds from Welsh Government i.e. in year slippage and to enable where possible, the preparation of forward plans. This is also addressed through the identification of high priority issues through the annual planning cycle.	Capital funding is significantly short of the level required to deal with backlog maintenance programme for estates, digital & equipment. Impact that COVID recovery may have on the requirement for Capital Resources. No approved funding to deliver the SOP for Digital Improvements.	Digital Bids have been forwarded to Welsh Government to access the £25m in capital and revenue funding available in 2019/20. This is intended however for innovation and the digital backlog issues contained in the PBC submitted to Welsh Government along with other UHBs in 2017 remains unresolved.	Thomas, Huw	Completed	Further digital allocations have been received in 2020/21.
		During 2020/21, the PBC for Major Infrastructure has been submitted to WG to address backlog issues across the UHB. Scrutiny Comments have been received by WG.	Elliott, Rob	Completed	Action complete- the UHB has completed all scrutiny returns with WG to their satisfaction.
		Diagnostic Imaging Priorities for the HB are the completion of the MRI replacement in WGH and CT replacements on all sites. HB has been asked to submit bids to WG for 2 highest priorities which are identified as 2nd CT in GGH and replacement in WGH.	Thomas, Huw	Completed	WGH MRI replacement is currently on site due for completion in June 2021. Bids have been submitted to WG for CT priority replacements 25th February 2021. WG decision on funding is awaited. Funding has been awarded for the two schemes in 2021/22.
		The annual submission of the Strategic Medical Device Replacement report to the CEIM&T Sub-Committee, and the additional investment made through COVID - 19 allocations has increased the number of medical devices in the organisation. Progression of a business case for funding to help address priority backlog areas remains a priority.	Davies, Lee	31/03/2022	It is likely that DCP funds will need to be supplemented through a bid for All Wales capital to support essential replacements for the future. Business case submission will be discussed further with WG.

* Reports to CE&IMT SC set out priorities for imaging equipment and established a much firmer baseline position in relation to medical devices backlog.		Major Infrastructure PBC to be considered at the WG Infrastructure Investment Board (IIB) on 24 June 2021.	Elliott, Rob	24/06/2021	The UHB will be in attendance at this Board to give a short presentation and answer any questions from members of the IIB. If supported the WG will be in a position to Endorse the PBC allowing the UHB to progress the delivery of the investment plan and discuss with WG the allocation of additional resources to appoint the relevant specialist support/Supply chain partners . This is a long term investment programme over an initial circa 7 years then a further period of similar to complete.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance against plan & budget.	Reports of delivery against capital plan & budget	1st			* DCP and Capital Governance Report - PPPAC Apr 21 and CEIM&T Sub-Committee Mar 21 * DCP Report 2021/22 Executive Team Mar 21, CEIM&T Mar 21 and PPPAC Apr 21 * Radiology Equipment Risk CEIM&T Sub-Committee Jan 20 & Sep 20 * Strategic Medical Device Replacement CEIM&T Sub-Committee Jun 20 * Estate Infrastructure PPPAC Oct 20 and CEIM&T Sub-Committee Jul 20 * IM&T Infrastructure					
	Capital Audit Tracker in place to track implementation of audit recommendations	1st								
	Monitoring returns to WG include Capital Resource Limit	1st								
	Datix & risk reporting at an operational management level	1st								
	PPPAC & CEIM&T Sub-Committee reporting (supported by sub-groups)	2nd								
	Bi-monthly Capital Review Meetings with WG to discuss/monitor Capital Programme	2nd								
	NWSSP Capital & PFI Reports on capital audit	3rd								

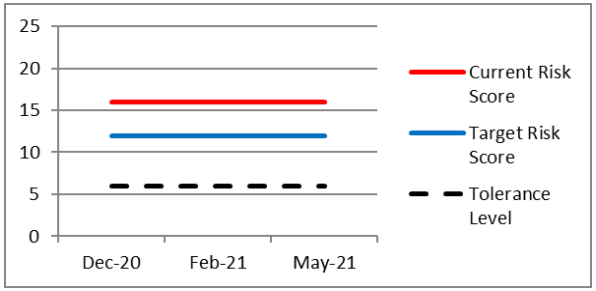
	WAO Structured Assessment 2017	3rd			CEIM&T Sub-Committee Jul20				

Date Risk Identified:	Nov-20
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	May-21
Lead Committee:	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Jun-21

Risk ID:	**1027**	**Principal Risk Description:**	There is a risk there will be disruption to the delivery of our Q1 Recovery Plans. This is caused by increasing fragility within the urgent and emergency care (UEC) system, the impact of COVID-19 on available bed and staffing resources and delays in discharges that are beyond the remit of the Health Board. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increased incidents of a serious nature relating to ambulance handover delays at the front door and delayed ambulance response to community emergency calls, increasing pressure of adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.
Does this risk link to any Directorate (operational) risks?	yes		

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
While case incidence of COVID-19 has regressed and its direct impact on acute care reduced, the level of risk escalation remains. The indirect impact of COVID-19 has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. As a consequence we continue therefore to have reduced availability of beds across acute sectors. This has reduced staffed bed availability across both sectors and has led to increasing delays in the discharge pathway and increasing delays for patients accessing unscheduled care services due to reduced capacity at ED departments. The situation remains fluid and changeable. This risk will be refreshed in Q2.

Rationale for TARGET Risk Score:
There is a significant challenge across the Urgent and Emergency Care system

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage unscheduled care risks on daily basis including multiple daily multi-site calls in times of escalation. # Reviews of patients admitted to surged areas to ensure patient acuity and dependency is monitored and controlled. # Surge beds continue as per escalation and risk assessment of site demand and acuity (where staffing allows). A daily review of the use of surge beds via patient flow meetings to facilitate step down of beds. # Continued use of Field Hospital capacity. # Discharge lounge takes patients who are being discharged. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites. # Regular training on discharge planning and complex care management is provided to ward based staff through Community Discharge Liaison teams, Social services and the Long Term Care Team support. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Escalation plans for acute and community hospitals (within limits of staffing availability). # Winter Plans developed to manage whole system pressures. # Joint workplan with Welsh Ambulance Services NHS Trust. # 111 implemented across Hywel Dda. # Transformation fund bids in relation to crisis response being implemented across the Health Board. # IP&C support for care homes to avoid outbreaks. # Care Home Risk and Escalation Policy. # Ability to deploy Health Board staff where workforce compromise is immediately threatening to continuation of care for residents. # Care Home risk & Escalation Policy to be applied to support failing care homes as required.	# Data has demonstrated that targeted improvement required across our UEC system to reduce conveyance, conversion and improve management of our Complex frail population and ensure enhanced 'front door' turnaround within max 72 hours and improved discharge coordination. # Fragility of Care Home Sector exacerbated by Covid related issues such as financial viability, increasing number of care home bed voids following outbreaks. # Fragility of Domiciliary care due to recruitment and retention of staff exacerbated by increased staff absences due to the TTP process. # Inability to secure GP medical oversight for step down/ intermediate care beds. # Inability to secure multidisciplinary resource to support discharge to assess model in the community. # Insufficient informatics support to enhance Complex Discharge caseload management tool. # Nurse staffing availability to ensure safe levels of care as a consequence vacancies and COVID 19 related absence across acute and community care.	To appoint HCSWs as supernummary aligned to the acute response teams to support failing community care capacity (secondary to COVID outbreak).	Dawson, Rhian	Completed	Appointed and in post.
		To consider alternative models of medical oversight i.e appointment of GP locums aligned to acute physicians	Dawson, Rhian	31/07/2021	Pending hibernation of Field Hospital will release medical oversight.
		Refer CRR 1018 detailing actions to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	31/12/2020	Ref CRR 1018 for detailed progress.
		To appoint additional support to lead on enhancement/ implementation of the Complex Discharge caseload management tool (SharePoint).	Dawson, Rhian	Completed	Appointed.
		To remind services to of the need to undertake robust sickness absence management to ensure staff are able to return to work safely and promptly.	Jones, Keith	Completed	Actioned. Impact of updated shielding guidance continues to limit the return of affected staff.
		To encourage and support staff to participate in the UHB's Covid-19 vaccination programme.	Carruthers, Andrew	Completed	Actioned.

# COVID-19 IP&C Outbreak policy in place to coordinate management of infection outbreaks, led by site HoNs (supported by IP&C teams). # Integrated whole system, cross-sector Winter Preparedness Plan agreed Oct20. # Establishment of a Discharge to Assess Group which reports to the Unscheduled Care group. # Establishment of a D2A Escalation Transfer panel which provides senior oversight of delays, assesses risk of the delay to the patient and organisation in terms of flow compromise	# Reduced acute bed availability due to impact of COVID-19 outbreaks and reduced staffing availability # COVID-19 has further exacerbated workforce capacity and availability of bank and agency staff who would be available.	To support asymptomatic testing pathfinders.	Carruthers, Andrew	Completed	LFT rolled out across targeted clinical areas (outbreak wards, Chemotherapy Day Units & selected planned care wards). Full rollout to priority groups be completed by May21.
		Each County System to produce UEC Improvement plans Implementation of Programme Management Structure in UEC Improvement Secure UEC Transformation fund to resource key deliverables that will enhance improvement capability	Dawson, Rhian	31/07/2021	Bid Submitted. Programme Management Structure to be agreed and implemented.

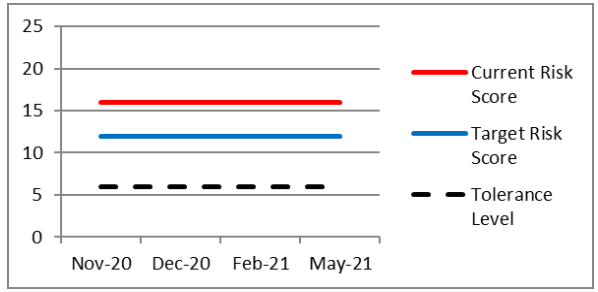
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance indicators for Tier 1 targets. A suite of unscheduled care metrics have been developed to measure the system performance.	Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st				None identified.				
	Daily performance data overseen by service management	1st								
	Delivery Plans overseen by Unscheduled Care Improvement Programme	2nd								
	Bi-annual reports to PPPAC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	Fortnightly monitoring of Winter Plan 2020 delivery.	2nd								
	IPAR Performance Report to PPPAC & Board	2nd								
	WAST IA Report Handover of Care	3rd								
	11 x Delivery Unit Reviews into Unscheduled Care	3rd								
	Delivery Unit Report on Complex Discharge	3rd								

Date Risk Identified:	Nov-20
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	May-21
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Jun-21

Risk ID:	**1032**	**Principal Risk Description:**	There is a risk that the length of time MH&LD clients (specifically ASD, memory assessment and psychology services for intervention) are waiting for assessment and diagnosis will continue to increase during 2021/22. This is caused by new environmental (due to social distancing measures) constraints to undertake required face-to-face assessments and patients' reluctance to attend clinics due to the risk of COVID, as well as certain elements of some assessments being restricted due to other agencies, such as education, providing limited services at present. This could lead to an impact/affect on increasing delays in accessing appropriate diagnosis and treatment, delayed prevention of deterioration of conditions and delayed adjustments to educational needs.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	⟺



Rationale for CURRENT Risk Score:

Referrals for ASD have continued throughout the pandemic at approximately the same level as pre-Covid. The service were experiencing significant waiting times as a result of demand levels. Due to the constraints to undertake the required face to face assessments, the implementation of social distancing and, in some instances patients reluctance to attend clinics due to the risk of Covid, has an impact on the services' ability to see the same volume of service users as they were previously able to. In addition, the estate footprint does not necessary lend itself to accommodate the social distance requirements and in some instances is not therapeutically beneficial.Certain elements of some assessments also being restricted due to other agencies, such as education, providing limited services.

Integrated Autism Service (IAS) is funded on fixed term basis which can make staff retention challenging along with having to train new incoming staff.

Rationale for TARGET Risk Score:

The Directorate is aiming to restore pre-Covid levels of assessment and intervention. This will be dependent on securing recurring funding for the IAS as well as having access to appropriate clinical venues and other agencies being able to undertaken their associated assessments.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Use of IT/virtual platforms such as AttendAnywhere when appropriate. Clinical prioritisation regarding assessment and treatment of service users by engaging in a dynamic process of reviewing waiting lists in line with any other referrals that may be received in respect of that service user. Additional funding provided for recruitment however national shortage of required skills - 3 new staff have been recruited into the ASD team. Services are in contact with individuals to provide information regarding community support, well being at home and guidance should their situation deteriorate. Regular meetings with Women and Children's Service to strengthen interdepartmental working. Process in place to ensure individuals on waiting lists are being contacted periodically through the wait for assessment/treatment to monitor any alteration in presentation.	Social distancing measures reducing the available space/offices that can be used to meet clients face-to face. Certain elements of some assessments also being restricted due to other agencies, such as education, providing limited services. Continued lack of IT impacts on staff who have to work from home not having full accessibility. Estates issues ongoing with no access to clinical areas in some localities to see CYP and unable to access GP or LA sites thus restricting clinical sessions. Telephone assessments ongoing, virtual assessment offered but uptake not good for ASD client group.	Assess and source further IT requirements.	Carroll, Mrs Liz	Completed	Some further IT equipment has been received and distributed on a priority basis. The Directorate will now need to rationalise working from home/agile working in order to maximise the potential office/clinical space.
		Identify alternative venues/space to hold clinics.	Carroll, Mrs Liz	~~31/03/2021~~ 30/09/2021	Working with the Estates Department and exploring options with external partners. Regular meeting with Estates to look at accessing/leasing/enhancing the current MH estates with a view to increase MH estate footprint.
		Head of Service to operationalise	Carroll, Mrs Liz	~~31/12/2020~~ 30/09/2021	Directorate have been asked to participate in Health Board wide Task & Finish group. The Directorate will raise the importance of Service User/Carer input into this group to ensure the patient experience is represented to inform the outcome. Outcome measures will form part of this project.
		Appointment of Service Delivery Manager.	Carroll, Mrs Liz	Completed	Service Delivery Manager has now taken up post.

Services will be in contact with individuals to provide information regarding community support, well being at home and guidance should their situation deteriorate.	Carroll, Mrs Liz	Completed	This process has been enacted.
Identify funding for Interim Clinical Psychologist lead post to assist with the waiting lists and service development.	Carroll, Mrs Liz	~~31/03/2021~~ 30/09/2021	Discussions taking place with Finance Business Partner to progress recruitment.
Health Board is engaging in work with WG to benefit from additional support re waiting lists, demand and capacity planning and service mapping to meet the national standards and new Autism Code.	Carroll, Mrs Liz	~~30/04/2021~~ 30/09/2021	Health Board will be early pilot site providing an early offer for children and young people and their families, who otherwise would be referred for direct support to the NHS.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**		
Welsh Government performance indicators along with internal monitoring arrangements will be used to ensure the actions are having the desires effect or whether there is more that needs to be done.	Management monitoring of referrals	1st			
	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd			

Gaps in ASSURANCES				
Identified Gaps in Assurance:	**How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
System to improve analysis of patient experience	There are outcome measure in place within Psychological Therapies following intervention with a plan to develop a Task and Finish group to look at themes and areas which may require further improvement.	Carroll, Mrs Liz	Completed	Directorate have been asked to participate in Health Board wide Task & Finish group. The Directorate will raise the importance of Service User/Carer input into this group to ensure the patient experience is represented to inform the outcome. Outcome measures will form part of this project.

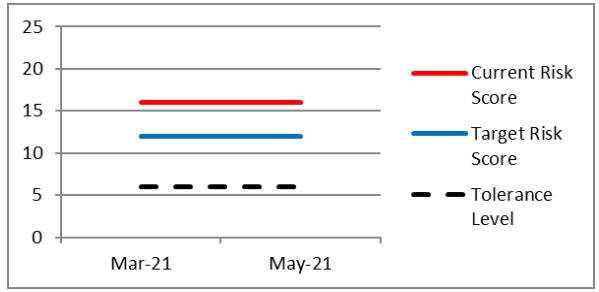
	MH&LD QSE Group overseeing patient outcomes	2nd							

Date Risk Identified:	Mar-21
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	May-21
Lead Committee:	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Jun-21

Risk ID:	**1048**	**Principal Risk Description:**	There is a risk there will be disruption to the delivery of planned care services set out in the Annual Recovery Plan 2021/22. This is caused by , in the short term, the legacy of the impact of the 2nd wave on available capacity and a continuing significant deficit in available staffing resources to support green pathways for urgent and cancer pathway patients. These pressures have necessitated the HB to apply the WG Local Options Framework of actions to prioritise resources for COVID and other essential emergency pathways. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increasing pressure of adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	⟺



Rationale for CURRENT Risk Score:

While case incidence of COVID-19 has regressed and its direct impact on acute care reduced, the level of risk escalation remains.

Limits to staffing resource both in theatre, and post operatively, was a challenge before COVID. The additional factors of providing separate staffing teams for red and green areas, is an added challenge and has shaped the model of provision suggested on each site. It is evident that our realisable capacity in the short term will not match that available prior to Mar20. The plans we have outlined do however reflect the maximum capacity we can achieve within the footprint of our existing hospital sites, particularly during the first half of 2021.

Whilst the plan for increased delivery of elective work (outlined within the HDUHB Annual Plan) is progressing in accordance with the plan outlined, challenges and risks around availability of supporting bed and theatre capacity remain which limits the ability of our clinical teams to expand activity delivery to pre-COVID levels, and further waves of the pandemic.

Rationale for TARGET Risk Score:

Across the UK, there is a significant challenge for health organisations in sustaining the recovery of planned care pathways as they emerge from the 2nd wave of the pandemic. The target score of 12 is based on the realistic assessment of the level of planned care work which can be achieved across the footprint of the HB over the next 12 months and acknowledges this will not reflect levels achieved pre-pandemic due to the current staffing challenge and the impact on capacity and throughput of expected requirements to maintain social distancing and enhanced IP&C procedures.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage planned care risks on daily basis including multiple daily multi-site calls in times of escalation. # Prioritised review of patients based on an agreed risk stratification model. # Provision of 'green' pathway beds on 4 sites (where staffing allows). # Discharge lounge takes patients who are being discharged. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Escalation plans for acute and community hospitals (within limits of staffing availability). # Outpatient transformation programme in place with a continuing focus on alternatives to face to face delivery of outpatient care to enable increases in care volumes delivered. # Risk assessed establishment of AMBER post-operative critical care pathway as a more practical alternative to dedicated GREEN post-operative critical care pathway to increase the flow of appropriate patients. # Robust sickness absence management arrangements in place.	# Nurse staffing availability to ensure safe levels of care as a consequence vacancies and COVID 19 related absence across ward, critical care and theatre areas # Reduced acute bed availability due to impact of COVID-19 outbreaks and reduced staffing availability # COVID-19 has further exacerbated workforce capacity and availability of bank and agency staff who would be available. # Limitations of the physical estate on hospital sites to enable protected/dedicated green pathway critical care facilities	Plan for Q1 & Q2 levels of capacity to be agreed via 2021/22 Annual Plan	Jones, Keith	Completed	Initial plan completed Mar021. Updated plan to be reflected in refreshed Annual Plan to be submitted Jun21.
		Opportunities to enhance dedicated green pathway capacity across sites are subject to continuous review and discussion between respective acute sites and Planned Care Directorate	Jones, Keith	Completed	Green pathways re-established on 4 sites.
		Refer CRR 1018 detailing actions to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	~~31/03/2021~~ 30/06/2021	Updated Workforce Plan to be reflected in refreshed Annual Plan due for submission Jun21.
		Assistant Director of Nursing (Acute Services) leading a review of overall acute nurse staffing resource availability with support from acute site and directorate heads of nursing	Jones, Keith	Completed	Staffing deficits confirmed. Current delivery progressing in accordance with available staffing.
		To remind services to of the need to undertake robust sickness absence management to ensure staff are able to return to work safely and promptly	Jones, Keith	Completed	Actioned however impact of updated shielding guidance continues to limit the return of affected staff.
		Planned Care Recovery programme to be formally established within HB, setting out governance arrangements at Gold, Silver and Bronze levels.	Jones, Keith	~~31/03/2021~~ 31/07/2021	Initial recovery proposals approved by WG with additional funding support confirmed. Delivery Plan for Planned Care Recovery Programme GOLD Planning Objective due for consideration by Executive Team 26May21.

	To support routine testing of staff	Carruthers, Andrew	Completed	LFT rolled out across selected planned care wards and clinical areas.
	Development of ward based post operative enhanced care pathways as an alternative to dedicated green critical care facilities.	Jones, Keith	31/05/2021	Implemented at PPH. Development continuing at other sites, timelines dependent on staffing availability.
	Development of plans to enhance capacity through consideration of demountable facilities and opportunities to develop regional solutions for key pathways (eg cataract surgery).	Jones, Keith	Completed	Proposal submitted to WG April 2021. Non-recurrent funding for 2021/22 confirmed by WG. Formal proposal due to be considered by Board July 2021.

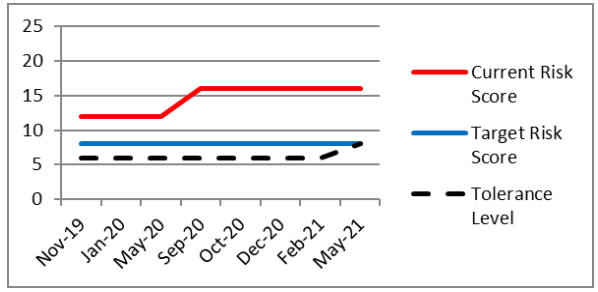
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance indicators for Tier 1 targets. A suite of planned care metrics have been developed to measure the system performance.	Activity volumes are reported daily on situation reports	1st				None identified.				
	Daily performance data overseen by service management	1st								
	Delivery Plans overseen by Acute Services Triumvirate	1st								
	Bi-monthly reports to PPPAC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	Fortnightly monitoring of Winter Plan 2020 delivery	2nd								
	IPAR Performance Report to PPPAC & Board	2nd								

Date Risk Identified:	Jun-19
Strategic Objective:	Delivery of the Quarter 3/4 Operating Plan

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jul-21
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Aug-21

Risk ID:	**750**	**Principal Risk Description:**	There is a risk unavoidable delays in the treatment of patients in Emergency Department (ED) at WGH. This is caused by a lack of substantive middles grade and high reliance on agency locum cover, which is not always available. This could lead to an impact/affect on patient care through prolonged stays in ED and delays in transferring to specialty, delays in diagnosis and treatment, poorer outcomes, and increased ambulance off load delays. Further impacts include inability to run a full rota and a decreased level of supervision of junior doctors, as well as deterioration in Tier 1 performance for 4 hours waiting time in A&E, and increased pressure on WGH financial position through use of agency at an enhanced time.
Does this risk link to any Directorate (operational) risks?	229		

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
WGH should have 7 middle grade doctors to fill rota. The rota remains under constant review and management as the department are fully reliant on temporary staff. The risk has therefore increased to 16 based on 3 substantive & 1 long term zero hours doctors being in place. Unfortunately, only 3 of these doctors work a full rota, including nights. This places additional pressure on the system. 24.12.20 3 posts left to appoint into. Recruited doctors have withdrawn. 1 new appointment due to start beginning of January but will need to customize the NHS program so will not be on the Rota immediately. Other posts are still out to advert, with active interviews being held regularly. Update March: Still have 4 posts left to fill with ongoing recruitment. April, still have 4 post to fill with on going recruitment. May: still have 4 posts to fill with ongoing recruitment. July: interviews taken place, one job offered waiting acceptance. post back out to advert.

Rationale for TARGET Risk Score:
It is anticipated that the completion of the recruitment process of 3 middle grade posts will provide some stability to the department. The contingency plan, which is currently under development, will ensure that robust procedures are in place in the event that the middle grade rota cannot be filled.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Daily review of team strengths by rota co-ordinators and service manager unscheduled care. Issues identified escalated to GM and SDM. Recruitment program on-going to fill gaps and recruit into vacant posts. Medacs agency filling whenever possible with long term locums. Continuous monitoring of the team strengths to ensure consultant and senior support and supervision. Links with other Health Board sites (HDUHB & SBUHB) to outline current pressures and any opportunities to cross cover and to assess overall medical staffing position across HDUHB	Contingency plan for when middle grade shift is uncovered. Inability to recruit middle grade doctors at WGH.	Develop contingency plan to respond to incidences when middle grade rotas cannot be filled in WGH ED.	Cole-Williams, Janice	~~30/09/2019~~ 07/11/2020	Draft procedure under review. Plan A drafted and circulated. Unable to provide ED with ad hoc paediatric middle grade or consultant cover when ED middle grade position is uncovered. Therefore, Plan B currently being drafted.
Weekly Urgent Response Group review rotas for the next six months. 1 x long term locum in place (2 left July 2020). Escalation procedures in place. March 2020 Middle grade rota merged with medical rota to strengthen workforce across 2 Emergency Departments. July 2020 - rotas have now separated as number of inpatients have increased and general medical teams have a larger inpatient & medical take to support.		Complete the recruitment of 4 middle grade doctors.	Cole-Williams, Janice	~~31/12/2019~~ 07/11/2020 13/05/2021	1 Post out to advert. Others offered but candidates are overseas. delays in transporting to the UK due to the Coronavirus pandemic and related travel restrictions.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
A&E 4hr waiting times (<95%) A&E 12hr waiting times (0 target) Number of ambulance handovers over one hour (0 target) Incidents level 4 or 5	Daily review of rotas	1st			* Executive Committee - Jul19 * In-committee Board - Jul19	None identified.				
	Daily review of incident reports	1st								
	Local governance meeting monthly	1st								
	Tier 1 target performance reviewed at Business Planning and Performance Committee	2nd								

Date Risk Identified:	Sep-18
Strategic Objective:	1. Putting people at the heart of everything we do and 2. Working together to be the best we can be and 3. Striving to deliver and develop excellent services and 4. The best health and

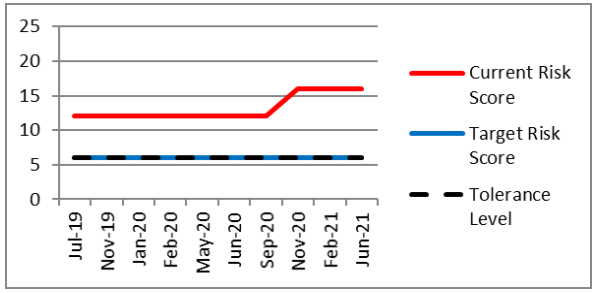
Executive Director Owner:	Thomas, Huw	**Date of Review:**	Jun-21
Lead Committee:	Finance Committee	**Date of Next Review:**	Jul-21

Risk ID:	**646**	**Principal Risk Description:**

There is a risk the Health Board not achieving breakeven over the medium term. This is caused by the inability to either:
1. Develop a sufficiently robust financial plan which shows an achievable improvement trajectory,
2. Manage the impact of the COVID-19 pandemic within available funding,
3. Manage the impact on the underlying deficit of resulting non-delivery of the recurrent savings requirement,
4. Recover the unmet demand arising as a result of actions taken and the financial implications, especially regarding RTT and Mental Health, or
5. Identify and implement opportunities in such a way that the financial gains are realised and an improvement trajectory is achieved. This could lead to an impact/affect on a significant long term detrimental impact on the Health Board's financial sustainability.

Does this risk link to any Directorate (operational) risks?	Corporate risk

Risk Rating:(Likelihood x Impact)	
Domain:	Finance inc. claims
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	⟺



Rationale for CURRENT Risk Score:

Issues have been raised over the ability of the Health Board to plan at a strategic and operational level for a number of years. The Health Board's performance over the last year has demonstrated a significant improvement in the ability to operationally plan and a developing maturity within the organisation. However, the Health Board's financial deficit has significantly deteriorated; significant workforce constraints remain; and the planning function remains small with significant opportunities to develop. These issues are exacerbated given the Health Board's financial deficit, with the need to not only shift resources to more appropriate settings, but provide care at considerably lower cost.

The Health Board's underlying deficit requires further refinement to fully explore and understand the opportunities for improvement which can be realised over the medium term. The forecast financial impact of COVID-19 on the underlying position is currently informed by modelling intelligence due to the fluid nature of the pandemic and the multitude of unknown variables inherent in such a situation. Furthermore, the funding from Welsh Government in response to the brought forward underlying position from FY21 (due to unidentified savings) has been confirmed on a non-recurrent basis. The WG funding for the direct response to the pandemic and for Elective Recovery plans is currently non-recurrent for FY22. For both, the recurrent funding position remains uncertain.

Rationale for TARGET Risk Score:

Achieving financial balance on a three-year rolling basis is a statutory requirement for the Board, and a clear requirement from the Board and Welsh Government.

Strategic and operational planning in an integrated Health Board is inherently complex leading to potential disconnections between demand, operational capacity planning; workforce planning and financial planning.

Given the challenge in delivering the savings required in FY21, a further (currently unidentified) requirement of £16.1m in FY22, and the implications of this in the medium term, it is unlikely that the Health Board will achieve a risk which is in line with the tolerable risk for the year. Consequently, the target risk score exceeds the tolerable risk at this point. This is not an acceptable position, and further work is ongoing to manage this risk.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Understanding the underlying deficit and Opportunities Framework. A pre-COVID-19 assessment has been completed, which will need to be refined as part of the Roadmap to Financial Sustainability. Very high level base-case long term financial model. A Planning Steering Group is in place to co-ordinate activities across key corporate functions. The Planning Team are embedded within the operational management structures across the organisation. A Strategic Enabling Group is in place to co-ordinate improvements to the Health Board's key systems to improve systems and processes across the organisation, including: Improving together - a programme to embed a quality management system to ensure consistency of approach in addressing quality and service improvement throughout the organisation. Agile Digital Business Group - a Group which reports into the Finance Committee which scrutinises business cases on digital investment to allow a rapid allocation, allocate resources promptly, learn from previous business case implementations and disinvest if appropriate. Value Based Health and Care Group: which ensures that the Health Board's rollout and deployment of VBHC is in line with plans and will facilitate the shift of resources over time.	Actions in response to external review of underlying deficit calculation largely superseded by necessary shift in focus in response to COVID-19. Assessment of impact of COVID-19 on underlying deficit requires refinement. Assessment not subject to planning scrutiny. Conversion of the Opportunities Framework, Savings Framework and Value for Money Framework into deliverable recurrent savings schemes. Early development of three-year Financial Plan.	Rollout of Improving Together across the organisation, with a feedback loop into relevant Corporate Teams to ensure that improvements are delivered at pace.	Thomas, Huw	~~30/04/2024~~ (Commencing Jun21)	Improving Together to be formalised into July 2021 System Engagement Meetings.
		Rollout of Value Based Healthcare (VBHC) across the organisation alongside the costing for the work.	Kloer, Dr Philip	31/03/2022	Refer to the VBHC action and rollout of identified pathways delivery timelines.
		Rapid deployment of digital solutions to support with better intelligence allowing better local decision-making based on evidence.	Thomas, Huw	31/03/2022	Refer to the Digital Strategy for actions and delivery timelines.
		The Executive Team are to determine the priority items on the Opportunities Framework to pursue in line with the Strategy and Roadmap to Financial Sustainability. The Finance and Operational teams will then need to convert these opportunities into deliverable recurrent savings schemes.	Thomas, Huw	30/09/2021	The framework has been presented to the Executive Team and is a key area of focus following the submission of the Annual Plan at the end of June.

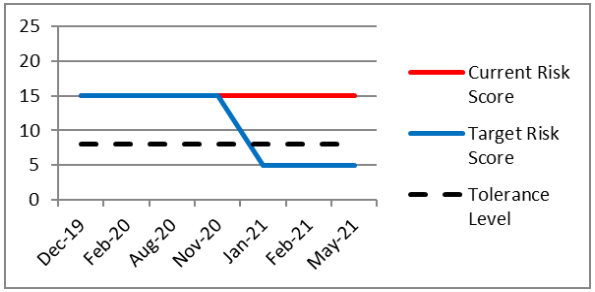
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Operational agreement to underlying deficit assessment. Welsh Government accepting of impact of COVID-19 on underlying deficit. Plan in place to develop a long term financial plan. High level financial assessment of A Healthier Mid and West Wales in place.	Reporting to Finance Committee .	1st			N/A	None				

Date Risk Identified:	Oct-19
Strategic Objective:	3. Striving to deliver and develop excellent services

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jun-21
Lead Committee:	Health and Safety Assurance Committee	**Date of Next Review:**	Jul-21

Risk ID:	**813**	**Principal Risk Description:**	There is a risk of failing to fully comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO). This is caused by 1. A lack of available resources within the current operational maintenance function, to undertake a fully HTM compliant pre planned maintenance programme (PPM's) for all fire safety components across the entire HB's estate. 2: The age, condition and scale of physical backlog, circa £20m relating to fire safety across our estate significantly affects our ability to comply with the requirements of the RRO in every respect. 3: A lack of fire safety ownership and understanding of fire safety responsibilities at local hospital management level. This could lead to an impact/affect on the safety of patients, staff and general public, HSE investigations and further fire brigade enforcement, fines and/or custodial sentences, adverse publicity/reduction in stakeholder confidence.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Statutory duty/inspections
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	1×5=5
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:

Despite significant progress being made since the NWSSP IA Fire Precautions Report in May 2017 with regards to the key recommendations, such as, the establishment of a fully resourced fire safety team, the embedding of appropriate reporting arrangements for fire safety and addressing the backlog of out of date fire risk assessments across the UHB. There are still some significant challenges faced by the UHB to fully comply with the fire safety order.

Whilst the fire safety team are in a position to provide support now to the UHB in the form of expertise and technical knowledge. The UHB still needs to manage and address the physical backlog of fire safety across its estate. Also successfully embed an improved fire safety management culture and management ownership for fire safety. This is evident from the recent fire safety improvement notice (FSIN) served on the UHB in Sep19 for Withybush General Hospital and Glangwili General Hospital on 17Apr20.

Rationale for TARGET Risk Score:

Whilst it is likely that the UHB will address its staff shortfall issues in respect of fire safety for HTM compliance there are further improvements in culture and ownership for fire safety. It is the scale of physical backlog for fire safety compliance (circa £8m at present predicted to increase following additional surveys) that will remain until appropriate measures are put in place to address the deficit.
Despite annual investment from statutory capital for fire safety components (circa £200k), the scale of current investment is clearly not adequate to address the true scale of backlog the UHB has.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
1.Pre Planned Maintenance (PPM) checks are carried out across the UHB on fire safety components. 2. A detailed physical estates backlog system is in place that identifies the scale (£) and risk of backlog for UHB. Data used to manage backlog maintenance & statutory decision making also regularly reported to WG. 3. Individual Fire Risk Assessments (FRA's) in place for all sites across the UHB identifying fire related risks. 4. Training Needs Analysis (TNA) for fire safety training in place, as defined in Fire Policy. 5. UHB has implemented a governance structure for fire safety reporting. 6. Estate plans with fire zones, fire doors, fire compartmentation, fire infrastructure items (alarm and detection system). 7. UHB assesses its performance in respect of operational maintenance work carried out on fire safety components and presents this information as a formal paper at all UHB wide fire safety meetings. 8. Annual prioritisation of investment against high risk backlog.	Significant staff shortfall to achieve agreed level of operational compliance (>85% target) for fire safety and other Health Technical Memorandum (HTM) engineering disciplines Significant additional investment is required to address physical and engineering backlog shortfall for the UHB (approx circa £20m). Inability to allocate fire risk actions to appropriate owners on current fire risk assessment system hosted by NHS Wales Specialist Estates Services (NWSSP-SES). Inability to manage and control recommendations within the HB's own Fire Risk Assessments. Shortfall in advanced fire safety training especially in bariatric evacuation.	Secure funding for the identified staffing gap identified in the operational staff gap analysis (based on size, geography and estate of the organisation)	Williams, Heather	Completed	A business case for additional staff support has been approved by the executive team subject to review by NWSSP-SES to substantiate its accuracy. Job descriptions have now been created for these roles, jobs are on Trac and interviews scheduled for April 2020.
		Reassess remaining backlog and develop a prioritised plan that will address the high risk areas and where possible, will align to TCS modernisation programme for the UHB. A Programme business case is being developed for the remaining acute hospital sites to identify key fire safety compliance issues in order to seek for additional capital funding.	Elliott, Rob	~~31/03/2020~~ 30/06/2021	Additional surveys across the estate are being scheduled to assess the scale of fire backlog. The HB has now developed a detailed programme for both WBH and GGH to deal with all fire enforcement notices and letters of Fire Safety issued by the fire brigade (NWWFRS). In the case of WBH, Tripartite meetings with WG,HB and MWWFRS have taken place to agree a programme of investment and business case development. In the case of GGH the HB has submitted a detailed programme to MWWFRS which has been agreed. (Whilst verbal agreement been given by MWWFRS we await formal written confirmation) A meeting is planned for mid to late September on Tripartite bases to agree the same process as WBH.

Introduce a system to manage fire risk assessment recommendations more effectively. System to have the ability to assign risks to risk owners, to track/manage risk and to demonstrate progress on the actions.	Evans, Paul	~~31/03/2020~~ 30/06/2020 28/01/2021 30/06/2021	The fire team are utilising the current system as best as possible. An Excel system is being introduced (completion Jun20) however a more robust automated system is needed by the HB to track the significant number of actions. Progressing this has been delayed due to COVID-19, however quotes have now been obtained and are under discussion with the Director of Facilities. Approval has now been provided to purchase a system. Completion date for system implementation with live data by June 2021
Undertake a review of fire training to address identified shortfall in training provision and site fire management responsibilities.	Evans, Paul	~~31/03/2020~~ 31/12/2020 20/01/2021 30/06/2021	A review has been undertaken and an action plan produced with the learning development teams. The HB has reintroduced the e-learning module for all levels of training instead of the face to face method which was suspended due to COVID-19, to improve fire training compliance which has dipped over recent months. A target of 85% for advanced training has been agreed, which will be achieved by Dec20. General fire safety training currently stands at 71%, which is not considered a concern at this stage and will now improve following the e-learning implementation. This will be reviewed monthly.

	Clarify responsibilities and identify management ownership for fire safety to facilitate an improved fire safety management culture across all sites. Revised date agreed as part of fire safety governance review.	Evans, Paul	~~30/09/2020~~ 31/01/2021 30/06/2021	General Managers (GMs)and Responsible Persons have been identified across the UHB who have responsibility for fire safety on sites. This will be supplemented with site management training (level 5 training for all responsible managers which was to be introduced by Mar20). This work has been delayed due to COVID-19 however regular discussions with GMs is taking place to remind them of their ongoing responsibilities.
	Undertake a review of scale of work required to improve fire drawings in the UHB.	Evans, Paul	Completed	CAD officer now in post for West region and started his work programme. CAD officer for East commencing in Feb 2021.
	Review the compliance report to include the gaps associated with any risks on the fire safety components and not just levels of PPM performance.	Evans, Paul	Completed	An update template has already been produced and discussed amongst the fire and operational maintenance teams. The compliance paper is tabled at all Fire Safety Group meetings. This is now being taken forward as the model for the department. Next review of this is on the 27th Jan 2021.

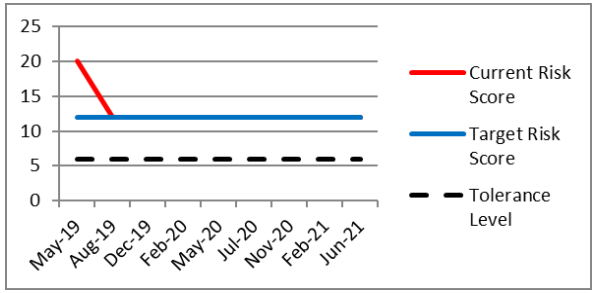
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Maintain 95% high risk PPM compliance. Maintain a zero number of outstanding fire risk assessments.	Bimonthly review of outstanding actions from fire risk assessments	1st			IA Fire Precautions Report - ARAC Jun18 Fire Action Update - H&SC - May20	General site management checks/walkarounds on all sites	Responsibilities of site management to undertake routine workarounds to be implemented level 5 training	Evans, Paul	~~30/09/2020~~ 31/12/2020 20/03/2021 30/06/2021	Site management training (level 5) training for all responsible managers which will be introduced by March 21 - delay due to Covid 19 .
	Site Fire wardens reporting fire safety issues	1st								
	Review of compliance through fire safety groups	2nd								
	Compliance reports regularly issued to HSEPSC	2nd								
	Fire inspections by Fire Service & Fire Improvement Notices	3rd								
	NWSSP fire advisor inspections	3rd								
	NWSSP IA Fire Precautions Follow Up May-18 - Reasonable Assurance	3rd								

Date Risk Identified:	May-17
Strategic Objective:	N/A - Operational Risk

Executive Director Owner:	Thomas, Huw	**Date of Review:**	Jun-21
Lead Committee:	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Aug-21

Risk ID:	**451**	**Principal Risk Description:**	There is a risk the Health Board experiencing a cyber security breach. This is caused by a lack of defined patch management policy, lack of management on non-ICT managed equipment on network, end of life equipment no longer receiving security patching from the software vendor, lack of software tools to identify software vulnerabilities and staff awareness of cyber threats/entry points. This could lead to an impact/affect on a disruption in service to our users cause by the flooding of our networks of virus traffic, loss of access to data caused by virus activity and damage to server operating systems.
Does this risk link to any Directorate (operational) risks?		451, 356	

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	3×4=12
30/05/2019 - Board 'Accept' Target Risk	
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:

There are daily threats to systems which are managed by NWIS and UHB. Current patching levels within the UHB of is on average 94% for desktop/laptops and 91% for the server infrastructure (May 2021). The patching levels fluctuate during the month depending on the number of updates released by the 3rd party vendor. Alongside the fluctuations there is lack of capacity to undertake this continuous work at the pace required. Impact score is 4 as a cyber-attack has the potential to severely disrupt service provision across all sites for a significant amount of time, however the processes and controls in place have reduced the likelihood due to the improvements in patching.

Rationale for TARGET Risk Score:

Increased patching levels will help to reduce to impact of disruption from a cyber threat. However this work is continuous and is dependent on obtaining the appropriate level of resources to undertake the patching anti-virus work at pace. The target risk score of 12 reflects the wider risk to other applications not Microsoft. The Board have accepted that there is an inherent cyber risk to the organisation, and have therefore accepted that the risk cannot be reduced lower than 12.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Controls have been identified as part of the national Cyber Security Task & Finish Group. Continued rollout of the patches supplied by third party companies, such as Microsoft, Citrix, etc. £1.4m national investment in national software to improve robustness of NWIS. Further Task and Finish Group established to review the future patching arrangements within NHS Wales - this will lead future work locally to implement recommendations. Capital funding has been made available by WG in 2018/19 to improve cyber security - this will be used to purchase required software/equipment for penetration testing. Additional UHB funding.	Lack of comprehensive patching across all systems used in UHB. Lack of staffing capacity to undertake continuous patching at pace. Lack of dedicated maintenance windows for updating critical clinical systems.	Work with system owners to arrange suitable system down-time or disruption.	Solloway, Paul	Ongoing	Patching policies have been created however little progress has been made due to lack of resources. Service catalogue creation is progressing well and this will be amalgamated with Information Asset Owners group to agree down-time for the key local systems. However patching KPI's will not be met until sufficient technical resources are in place.
		Continue to implement the recommendations of the Stratia report	Solloway, Paul	Ongoing	The additional resources will be targeted towards the recommendations
		Implement the national products previously purchased (i.e. Security Information Event Management (SIEM)	Solloway, Paul	Ongoing	The additional resources will be targeted towards the recommendations
		Hire agency staff until such time that a permanent resource can be appointed.	Tracey, Anthony	Completed	The first round of appointments did not provide suitable candidates so agency staff will be used to provide progression of the recommendations.

		Appoint a dedicated cyber resilience resource to take forward the recommendations outlined within the Stratia report, and the recent Audit Wales Report, presented to ARAC.	Tracey, Anthony	Completed	The New Cyber Resource began in May 2021, and is in the process of addressing the Stratia report, and developing a Cyber Resilience Plan. The Digital Team, have also contracted with a third party company to work with us to develop our Cyber Resilience Plan.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
No of cyber incidents. Current patching levels in UHB. No of maintenance windows agreed with system owners. Removal of legacy equipment.	Department monitoring of KPIs	1st			External Security Assessment - IGSC - Jul 18 Update on WAO IT follow-up - ARAC - Oct19	National accreditation.	Progress the attainment of certificates and assurances as outlined by the National Cyber Security Centre (NCSC)	Tracey, Anthony	Ongoing	Regular reports on progress on External assessment to IGSC
	IGSC monitoring of cyber security workplan addressing recent internal and external audits/assessments	2nd								
	IGSC monitoring of National External Security Assessment	2nd								
	Follow-up Information Backup, Disaster Recovery & Business Continuity and Data Quality: Update on Progress	3rd								
	NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB) Oct17	3rd								
	WAO IT risk assessment (part of Structured Assessment 2018	3rd								

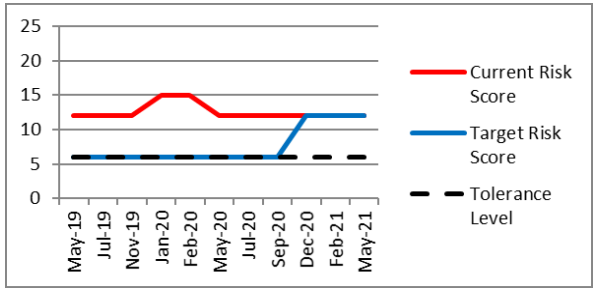
Internal Audit IM&T Security Policy & Procedures Follow-Up - Reasonable Assurance	3rd							
IM&T Assurance - Follow Up - Reasonable Assurance - May20	3rd							
Cyber Security (Stratia Report) - Reasonable Assurance - Feb20	3rd							

Date Risk Identified:	Apr-17
Strategic Objective:	N/A - Operational Risk

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	May-21
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Jul-21

Risk ID:	**129**	**Principal Risk Description:**	There is a risk disruption to business continuity of the Hywel Dda Out of Hours (OOH) Service. This is caused by a lack of available of labour supply as GPs near retirement age and pay rate differentials across Health Boards in Wales impact the UHB's ability to recruit in the mid-long term. In the short term, any lifting of COVID-19 lock down measures (all clinicians are currently working as holidays and foreign working are temporarily unavailable to them) as well as possible impacts on in-hours provision is likely to result in a fragile workforce position once again. This could lead to an impact/affect on a detrimental impact on patient experience and the unscheduled care pathway.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×3=15
Current Risk Score (L x I):	4×3=12
Target Risk Score (L x I):	4×3=12
26/11/2020 - Board 'Accept' Target Risk	
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:

The COVID pandemic combined with the temporary overnight service changes has brought some respite to the service fragility, and this is reflected in the current risk score. Stability in the Carmarthen rota is now being seen but it coincides with destabilisation within Pembrokeshire. Any further absence on out of hours provision is likely to rapidly result in further deterioration of the current position.
As of May 2021 there has been no notable change/definite trend in the service fragility.

Rationale for TARGET Risk Score:

Service rota positions remain variable with continued shortfalls in clinical cover variably affecting service provision. Despite the Carmarthen base rota now predominantly being stable, shortfalls in Pembrokeshire and Ceredigion have become evident- and this is further compounded by the need for staff to take leave. Medium term actions are still required, especially in terms of service modernisation. Work to develop a long term plan for OOH Services has now recommenced following Covid-19 and the settling in period of the new Service Delivery Manager, in order to reduce this risk on a permanent basis so to ensure the out of hours service provision is not interrupted. Workforce and service redesign requirements have been flagged as part of the IMTP.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# GP's rotas across the 3 counties are now managed centrally via the administration team based in Haverfordwest # Dedicated GP Advice sessions in place at times of high demand (mostly weekends). # Remote working telephone advice clinicians secured where required. # Additional remote working capacity has been secured to assist clinicians who may be shielding/ isolating to continue to support operational demand. # Workforce support from 111 programme team in addressing OOH fragilities available if required. # Health Professional feedback form in use between clinicians, service management and 111 (WAST) leads. # WAST Advance Paramedic Practitioner (APP) resource enhanced to provide more flexibility. # Rationalisation of overnight bases in place since March 2020, now subject to service review. # Workforce and service redesign requirements flagged as part of IMTP.	The ability to influence workforce participation remains limited due to the lack of contractual agreements (reliance on sessional staff). At present the staffing remains challenging despite a stable rota now being agreed at the Carmarthen base- there are shortfalls in Pembrokeshire and Ceredigion that are affecting service provision throughout the 7 day operating period. Need for formalised workforce plan and redesign is still required - reflected in IMTP submission. In relation to service demand, activity appears to have stabilised but Covid continues to influence the risk-position, complicated by the inability to see red flow patients in an Out of Hours setting. The focus on delivery of care via the telephone advice method is the significant factor in stabilising the risk at this time (70-80% of consultations is now dealt with on the phone)- but any reduction in capacity remains likely to require an increase in the risk level as the service	Ensure Transforming Clinical Services Programme incorporates a long term, viable plan for OOH.	Rees, Gareth	~~30/09/2020~~ 31/12/2021	As of January 2020 the development of a detailed redesign plan is underway but the timescale has yet to be identified. Feb 2020- this work is continuing to progress and work on medium term resolution has now commenced. March 2020- Working group stood down due to Covid-19 commitments June2020- Requests to restart working group are subject to re-prioritisation. Dec2020- inclusion in new IMTP process, awaiting decision on how to progress with service change. Delayed by Covid-19. Feb2021- Change in SDM, now subject to new focus. Still awaiting decision/direction on how to progress with service change. May 2021- Still awaiting decision/direction.
		Development of home working provision for GPs.	Rees, Gareth	Completed	Completed and evolving.

	delivery will be adversely affected.	Implement a change to the pathway in PPH Minor Injury Unit as authorised by Executive Team 06/11/19	Davies, Nick	Completed	ET approval gained following discussions with affected GP groups. Further engagement with affected staffing groups has been completed. New provisional dates agreed by engagement on 07/01/20. On target for rationalisation of night base cover from 09 March 2020
		Investigate potential external alternatives to current workforce position.	Davies, Nick	Completed	The Service is working with shared services and the 111 programme to develop a GP Hub where locum sessions can be accessed centrally to support service provision. This is similar to the Covid GP Hub and is supported by GP Wales. Access to this workforce stream (coordinated by GP Wales/111 project team) is anticipated to be available by end of December 2020
		Review the rationalisation of overnight temporary service change.	Richards, David	~~31/05/2021~~ 30/09/2021	New SDM now in place. All operational staff are aware that this review is now underway as of February 2021. The review is being designed and will look at patient demand and experience, and service risks. As of May 2021 this is being actively reviewed with the Director of Operations. The consultations will now take place into June 2021 with outcomes to be reported to the relevant UHB Committees in September 2021.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Bi-monthly IPAR. National Standards and Quality Indicators-submitted monthly to WG. Issues raised, and performance Matrix reviewed, at National OOH forum (bi-monthly, attended by WG).	Daily demand reports to individuals within the UHB	1st			QSEAC OOH Update Sep19 & Feb20 QSEAC - Peer review - Feb20 QSEAC- Review of risk 129 - Oct20 QSEAC- Review of risk 129 Apr21 ET- Risk to OOH business continuity - Sep19 ET- OOH resilience - Nov19 & Jan20 BPPAC Quarterly monitoring Nov19 BPPAC - update on the OOH Services peer review paper Dec19 BPPAC - OOH service design Feb20	Lack of meaningful performance indicators.	Assess NHS 111 performance metrics to understand how they may influence Hywel Dda OOHs performance, and if a viable alternative - which may support improvement in shift fill.	Davies, Nick	Completed	New 111 Wales performance metrics are being prepared and will soon be circulated for review.
	Twice a week sitreps and Weekend briefings for OOH	1st								
	Monitoring of performance against 111 standards	1st								
	Issues raised at fortnightly meeting with Primary Care Deputy Medical Director and Associate Medical Director	1st								
	Monthly report to Joint Operations Group (WAST, 111 team & 111 Health Boards)	2nd								
	PPPAC monitoring	2nd								
	QSEAC monitoring	2nd								

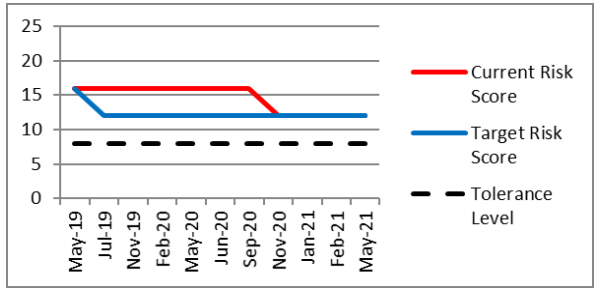
Issues raised, and performance Matrix reviewed, at National OOH forum (bi-monthly, attended by WG)	3rd							
WG Peer Review Oct 19	3rd							

Date Risk Identified:	Sep-18
Strategic Objective:	2. Working together to be the best we can be

Executive Director Owner:	Shakeshaft, Alison	**Date of Review:**	Jun-21
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Jul-21

Risk ID:	**628**	**Principal Risk Description:**	There is a risk that patients in need of therapy services do not receive them in a timely period or do not receive the required level or intensity. This is caused by gaps or fragile staffing levels in the therapy service provision across acute, community and primary care settings from historical under-resourcing, exacerbated by recurrent savings targets, vacancies and recruitment/retention issues due to national shortages. There is the additional challenge that COVID-19 has placed upon workforce models due to increased complexity and acuity of patients presenting post lockdown having had treatments suspended of not able to access timely care. This could lead to an impact/affect on patient outcomes, longer recovery times, increased length of stay, a reduction in performance against performance targets including 14 week waiting time, non-compliance with clinical guidance, and potential adverse impact on patient safety/harm.
Does this risk link to any Directorate (operational) risks?	yes		

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	8
Trend:	⟺



Rationale for CURRENT Risk Score:

#Therapy service provision across acute, community and primary care continue to be challenging, as described in the cause section, but have improved following additional resourcing (Major Trauma, Nutrition, Rehabilitation, Lymphoedema, Dementia, MSK, Winter Funding) , workforce redesign and over recruitment of Band 5 graduates (Physiotherapy, OT, Podiatry & S&LT).

#Impact to service provision by COVID-19 pandemic and rehabilitation requirements have added an additional challenge to workforce models, but have also enabled the roll out at scale of digital and virtual consultations.

#Across therapy services, current demand is largely being met for new patient referrals, apart from those clinical areas where physical delivery of hands on treatment is impacted by the demands of physical distancing and IP&C requirements.
Post Covid Recovery modelling suggests additional demand to support patients displaying ongoing symptoms post 12 weeks Acute Covid infection, with complex rehabilitation needs.
Further work is underway to understand the potential additional demand for rehabilitation for those indirectly affected by the interruption of access to routine service provision.

Rationale for TARGET Risk Score:

The target risk score has been assessed as 12 as although priority areas have been agreed and progressed, the risk will not be completely addressed in the coming year. A sustainable therapy workforce solution aligned to the Health and Care Strategy has been agreed. The following high impact/workforce priority areas were prioritised within the Annual Plan for focus during 2020/21: older people (incorporating frailty and stroke); improving self-management (including pulmonary rehabilitation and diabetes); therapists as first point of contact in primary care (including musculoskeletal, older people and irritable bowel syndrome); Major Trauma Plan. An additional requirement will be the delivery of the COVID-19 Rehabilitation Framework, and work is underway to identify the impact of this locally. A sustainable solution is currently in place 14 week waiting time target, with additional support required for Occupational therapy and Podiatry as a result of IP&C requirements. Therapy services will continue to pursue practical, prudent and incremental workforce solutions to improve patient care, outcomes and experience, and to ensure sustainably funded models are identified through whole-system review and potential shifting of resource from elsewhere in the health and care system.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Individual service risks identified and discussed at a range of fora; i.e. QSEAC, OQSESC, Performance Reviews and Therapy Forum. # Priority areas agreed in the 2020/21 Annual Plan, to increase capacity in key areas identified in plan. Additional Capacity created in MSK service # Locum staff utilised where appropriate, funded from within core budget (2 vacancies required to fund 1 Locum) # Short-term contracts/additional hours within budget used to cover maternity leave. # Training of support staff to safely deliver delegated tasks. # Over-recruitment of Newly Qualified Staff / B5 staff where appropriate and approved by the Clinical Director to mange foreseeable and predictable staffing level capacity gaps. # Local solutions include review of each vacant post to make them attractive, including skill mix review, early advertisements for new graduates. # Student streamlining of B5 graduates from June 2021 # Prioritisation of patients is undertaken through triage and risk assessment by therapy services. # Use of Digital Platforms to support agile working and remote access # Continued training of the Malcomess Care Aims Framework for MDT/Therapy Service.	Inability to secure funding for all developments identified in 21/22 annual plan. Shortage in some clinical specialities of qualified and specialist staff nationally Rurality of HDdUHB has historically limited applications to some posts. Unplanned service development due to short term or opportunistic funding. Lack of cohesive approach to workforce planning across therapy services. Reactive deployment of Therapy workforce to support surge or Covid Pandemic response.	Developing robust plans to evidence improved patient outcomes and experience through reprovision of resource from elsewhere in the health and care system aligned with strategic direction of the HB. This is a significant, long term piece of work, which will need to run alongside strategic development through the Health and Care Strategy. This will include skill mix review such as new HCSW and Advan	Reed, Lance	Completed	Plans under development. Funding already secured for developments in pulmonary rehab, dementia, lymphoedema and to support some increase in front door/acute therapy input including plans to address malnutrition. Continued operational and strategic engagement with DoTHS, DOO, HoS, CDs and GMs to address COVID-19 response and to service developments that would release resource and savings from the wider health and care system through increased therapy provision, including areas of pathway re-design. WG funding for Therapy Assistant Practitioner HCSW role to support workforce model changes.
	Appropriate resources to support Covid recovery and Long Covid demand	Ensure process for robust workforce planning is in place to inform HEIW in respect to future graduate numbers required by the UHB/Region, which are aligned to the Health and Care Strategy workforce plan.	Shakeshaft, Alison	Completed	Long-term piece of work informed by action above on an annual basis. Lead in time of 3 years to benefit from graduate programme. HEIW AHP Streamlining to commence 2021

	Pursue opportunities to attract local people into therapy careers in the HB, eg 'grow your own' schemes, apprenticeship programmes, development of career pathways from HCSW to graduate, development of local graduate training programme.	Reed, Lance	Completed	Commitment given to extend apprenticeship scheme to AHPs, agreed from 2020. Variety of HCSW training modules for level 3 and 4 developed and being implemented. HEIW review to commission local training provision for Physio & Occupational Therapy Undergraduate Training locally.
	Develop robust workforce plans that align to stroke, major trauma and neurology and COVID-19 rehabilitation service needs to maximise workforce opportunities.	Shakeshaft, Alison	~~31/03/2020~~ 31/03/2022	Plan being developed as part of Therapy 3 Year Plan 2021/23 to include extended and 7 day working.

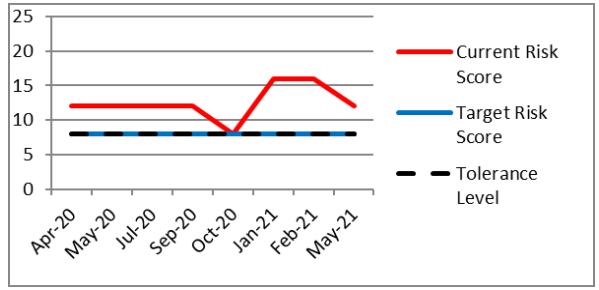
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Maintenance of 14 week waiting times for therapy services. Clearance of backlog for pulmonary rehabilitation, with 100% achievement of 14 week maximum wait by Dec21. Improved compliance with minimum standards for stroke therapy care by Q2 2021/22 (Dec21). Improved staffing ratios for priority areas by Dec21. Recruitment & Retention monitoring	Management monitoring of breaches of 14 week waiting times	1st			Briefing on current position - QSEAC: Risk 628 - 06.10.2020 Briefing Paper on Therapy Staffing - HDCHC Services Planning Committee 14.12.20 Briefing on Therapy Staffing - HDCHC Services Planning Committee 16.02.21 Executive Team Briefing - Plan on a Page Covid Rehabilitation 23.06.21.					
	Exceptions to achieving 14 week waiting times reported via IPAR to PPPAC	2nd								
	Monitored nationally via SSNAP and monitored via Stroke Steering Group & RCP Annual Report with recommendations produced	2nd								
	External Peer Reviews, Delivery Unit Reviews & national audits, eg Diabetes paediatric audit - action plans developed	3rd								

Date Risk Identified:	Apr-20
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Moore, Steve	**Date of Review:**	May-21
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Jul-21

Risk ID:	**855**	**Principal Risk Description:**	There is a risk that the UHB will be unable to address the issues that arise in non-covid related services and support functions. This is caused by our ongoing operational response and the implementation of a COVID mass vaccination programme. This could lead to an impact/affect on poor patient outcomes and experience, increase in complaints, increased follow-ups, delays to treatment, increase in financial deficit, increase scrutiny by regulators/inspectors.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	8
Trend:	↓



Rationale for CURRENT Risk Score:
With levels of COVID-19 patients at very low levels, a limited restart of some planned care services got underway in April. Work has also commenced on our waiting list support / SPOC programme to support patients waiting for our services. This has reduced the likelihood to a 3 giving a rating of 3 x 4 = 12. The likelihood will reduce further once the 1st tranche of recovery funding is deployed to overcome the HB's capacity in all planned care services.

Rationale for TARGET Risk Score:

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Ethics Panel established and asked to consider issues related to the care of non-COVID-19 patients. Clinicians are making case by case risk based decisions for high risk/vulnerable patients. All available capacity being utilised at the Werndale to support cancer and urgent planned care activity. Revised Strategic Plan Requirement issued by Gold to Tactical on 27/04/20 to include non-COVID planning. The Winter Plan sets out arrangements for non-COVID services during winter ensuring focus is maintained on these services during a challenging winter period. Cancer Helpline in place for patients. Transformation Steering Group established. Quarterly planning process to ensure essential services are maintained and other services are cautiously restored as progress of the pandemic allows. Waiting listing support/SPOC Programme rolling out to support patients waiting for our care. Additional funding for recovery recently announced - plans developed which will reduce the risk score looking forward.	Plan required to restart services.	To establish a formal planned care recovery programme.	Moore, Steve	Completed	Devloped as part of the Health Board's Annual Recovery Plan for 2021/22.
		To establish a communication hub to mitigate harm and complaints.	Rayani, Mandy	31/03/2023	A workstream has been established to intitiate this work. Communications with patients has started.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
None identified.	Command and Control Structure developing and approving plans to re-establish and maintain essential services	2nd			Responding to the COVID-19 pandemic - Board (Nov20)	No performance measures. Internal and External Audit Plans in 20/21 are being reviewed to incorporate review of organisational response to COVID-19.	Develop KPIs following development and approval of plan to restart services.	Carruthers, Andrew	31/07/2020	The UHB asked the medical advisory board to give their view on international best practice in monitoring the population impact of this issue which will inform the KPIs we track. Nothing emerged from initial contact and no new indicators were developed. The UHB has continued to use existing indicators that the UHB has in place to measure the impact of patients waiting for treatment.
	Bi-monthly Covid-19 QSEAC	2nd								
	Weekly Formal Covid-19 Executive Team Assurance Meeting	2nd								
	Board oversight of revised quarterly plans	2nd								

Date Risk Identified:	Jun-21	**Executive Director Owner:**	Thomas, Huw	**Date of Review:**	Jun-21
Strategic Objective:	6. Sustainable use of resources	**Lead Committee:**	Sustainable Resources Committee	**Date of Next Review:**	Aug-21

Risk ID:	**1163**	**Principal Risk Description:**	There is a risk to the delivery of the Health Board's draft interim Financial Plan for 2021/22 of a £25.0m deficit. This is caused by 1. Costs of addressing our local COVID-19 needs may exceed funding available from UHB, Regional and WG sources. 2. Unidentified savings schemes included in the Financial Plan are also at risk of non-delivery due to both the operational focus being diverted to respond to COVID-19 and where identified schemes are not supportive of the response needed (e.g. bed closures). This could lead to an impact/affect on the Health Board's underlying deficit position, reduction in stakeholder confidence and increased scrutiny from WG.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Statutory duty/inspections
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	

Rationale for CURRENT Risk Score:
Financial planning assumptions have been assessed assuming up to 12 months of COVID-19 prevalence at a level similar to Q3 of 2020/21. Whilst the operational responses and corresponding financial impact of the pandemic during 2020/21 has provided a sound basis for modelling scenarios, it should be acknowledged that the scale and duration of the pandemic and the likely impact on the Health Board is as yet unknown for 2021/22. WG funding streams are partly confirmed, however there will be a reliance on the success of bids for specific funding to support the Health Board's further Elective Recovery Plans, Digital Transformation and enhanced Mental Health service support in response to the pandemic and in the acceleration of the Health Board's Strategy. There is also ongoing WG scrutiny of the opening underlying deficit for 2021/22, and the Health Board has not yet had confirmation from WG that the June submission of the Financial Plan for 2021/22 will be approved.

Rationale for TARGET Risk Score:
The Health Board needs to demonstrate that it is able to manage its financial position effectively, cognisant of the risks which are inherent in the delivery of safe and timely care. As the actual activity in the Health Board manifests, the level of risk may be considered to be reduced, however the impact of the mass vaccination programme and risk of new variants is as yet unknown. As further clarity is provided by partner organisations and Welsh Government as to funding arrangements, the risk of unfunded activity may be reduced. Given the challenge in delivering the financial position this year, it is unlikely that the Health Board will achieve a risk which is in line with the tolerable risk for the year. Consequently, the target risk score exceeds the tolerable risk at this point. This is not an acceptable position, and further work is ongoing to manage this risk.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
1. Modelling of anticipated patient flows, and the resultant workforce, equipment and operational requirements is managed through operational teams. 2. Financial modelling and forecasting is co-ordinated on a regular basis. 3. Timely financial reporting to Directorates, Finance Committee, Board and Welsh Government on local costs incurred as a result of COVID-19 to inform central and local scrutiny, feedback and decision-making. 4. Oversight arrangements in place at Board level and through the Executive Team structure. 5. Exploration of a number of funding streams being explored, including: Local Health Board funding arrangements; Funding arrangements through the Regional Partnership Board and Local Authority partners. Funding from Welsh Government's own sources or from HM Treasury via Welsh Government. 6. Opportunities Framework and Roadmap to Financial Sustainability, refreshed to identify alternative ways of working in response to COVID-19 that may result in cost reductions/formal savings schemes identified. 7. Accountability statements in relation to the Opening Directorate Budgets underpinning the draft interim Financial Plan for 2021/22 were issued to all budget holders in April 2021. The letters clarify that it is expected that all budget holders manage their services within their allocated budgetary envelope; that it is incumbent on all to ensure that expenditure, including the operational response to COVID-19, represents best value; and, that there is the expectation that these operational needs can be clearly demonstrated and that additional costs will reduce as and when decision making through the command structure allows. 8. Performance against plan monitored through System Engagement Meetings with Services, including Performance, Quality and Financial information. To be improved through Improving Together.	The costs of addressing the Health Board's local needs may exceed available funding. This is in relation to the direct response to COVID-19, the continuation of essential services and delivery of the Recovery Plan. Identification and assessment of sustainable opportunities arising from cost reductions due to changes in activity levels or other service changes in response to COVID-19.	Alignment of strategic response to current demand modelling indicators between Welsh Government, Gold Command and operational teams.	Carruthers, Andrew	30/06/2021	A refreshed Annual Plan will be submitted to Welsh Government in June 2021, as required by WG. The Board will be asked to approve the Plan at the June 2021 meeting. The dataset required includes activity, workforce and financial KPIs and will be driven by the Operational modelling.
		Feedback/clarity from WG as to levels of additional revenue and capital funding available	Thomas, Huw	07/01/2021	A level of Sustainability Funding for 21/22 has been confirmed by WG, with a further tranche to be assumed but not confirmed. Guidance has been received from WG to assume funding in respect of the programme responses to the pandemic such as the MVP, TTP, adult social care provider support, enhanced cleaning standards and PPE. Futher clarifications are anticipated following the submission of the Financial Plan, however no clear timelines provided. The HB has received approval of funding bids to WG re Elective Recovery Plans. WG also advised the HB to assume non-recurrent funding to offset

Implementation of the Digital Strategy	Tracey, Anthony	31/03/2022	Please refer to the Digital Strategy for required Actions and specific timescales.
Implementation of Improving Together.	Thomas, Huw	31/07/2021	To replace current System Engagement meetings with formalised Improving Together meetings.

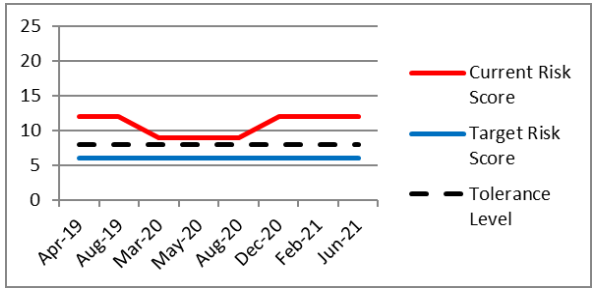
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**			**Identified Gaps in Assurance:**	**How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
Performance against planned response to COVID-19 In-month financial monitoring	Performance against plan monitored through System Engagement Meetings with Services	1st			Mth 12 Finance Report - Finance Committee April 2021	None				
	Sustainable Resources Committee (SRC) oversight of current performance	2nd								
	Transformation & Financial Report to Board & SRC	2nd								
	WG scrutiny through monthly Monitoring Returns	3rd								
	WG scrutiny through revised monthly Monitoring Returns (specific COVID-19 template) and through Finance Delivery Unit	3rd								
	Audit Wales Structured Assessment 2021	3rd								

Date Risk Identified:	Sep-18
Strategic Objective:	N/A - Operational Risk

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jun-21
Lead Committee:	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Aug-21

Risk ID:	**633**	**Principal Risk Description:**	There is a risk of the UHB not being able to meet the 75% target for waiting times for 2020/21 for the new Single Cancer Pathway (SCP). This is caused by the lack of capacity to meet expected increase in demand for diagnostics and treatment delays at our tertiary centre. This could lead to an impact/affect on meeting patient expectations in regard to timely access for appropriate treatment, adverse publicity/reduction in stakeholder confidence and increased scrutiny/escalation from WG.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	3×2=6
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:
The impact of COVID-19 may increase the risk of being unable to meet the target due to recommendations from Royal Colleges to suspend diagnostics and some surgery that are aerosol generating. During the pandemic, endoscopy was centralised in GGH. Endoscopy services were reinstated on all 4 hospital sites, with capacity increasing to 53%. With the introduction of a Green pathway in Endoscopy as of 7th June 21, capacity will increase to 81%. High acuity elective cancer surgery with green pathway and green ITU/HDU commenced in PPH & BGH on 6 July 2020 with WGH commencing intermediate surgery on the 10 Aug 2020. Following the second wave of COVID in December, all green HDU/ITU pathways have been reinstated and the surgical backlog has been addressed. A full Covid-19 plan is in place.

Rationale for TARGET Risk Score:
The aim is to treat patients within target waiting times, which has now been confirmed as 75% for the first year, 80% for the 2nd year and 85% thereafter non adjusted. Due to the pause in Cancer elective surgery over the christmas period for a 4 weeks , there was no HDU/ITU green pathway available, caused a surgical backlog for cancer surgery. This backlog has now been addressed. The tolerance level will be met if the UHB continues to meet the 1% per month improvement trajectory throughout 2021/22. Publication of performance data by WG recommenced in February 2021 with health boards only reporting against the SCP, with no wait adjustment.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Working with all Wales Cancer Network to gain full understanding of implications of new pathway. Implementation Group established, reporting to Cancer Board with awareness / engagement sessions held on each hospital site. Shadow monitoring in place. Further Demand & Capacity exercise planned 2020/21 with support from Delivery Unit. New Cancer tracking module in W-PAS now fully operational as of Dec19 with tracking team in place from Dec19 to allow patients to proactively tracked through treatment pathways. Routine daily communication feed from ED to cancer information team which helps identify the point of suspicion. COVID-19 escalation plan in place. Monitoring data of patients whose treatments have changed or suspended (some through patient choice) as a result of COVID-19. A 4-week follow up process has been implemented for these. Utilisation the private sector for surgery during COVID-19. Joint working with regional colleagues to offer patients on a tertiary pathway surgery locally. Resumed aerosol generated diagnostics cross all 4 hospital sites.Due to the current COVID situation, these services are now being scaled back with Endoscopy services being mainly centralised in GGH. Reinstated high acuity elective Cancer surgery with green pathway and green ITU/HDU has commenced on PPH and BHG sites as of 06/07/2020, and WGH Intermediate surgery from 10/08/20. Due to the current	Anticipated significant gaps within key diagnostic services to address required levels of activity to support SCP. Full engagement for all supporting services. Performance is lower than USC/NUSC published performance. Key diagnostic information systems do not support effective demand / capacity planning. Need for new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment pathways.	Demand & capacity assessment work continuing. Solutions will necessitate regional cooperation to address anticipated capacity gaps.	Humphrey, Lisa	~~31/03/2020~~ 31/03/2021 31/12/2021	Initial planned work with Delivery Unit suspended and will be under constant review in light of COVID and recovery planning phase. Work is ongoing .
		See above re diagnostic services plus improved systems to support identification of 'date of suspicion'.	Humphrey, Lisa	~~31/03/2019~~ 31/08/2019 31/07/2020 31/10/2020 31/03/2021 31/08/2021	HB performance compares well with other HBs however below current SCP performance level. Ongoing work in progress with OPD, Diagnostic & ED teams along with the informatics department to improve real time identification of date of suspicion. Informatics are beginning to pick up routine reporting requests which were on hold due to COVID-19.
		Each MDT to review and adopt recommended optimal tumour site specific pathways	Humphrey, Lisa	~~31/08/2020~~ 30/09/2020 31/03/2021 31/12/2021	Each MDT is currently assessing implications of published proposed pathways. A Macmillan Cancer Quality Improvement Manager post which was developed to work with the teams with regards to implementing the new pathways has been appointed to and the new appointee took up post on 1st November 2020. Agreement over funding was delayed as a result of COVID-19.

and WGH Intermediate surgery from 10/08/20. Due to the current COVID situation, only urgent cancer elective surgery will be carried out from the 21st December for a period of 4 -6 weeks due to staffing levels. All patient are being clinically prioritised to ensure no harm is caused by the delay. 7 Day Diagnostic Group and RDC. FIT and Digital Delivery of Care.		Explore opportunities for alternative providers to address tertiary centre delays for cancer treatment.	Humphrey, Lisa	Completed	Some arrangements were agreed however these have been suspended due to COVID-19, however COVID has provided opportunities to enable new arrangements to be put in place with regional centres.

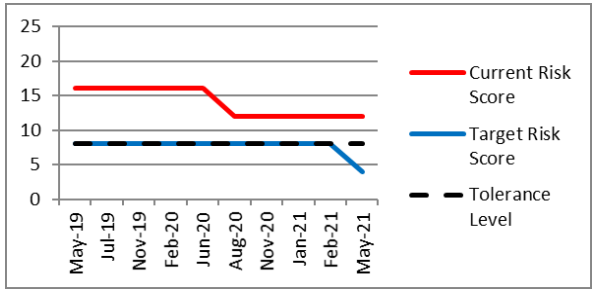
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Deliverable indicator targets - 1% improvement per month during 2020/21. Shadow performance data.	Daily/weekly/monthly/ monitoring arrangements by management	1st			* Implementation of Single Cancer Pathway Report - BPPAC - Feb20 * IPAR Report - Board - Jan21 * COVID-19 Impact on Cancer Services - Board - May20 * Cancer Updated to QSEAC Jun20 & OpQSESC Jul20 * Risk 633 QSEAC - Feb21	No gaps identified.				
	Executive Performance Reviews (suspended due to COVID-19)	2nd								
	Service plans in response to COVID-19 overseen and agreed by Bronze Acute & Gold	2nd								
	IPAR Performance Report to PPPAC & Board	2nd								
	Monthly oversight by Delivery Unit, WG	3rd								

Date Risk Identified:	Oct-17
Strategic Objective:	N/A - Operational Risk

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	May-21
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Jul-21

Risk ID:	**291**	**Principal Risk Description:**	There is a risk patients having poorer outcomes and increased mortality due to the lack of access to mechanical clot retrieval services (thrombectomy). This is caused by thrombectomy services being withdrawn by Cardiff and Vale Health Board due to a lack of interventional neuroradiologists. This could lead to an impact/affect on increased mortality rates, increased dependency of patients and an inability to access a National Institute for Health and Care Excellence (NICE) approved intervention within 5 hours of onset of stroke symptoms.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×2=4
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:

Mechanical intervention for Stroke is available at North Bristol NHS Trust (NBT) (and Walton Centre NHS Foundation Trust for Bronglais Hospital). The service has expanded to a 7 day service 8am-8pm, cut off for patient arriving at NBT is 6pm. We still do not have 24/7 service, any patients presenting after the cut off point will not be accepted by NBT.

Rationale for TARGET Risk Score:

The uncertainty surrounding the changes proposed in the Transforming Clinical Services programme have a significant impact upon the development of acute and hyper acute services within the UHB. Thrombectomy services continue to be sought and escalated with English Neuroscience units until the Cardiff and Vale service is reinstated and the instigation of a WHSSC commissioned service with North Bristol NHS Trust.

Mechanical intervention for Stroke is now available at Bristol (and Walton for Bronglais. The service in NBT has expended to 8am-8pm however we still do not have 27/7 service.The risk for out of hours would stay the same. March 21. There are ongoing meetings, to extend the service already offered. Ward staff will then be informed of the new process.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
WHSSC have commissioned a service in North Bristol. Below is a link for the thrombectomy pathway with Bristol. It has the referral criteria and pathway. They are developing an imaging pathway as well. https://www.nbt.nhs.uk/clinicians/services-referral/stroke-service-clinicians/stroke-thrombectomy-service-clinicians. New all wales Thrombectomy group has been set up to discuss issues and to finalise pathway. HDUHB patients can now access Bristol Thrombectomy services 7days a week. They will provide a service from 8am-8pm. the patient must arrive at Southmead by 6pm. Incident reviewing in place.	All patients must have a CT and CTA performed before referral with a diagnosis of a large vessel occlusion. Timely investigations that are required to support transfers for thrombectomy not supported 24/7 on all sites. Work is ongoing to ensure that CT Angiography is available in all Hywel Dda units to provide the necessary diagnostic investigations prior to transfer to a specialist neuroscience centre.	Develop and review the Thrombectomy pathway, throughout the Health Board.	Andrews, Bethan	Completed	Review of thrombectomy pathway undertaken, no facility to procure ad hoc services from North Bristol or Stoke. National Stroke Implementation Group have worked with WHSSC to commission an all Wales Thrombectomy service with North Bristol NHS Trust for Welsh patients. North Bristol Trust has issued a Thrombectomy check list and referral document. Pathway for referral is being worked on by clinicians who have been involved with WHSSC regarding setting up service with Bristol. However we are still waiting for full guidance.
		Development of pathway and protocols for the referral of stroke patients within each of the Hywel Dda Acute Hospitals to suitable neuroscience in England.	Mansfield, Simon	Completed	Briefing paper and protocols developed for the direct commissioning of ad hoc thrombectomy services from English Neuroscience units.
		Negotiate short-term commissioning arrangements with neuroscience units.	Teape, Joe (Inactive User)	Completed	Completed - however unable to secure new commissioning arrangements whilst WHSSC work to commission all Wales service

		Work with WHSSC to ensure all Wales thrombectomy service is commissioned.	Teape, Joe (Inactive User)	Completed	A service is now available from Bristol 9 to 5 Monday to Friday. However no service out of hours, therefore this action stays open. There is a plan for Bristol to be available from Sep20 to be 9-5, 7 day a week service.

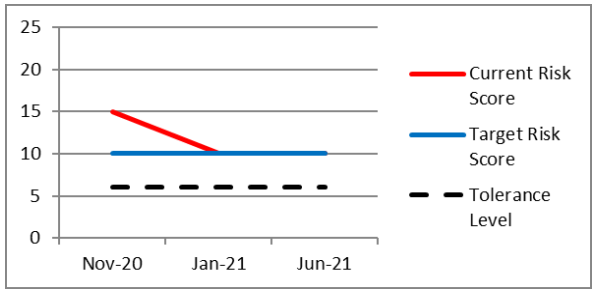
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Datix incident reports	Daily/weekly/monthly/ monitoring arrangements by management	1st			Thrombectomy Report - ET - Sep17.					
	Executive Performance Reviews	2nd								
	IPAR Performance Report to BPPAC & Board	2nd								
	Stroke Delivery Group review of patient cases	2nd								

Date Risk Identified:	Nov-20
Strategic Objective:	Delivery of the Quarter 3/4 Operating Plan

Executive Director Owner:	Rayani, Mandy	**Date of Review:**	Jun-21
Lead Committee:	Health and Safety Assurance Committee	**Date of Next Review:**	Aug-21

Risk ID:	**1016**	**Principal Risk Description:**	There is a risk of increasing COVID infections across the Health Board. This is caused by staff and others not adhering to the Health Board guidance and National Social Distance legislation. This could lead to an impact/affect on increased levels of staff absence due COVID infection and self isolation, some essential services being closed leading to longer waiting times and delays for treatment for patients, enforcement action/fines from HSE for non-compliance with Social Distancing legislation.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	2×5=10
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:

Social Distance risk assessments have been undertaken that highlight ways to allow services to be re-introduced while maintaining the social distance measures, however successful management of the risk depends on staff, visitors or patients adhering to the social distance guidance or using the 'Key Controls' measures in place.

Rationale for TARGET Risk Score:

The TARGET score focuses on reducing the likelihood of an incident as the impact score would remain at 5 (as outlined under CURRENT score). By introducing effective social distancing measures such as screening in high priority areas and alternative solutions in other areas, such as PPE, staff would be able to man more areas thus allowing services to resume as far as reasonably practicable. In terms of inpatient bed space, by reviewing all ward spaces and field hospitals against current guidelines and introducing either physical barriers or increasing spaces, as many services as possible will be able to return, however, strict adherence to the controls in place will be required to meet the target score.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Social distancing guidance in place for staff and is available on the intranet # Safety screen installations in hospital and ward/clinic reception areas # Instructional social distance posters and floor signs # Hand sanitisers stations # Personal protective equipment (PPE) # Reducing room capacities to allow for social distancing # Use of IT systems e.g. Microsoft Teams to reduce the need for face to face meetings # Reduction in travelling between sites # Home working being encouraged where possible # Accommodation facilities for medical staff have been risk assessed and alterations made in line with social distance measures. # Additional accommodation has been considered at Trinity St David's College University campus to assist with social distance arrangements. # SD information on patient appointment letters, leaflets # Meet and greet staff at main entrances # One way pedestrian walkways # Controlled access into Surgical wards and theatres # Hospital bed screens installed in identified wards in order to maximise inpatient capacity and minimise bed losses # Safety monitoring forms and routine audit process in place to monitor compliance. # Additional accommodation in Trinity St David's Campus to improve social distancing. # Patient visiting arrangements recently updated including agreed timeslots and management arrangements.	If staff, visitors or patients do not adhere to the social distance guidance or use the 'Key Control' measures provided. Staff returning to work on sites may lead to a reduction to the availability of staff room and changing facilities as these spaces return to their original use. Longer term working from home/agile working will need further consideration for ensuring compliance with DSE Regulations.	Replace floor signs due to wear and tear	Harrison, Tim	31/07/2021	Work underway
		Increase screens in outpatient areas in GGH to provide additional protection for patients whilst maintaining capacity	Davies, Damian	31/07/2021	Work is underway.
		Information messages to be included on telephone networks to remind patients of the need to socially distance	Hackett, John	31/07/2021	Work is underway.
		Review current home working guidance and request an update from the Agile/Homeworking Group regarding compliance with the DSE Regulations and Work Equipment Regulations.	Harrison, Tim	30/09/2021	Guidance is under review.

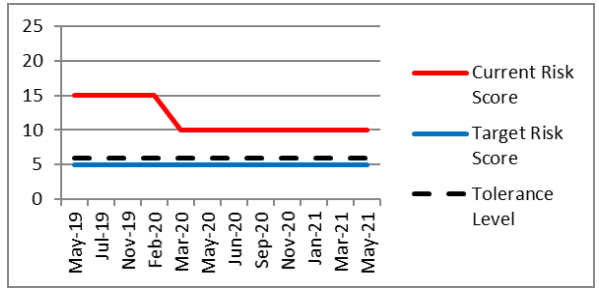
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Oversight is provided by the Social Distancing Cell, Chaired by Director of NQPE	1st				None identified.				
	Reviewing grade 4&5 incidents (RIDDOR reportable) involving staff contracting hospital acquired COVID	1st								
	Social Distancing Cell reports into Silver and Gold Groups	2nd								
	HSE visit 20/01/21 reveiwed social distancing measure as part of their reevaluation of existing improvement notices - final report received - notice of contravention at BGH. Issues addressed	3rd								

Date Risk Identified:	Sep-18
Strategic Objective:	N/A - Operational Risk

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	May-21
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Jun-21

Risk ID:	**634**	**Principal Risk Description:**	There is a risk avoidable harm of maternity patients who require an emergency c-section (category 1) at Bronglais General Hospital (BGH) outside of normal working hours. This is caused by not being able to meet the required standard of 'call to knife' within 30 minutes as there is no overnight theatre provision located on site. This could lead to an impact/affect on complications for mother and baby resulting in long term, irreversible health effects.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	3×5=15
Current Risk Score (L x I):	2×5=10
Target Risk Score (L x I):	1×5=5
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:

There is currently a resident Operating Department Practitioner 24/7 at Bronglais Hospital alongside a resident anaesthetic and obstetric team. The theatre scrub currently work on an on-call basis from home, which must be within 20 minutes travelling distance from the site. There is the potential for outside factors to impede timely arrival on site which are outside the control of the team which is reflected in the likelihood score of 3. While there have been no breaches of the 30 minute target it remains a potential risk which could have significant consequences. The Bronglais unit is a obstetric unit with modified criteria for delivery, with mothers assessed as being at high risk of complications during labour requiring medical intervention, being managed though the Maternity Unit in Carmarthen.

Rationale for TARGET Risk Score:

The UHB is aspiring to reduce this risk to the minimum by establishing a resident primary theatre team 24/7 in Bronglais Hospital to mitigate against the potential for outside factors to impact upon the delivery of care.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Resident Operating Department Practitioners (OPD) Team 24/7 anaesthetic cover on site (obstetrician and consultant anaesthetist). All families are informed by the Maternity Service at Bronglais Hospital of the services available at the hospital and that they will be a Continual Risk Assessment throughout pregnancy for the suitability of the Mother to deliver at BGH. Maternity staff are trained to deal with emergencies, with protocols in place for transfer out to appropriate centre is issues are identified. Principle of removal of on-call compensatory rest approved by Executive Team.	Not having 24/7 resident theatre team.	Establish funding for 24/7 resident theatre team.	Teape, Joe (Inactive User)	Completed	Funding approved by Executive Team. Implemented new rota Oct19.
		Advertise and appoint to expanded theatre Team following agreement on funding.	Hire, Stephanie	Completed	Every vacancy is advertised although applicants can be limited. Exploring options for bulk shifts with on-contract agencies agency.
		Agreement with theatre teams (employee relations) for removal of compensatory rest. Formal 90 day OCP for Scrub and Band 3 circulatory staff to commence 16/01/19.	Carruthers, Andrew	~~30/11/2018~~ 14/06/2019 31/03/2020 31/12/2020 31/03/2021 30/09/2021	OCP completed for SCRUB and Band 3 team. COVID has delayed finalising and communicating the conclusion of the hearing as well as the discussion of the risk assessment by OQSEAC. On 28Jan21, OQSEAC met to review the risk assessment, and now the hearing conclusion has issued by the Director of Operations, with implementation by end of Q2. Based on the risk assessment for option 3, the risk would be reduced to within the HB tolerance and would be consistent with the model in GGH. A readiness assessment is being prepared ahead of implementation for Executive sign off.
		E-roster build to support the new resident on call theatre team rota	Barker, Karen	Completed	Complete - e-roster is in place.
		Develop a formal implementation plan for the new staffing arrangements.	Barker, Karen	Completed	Establishment confirmed and work patterns in place. Recruitment ongoing.

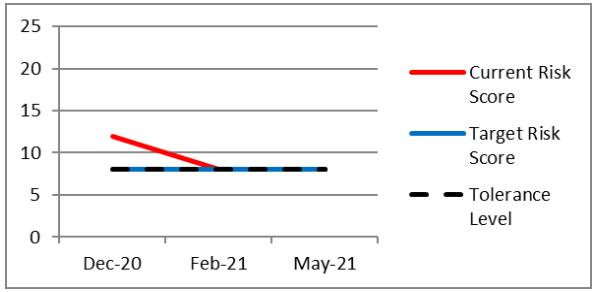
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
No of incidents reported where 30 minute response target is missed.	Maternity Services governance systems review of incident reports	1st			Executive Team - Jul18 Executive Team - Dec18 ARAC - Jun19	None identified.				
	Management audit of cases presented to QSEAC	2nd								
	Discussions with WG Chief Nursing Officer & UHB Medical & Nursing Director	3rd								

Date Risk Identified:	Dec-20
Strategic Objective:	N/A - Operational Risk

Executive Director Owner:	Jervis, Ros	**Date of Review:**	May-21
Lead Committee:	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Jul-21

Risk ID:	**1030**	**Principal Risk Description:**	There is a risk to the Health Board's reputation should there be a perception that the HB does not have a coherent and/or deliverable plan for the COVID-19 Vaccination Programme. This is caused by significant and ever changing vaccine policy requirements, delivery parameters such as workforce requirements and vaccination supplies in overall doses and vaccine type. This could lead to an impact/affect on a reduction in stakeholder confidence, increased scrutiny from the local community, the media, regulators and WG increasing pressure to deliver on all aspects of the programme, at pace, whilst competing with other Health Board priorities and operational challenges.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Adverse publicity/reputation
Inherent Risk Score (L x I):	3×4=12
Current Risk Score (L x I):	2×4=8
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:
The Board have approved the Mass Vaccination Delivery Plan, which addressed many of the previously articulated gaps in control. The plan is progressing at pace and is being managed by the Bronze Vaccination Delivery Group and overseen by the Silver Tactical Group. As we move through the programme, achieving each milestone we continue to manage programme delivery despite regular advice and policy changes within the context of unpredictable and inconsistent vaccine supplies.

Rationale for TARGET Risk Score:
As the programme delivery embeds, and initial uncertainties settle and knowledge/understanding of each vaccine and their individual characteristics improve. Expectations of individuals within our workforce and our communities will be better understood and supported over time.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Director of Public Health and Vaccination Programme Leads have a direct link with COVID -19 National Board (stakeholder and operational level). Command & control structures in place. Bronze Vaccine Delivery Group. Board approved Mass Vaccination Delivery Plan, including communications strategy. Continued support at national level via NWIS and internal IT colleagues. 4-week Forward Plan of Predicted Vaccine Supplies. Full functionality of national WIS (Welsh Immunisation System) to facilitate call/recall service to ensure prioritised groups are vaccinated first. This requires our local call centre to be within the Command Centre. Dedicated security arrangements in place.	Lack of control of volumes of vaccine by type. Changeable advice and guidance on vaccination. Competing COVID and non-COVID priorities across all services in respect of workforce. Lack of control on future use/changes of external venues.	Awaiting confirmation of vaccine delivery schedule to inform planned programme roll out.	Jervis, Ros	Completed	4 week forward predicted plan in place.
		Future meeting with external partners agencies to look at risks associated with external venues.	Jervis, Ros	Completed	Ongoing dialogue with key partners and scoping of possible venues underway.

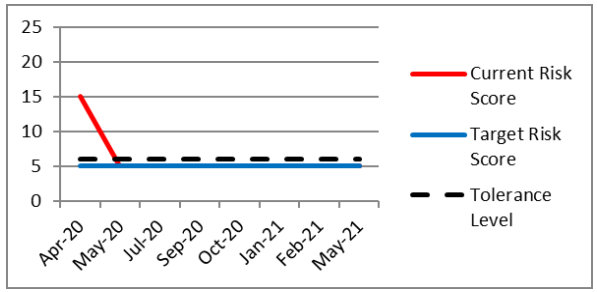
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Regular reporting of progress and position to National Covid Vaccine Board (CVB).	Regular reporting into Hywel Dda Tactical (Silver) Group	2nd				None identified.	To complete Internal Audit review of Hywel Dda Vaccination Programme	Jervis, Ros	Completed	Internal audit review undertaken and presented to ARAC.
	Regular updates to Executive Team and Integrated Executive Group (RPB)	2nd								
	Regular reporting into Dyfed Powys Local Resilience Forum	2nd								
	Core member of, and regular reporting to (including daily sitreps), the National Covid Vaccine Delivery Board (CVB)	2nd								
	Mass Vaccination Programme IA advisory report (Apr21)	3rd								

Date Risk Identified:	Apr-20
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Moore, Steve	**Date of Review:**	May-21
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Jul-21

Risk ID:	**853**	**Principal Risk Description:**	There is a risk that the UHB's response to COVID-19 will be insufficient to address peaks in demand terms of bed space, workforce and equipment and consumables. This is caused by an increased demand for services above the level secured. This could lead to an impact/affect on difficult triaging decisions for our clinicians, poor quality and safety for patients and an inability to accommodate every patient that needs us.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	3×5=15
Current Risk Score (L x I):	1×5=5
Target Risk Score (L x I):	1×5=5
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
Impact of the risk recognises the significant clinical risk of the risk if it becomes reality. At present, based on estimated COVID demand and the planning undertaken to respond to COVID-19, the likelihood of this risk has been reduced from 3 to 1. Likelihood is based on actual experience of the progress of the pandemic, field hospital provision, improvements in our modeling and WG planning assumptions regarding the likely transmission rate in Wales.

Rationale for TARGET Risk Score:
Target score has been met.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
A strong Command & Control structure has been implemented and judged fit for purpose by our assigned Military Liaison Officer. Planning numbers have been clearly communicated from Gold to Tactical and Bronze groups at the earliest opportunity. An Ethics Panel has been established to consider the challenges ahead and provide guidance. QSEAC will scrutinise PPE and areas of concern such as oxygen supply and ventilators. Modelling cell established to provide regular forecasts of the progress of the pandemic at local level. Functional capacity forecasting tool provides time to respond to changes in forecasting. Field hospital capacity secured for the Q3/4 period and is sufficient to accommodate patients up to the peak level of configuration set out by Welsh Government. Comprehensive Prevention and Response Plan agreed with the 3 local authorities to ensure Track, Trace and Protect (TTP) is effective in reducing transmission rates.	Inability to directly control lift of lockdown measures.				.

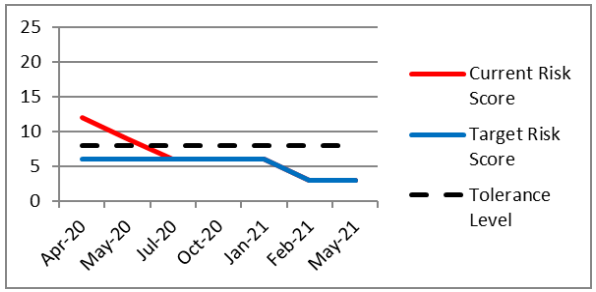
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
None identified.	Response to COVID-19 reviewed by Command and Control Structure	2nd			Responding to the COVID-19 Pandemic Board Report - Apr20, May20, Jun20, Jul20 & Sep20	Assurance being sought from councils regarding ability to access field hospitals when needed (specifically Carmarthen Leisure Centre Judo Hall)	Director of Operations requested to seek clarification and assurance regarding ability to access field hospitals when needed.	Carruthers, Andrew	30/06/2021	Director of Operations has been notified by Carmarthenshire County Council (CCC) that they request the return of Carmarthen Leisure Centre to reinstate as judo hall. CCC intention is that Health Board could regain access to it as FH ward within 3 to 4 weeks of it being requested. Field Hospital Team currently testing that time line to be assured that would be possible.
	Board oversight of response to COVID-19	2nd								

Date Risk Identified:	Apr-20
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Moore, Steve	**Date of Review:**	May-21
Lead Committee:	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Jul-21

Risk ID:	**854**	**Principal Risk Description:**	There is a risk that UHB's response to COVID-19 proves to be larger than needed for actual demand. This is caused by incorrect modelling assumptions or changes in the progression of the pandemic. This could lead to an impact/affect on abortive costs and possible reputational damage.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Adverse publicity/reputation
Inherent Risk Score (L x I):	5×3=15
Current Risk Score (L x I):	1×3=3
Target Risk Score (L x I):	1×3=3
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:
Likelihood recognises that limits to our ability to grow our bed base reduce the risk of over capacity and our modelling is informing the scale of gap. It also reflects revised planning assumptions from Welsh Government (WG) for winter COVID-19 demand which will be close to available Field Hospital capacity. The WG funding process for COVID-19 has been clarified and our current forecast out turn is in line with pre-covid plans at £25m.Likelihood further reduced in light of the growing certainty of achieving our year end financial target.

Rationale for TARGET Risk Score:
Planning has been based on current planning assumptions and the Public Health Plan being effective. Target risk score has been met.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Modelling cell established to provide regular updates on planning numbers, linked into the Welsh Government modelling group and other Health Boards. Welsh Government direction to risk over provision rather than under provision will limit reputational damage. All developments subject to a business case approach to ensure value for money is considered alongside other issues. Board oversight and sign off of decision-making at all levels of the Command Structure. Good Communications with Community Health Council, local politicians and Local Authorities. Regular media engagement (internal/external). Revised Strategic Planning Requirements Directive from Gold to Tactical on 27/04/20 includes field hospitals available as alternative sites. WG informed of COVID-19 related costs on regular basis. Financial Framework/Business Case approval process in place and the Finance Committee is providing assurance to Board.					

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Delivery of £25m deficit at year end.	Response to COVID-19 reviewed through Command and Control Structure	2nd			Responding to the COVID-19 Pandemic - Board - Apr20, May20, Jun20, Jul20, Sep20, Nov20, Jan21, Mar21, May21 Finance Report Month M012 - FC - May21 Q1 Covid-19 Costs - FC - May20					
	Board oversight of Response to COVID-19	2nd								
	Finance Committee (FC) review of COVID-19 costs as part of monthly finance report	2nd								
	WG support (to date) of UHB response to COVID-19	3rd								
	KPMG Review of Field Hospital Provision - Sep20	3rd								
	AW Structured Assessment 2020	3rd								

RISK SCORING MATRIX

Likelihood x Impact = Risk Score					
Likelihood	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	**This will probably never happen/recur (except in very exceptional circumstances).**	**Do not expect it to happen/recur but it is possible that it may do so.**	**It might happen or recur occasionally.**	**It might happen or recur occasionally.**	**It will undoubtedly happen/recur, possibly frequently.**
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
	* time-framed descriptors of frequency				
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	**(0-5%*)**	**(5-25%*)**	**(25-75%*)**	**(75-95%*)**	**(>95%*)**
	*used to assign a probability score for risks related to time-limited or one off projects or business objectives.				
Risk Impact Domains	**Negligible - 1**	**Minor - 2**	**Moderate - 3**	**Major - 4**	**Catastrophic - 5**
Safety of Patients, Staff or Public	**Minimal injury requiring no/minimal intervention or treatment.**	**Minor injury or illness, requiring minor intervention.**	**Moderate injury requiring professional intervention.**	**Major injury leading to long-term incapacity/disability.**	**Incident leading to death.**
	No time off work.	**Requiring time off work for >3 days**	**Requiring time off work for 4-14 days.**	**Requiring time off work for >14 days.**	**Multiple permanent injuries or irreversible health effects.**
		Increase in length of hospital stay by 1-3 days.	**Increase in length of hospital stay by 4-15 days.**	**Increase in length of hospital stay by >15 days.**	**An event which impacts on a large number of patients.**
			Agency reportable incident.	**Mismanagement of patient care with long-term effects.**	
			An event which impacts on a small number of patients.		
Quality, Complaints or Audit	**Peripheral element of treatment or service suboptimal.**	**Overall treatment or service suboptimal.**	**Treatment or service has significantly reduced effectiveness.**	**Non-compliance with national standards with significant risk to patients if unresolved.**	**Totally unacceptable level or quality of treatment/service.**
	Informal complaint/inquiry.	**Formal complaint.**	**Formal complaint -**	**Multiple complaints/ independent review.**	**Gross failure of patient safety if findings not acted on.**
		Local resolution.	**Escalation.**	**Low achievement of performance/delivery requirements.**	**Inquest/ombudsman inquiry.**
		Single failure to meet internal standards.	**Repeated failure to meet internal standards.**	**Critical report.**	**Gross failure to meet national standards/performance requirements.**
		Minor implications for patient safety if unresolved.	**Major patient safety implications if findings are not acted on.**		
		Reduced performance if unresolved.			
Workforce & OD	**Short-term low staffing level that temporarily reduces service quality**	**Low staffing level that reduces the service quality.**	**Late delivery of key objective/ service due to lack of staff.**	**Uncertain delivery of key objective/service due to lack of staff.**	**Non-delivery of key objective/service due to lack of staff.**

	(< 1 day).		Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
		Reduced performance levels if unresolved.	Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty.	Prosecution.
				Improvement notices.	Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
				Critical report.	Severely critical report.
Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage
					Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.

RISK MATRIX

IMPACT ↓	LIKELIHOOD →				
	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
	1	2	3	4	5
CATASTROPHIC 5	5	10	15	20	25
MAJOR 4	4	8	12	16	20
MODERATE 3	3	6	9	12	15
MINOR 2	2	4	6	8	10
NEGLIGIBLE 1	1	2	3	4	5

RISK ASSESSMENT - FREQUENCY OF REVIEW

RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	Extreme	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.	This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly.
8-12	High	Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Urgent action should be taken. A number of control measures may be required.	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	Moderate	Not normally acceptable. Efforts should be made to reduce risk, providing this is not disproportionate. Establish more precisely the likelihood & harm as a basis for determining the need for improved measures.	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	Low	Risks at this level may be acceptable. If not acceptable, existing controls should be monitored & reviewed. No further action or additional controls are required.	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.