Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	29 September 2022
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, Assistant Director 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

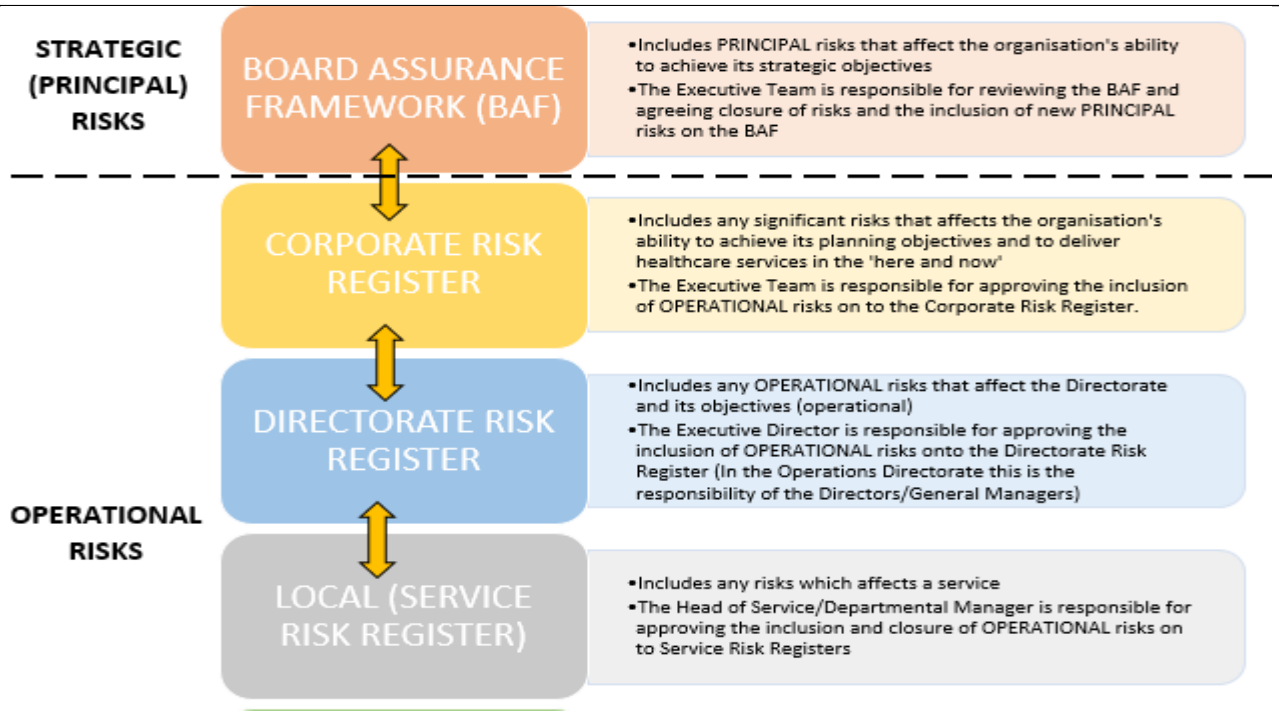
The Corporate Risk Register (CRR) is presented to the Board to advise of the corporate risks of Hywel Dda University Health Board (HDdUHB) and provide assurance that these risks are being assessed, reviewed and managed appropriately/effectively.

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 Executive Directors, through the monthly Executive Risk Meeting, 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.

The CRR includes significant risks that affect the organisation's ability to deliver healthcare in the 'here and now' and its ability to achieve its planning objectives (linked to directorate objectives). This is how the Corporate Risk Register interacts with the principal risks on the Board Assurance Framework and the operational risks that are on Directorate and Service risk registers.



Asesiad / Assessment

Since the CRR was previously presented to the Board in March 2022, the risks have been discussed in detail at its Board Committees, and reported to the Board via the Committee Update Reports. Where assurance has not been received that corporate risks are being managed effectively, the Committees can request a more in-depth report at a subsequent meeting.

The CRR includes significant risks associated with delivering the 'here and now', 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 refreshed Board Assurance Framework (BAF) dashboard is reported to every other Board meeting.

The following changes have taken place since the CRR was previously presented to the Board in March 2022.

Total Number of Risks	17	
New risks	6	*See note 1*
De-escalated/Closed	7	*See note 2*
Increase in risk score ↑	2	*See note 3*
Reduction in risk score ↓	1	*See note 3*
No change in risk score →	8	

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.

The 17 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			813 (→)		1027 (↑)
MAJOR 4			1433 (NEW) 1337 (↓), 1350 (→)	684 (→), 129 (↑) 1340 (→) 1352 (→), 1406 (NEW), 1407 (NEW), 1439 (NEW)	1032 (→), 1349 (NEW), 1432 (NEW)
MODERATE 3				1328 (→) 1335 (→)	
MINOR 2					
NEGLIGIBLE 1					

Note 1 – New Risks

Since the previous report in March 2022, 5 new risks have been added to the CRR:

Risk	Lead Director	New/ Escalated	Date	Reason
1349 (Previously aligned to OQSESC) - Ability to deliver ultrasound services at WGH	Director of Operations	Escalated	13/04/22	Service failure has already occurred with a likelihood of recurrence due to a lack of trained obstetric sonographers, particularly post March 22 due to staff retirements. The service remains fragile despite being granted a locum for 2 months. In-sourcing an ultrasound service as at July 2022, with staff due to commence in post August 2022 for a rolling three month period, therefore a temporary solution due to funding.

Risk 1406 - Risk of insufficient skilled workforce to deliver services outlined in Annual Plan 22/23 & deliver UHB strategic vision by 2030	Director of Workforce & OD	New	04/05/22	This corporate risk was approved by the Executive Risk Group on 04/05/22. This risk has been scored as 16 (the likelihood has decreased to "likely" and has the potential to have a "major" impact) as the number of key staff unavailable for work from staff sickness and self-isolation is still as high, although there has been a slight improvement. The reasons for which may also impact on staff resilience and ability to maintain performance. Staffing levels (acute & community) continue to operate well below established levels due to both vacancies and sickness/absence with the nurse staffing escalation policy applied. There is still a significant risk of workforce misalignment with activity and required competence levels. Further work needs to be undertaken to understand the level of risk across each staff group, specialty and site to fully comprehend the level of risk the organisation as a whole. Further work will be undertaken to understand the level of risk across each staff group, specialty and site to fully comprehend the level of risk the organisation as a whole.

Risk 1407-Risk to delivery of Annual Recovery Plan & achievement of WG Ministerial Priorities for the reduction in elective waiting times	Director of Operations	New	15/06/2022	This risk was approved via Chair's action on 17/06/22 to replace the previous risk 1048 which related to planned care delivery in 2021/22. The combined impact of urgent and emergency care pressures (as reflected in risk 1027) and a continuing significant deficit in available staffing and financial resources continues to limit available capacity for elective, urgent and cancer pathway patients and, as a consequence, represents a risk to delivery of Ministerial Measures for the reduction in waiting lists/times during 2022/23. Limits to staffing resource both in theatre, and post operatively, was a challenge before the COVID pandemic. As we continue efforts to progress recovery following the pandemic, significant staffing deficits with the Health Records service (impacting on the volume of outpatient activity delivered) and Anaesthetic medical team (limiting the volume of elective operating sessions undertaken) continue to limit progress in expanding overall activity levels to match/exceed pre-pandemic levels. The impact of increasing unscheduled care pressures continues to limit capacity to be dedicated to elective & surgical pathways. An elective care recovery plan has been developed which seeks to increase outpatient and treatment capacity beyond levels delivered prior to the pandemic. However, the capacity required during the 2022/23 year to enable achievement of the Ministerial Measures exceeds that currently available. Whilst outsourcing programmes are continuing supported by Recovery funding provided by WG, the additional capacity required exceeds the level

				currently being commissioned and reflected with the UHB's Annual Recovery Plan.
1432 - Risk to the delivery of the Health Board's draft interim Financial Plan for 2022/23	Director of Finance	New	05/08/22	This risk was approved by Chair's action on 05/08/2022 to replace corporate risk 1371 (Risk to the delivery of UHB's Draft Interim Financial Plan for 2022/23). Financial planning assumptions have been assessed assuming up to 12 months of "Low" COVID-19 prevalence (defined as COVID-19 circulating in the community, perhaps at levels of Summer 2021, but lower severity (equivalent to Omicron variant)). Whilst the operational responses and corresponding financial impact of the pandemic during 2020-2022 has provided a sound basis for modelling scenarios, it should be acknowledged that this "Low" scenario may not be the case throughout the year, which may have resource implications. Welsh Government funding streams are partly confirmed, however there will be a reliance on the success of bids for specific funding to support the specific exceptional costs, transitional COVID-19 support in response to the pandemic and in the acceleration of the Health Board's Strategy. A strategic transformation of our operating model is required to make the shift in services that are required to deliver workforce and finance sustainability - this is a medium term outlook however will impact the in-year position. Through our revised planning process, operational plans to address the financial savings gap and operational variation have not provided sufficient assurance to mitigate the current financial trajectory.

1433 - Inability to maintain routine and emergency services in the event of a severe pandemic event	Director of Therapies & Health Science	New	05/08/22	This risk was approved by the Executive Risk Group on 3rd August 2022, to reflect the ongoing risk of a novel virus (or emerging variant or mutation of concern) causing a pandemic as declared by the World Health Organisation (WHO) and the subsequent ability of the Health Board to respond to the scale and severity of the outbreak. Currently Pandemic Flu is the highest risk on the UK National Risk and Threat Register. This is due to be reviewed imminently when the definition is likely to be expanded to cover any infection rather than just influenza that could cause a pandemic. Current likelihood scored at a 3 to reflect the risk of the Health Board being unable to respond to the scale and severity of the pandemic - not the likelihood of the pandemic actually occurring.
1439 - Risk of delays of specialist wound management advice resulting in deep tissue damage, vascular disorders and sepsis	Director of Operations	Escalated	07/09/22	This risk was approved via Chair's Action of the Executive Risk Group, to reflect the fragility of the Tissue Viability Service. This risk has been considered extensively at Executive level and additional resources have recently been approved strengthen the service and develop a new service model with a varied skill mix.

Note 2 - De-escalated/Closed Risks

Since the previous report to Board in March 2022, the following 7 corporate risks have been closed/de-escalated:

Risk	Lead Director	Close/De-escalated	Date	Reason
1296 - Risk that the Health Board will not deliver a financial out-turn position in line with our original plan of £25m deficit	Director of Finance	Closed	13/04/22	The Executive Risk Group agreed to the closure of this risk as it relates to the previous financial year (2021/22) and has been replaced by a new risk for 2022/23 (see risk 1371 above).

1297 - Risk that the Health Board's underlying deficit will increase to level not addressed by additional medium term funding	Director of Finance	Closed	13/04/22	The Executive Risk Group agreed to the closure of this risk as the new financial risk (risk 1371 above) will address this through the targeted operating model.
1307 - Risk to achieving the Capital Resource Limit 2021/22	Director of Finance	Closed	13/04/22	The Executive Risk Group agreed to the closure of this risk as the Health Board has met its statutory duty to breakeven against its Capital Resource Limit for 2021/22.
1342 - Inability to plan and respond effectively to the pandemic due to changes in COVID testing and reporting policy	Director of Operations	Closed	13/04/22	This risk was reviewed by the Executive Risk Group, who agreed to reduce the risk score to 9 and close the risk as no further action can be taken to mitigate the risk and responding to COVID-19 demand has become part of normal business.
Risk 1219 - Insufficient workforce to deliver services required for "Recovery" and the continued response to COVID-19	Director of Workforce & OD	Closed	04/05/22	The Executive Risk Group agreed to close this risk as it relates to the previous financial year (2021/22) and has been replaced by new risk associated with the workforce requirements for 2022/23.
Risk 1016 - Increased COVID-19 infections from poor adherence to Social Distancing	Director of Nursing, Quality and Patient Experience	Closed	01/06/22	The Executive Team agreed to close this risk as social distancing requirements have been removed within the Health Board. Risk 1433 (see above section) reflects that the previous COVID-19 response measures would need to be adapted to respond to any future pandemic.
1048 - Risk to the delivery of planned care services set out in the Annual Recovery Plan 2021/22	Director of Operations	Closed	17/06/22	This was closed via Chair's action on 17/06/22 as it relates to delivery of planned care services in 2021/22. A new risk (1407) has been articulated for 2022/23 (see section above).

Note 3 – Increase/decreases in Current Risk Score

Since the previous report to Board in March 2022, there have been changes to the following 3 risks:

Risk	Risk Owner	Previous risk Score	Risk Score March 2022	Date	Reason
1027 - Delivery of integrated community and acute unscheduled care services	Director of Operations	**5x4=20**	**5x5=25** ↑	27/07/2022	Levels of emergency demand continue to increase significantly. This is not related to COVID-19 per se but is driven by post pandemic demand and the broader impacts of COVID -19. Workforce deficits, handover delays, 4 and 12 hour performance and bed occupancy rates are all demonstrating significantly worrying trends. The indirect impact of COVID-19 has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. The situation remains at high levels of risk escalation across our acute sites on a daily basis.

129 - Ability to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda patients	Director of Operations	**3×4=12**	**4×4=16** ↑	02/09/2022	Fragility of out of hours service delivery continues. Rotas continue to be fragile, particularly at weekends and holiday periods. The inability to recruit GPs (caused by aging workforce and a reluctance of new GPs taking on out of hours roles), combined with increased demand for face-to-face, longer complex consultations, and increasing pressures in day-to- day primary care which is impacting the ability of GPs to be available for OOH shifts. In addition, some clinicians may preferentially work in other urgent emergency care initiatives such as 111 First or SDEC, as they are potentially much lighter (as reported by SBU OOH service). Any further absence on out of hours provision is likely to rapidly result in further deterioration of the current position. Availability of day time work, potentially leading to less availability of locums available for OOH. The Health Board currently have approximately 49 GPs (down from 100, 5 years ago) who regularly work the rotas, and an additional 10-20 who only work bank holidays rotas due to enhanced rates. ANP staff have reduced from 4 to 1 which covers 4 hours over a weekend period (0.1 WTE).

1337 - Risk of reputational harm if the health board is found to have not managed the Llwynhendy TB outbreak as well as it could have	Medical Director	**4x4=16**	**3x4=12** →	08/06/2022	The outbreak investigation has been re-opened four times in response to new cases of TB, leading to a rapid internal review carried out by PHW in 2019, to identify immediate actions and to make recommendations for the ongoing management of the outbreak. One of the key recommendations of the review was to commission, jointly with PHW, an external review of the outbreak and its management, to inform the approach to the management of TB disease in Wales. The Board agreed to proceed with the external review, the start was delayed by COVID-19. The review commenced in April 2022 with an anticipated completion during Autumn 2022. The risk score has been reduced as no significant findings have been reported to date.

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 SEPTEMBER 2022

Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Sep-22	Trend	Target Risk Score	Risk on page no...
1027	Delivery of integrated community and acute unscheduled care services	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×5=25	5×5=25	↑	3×4=12	6
1032	Timely access to assessment and diagnosis for Mental Health and Learning Disabilities clients	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	5×4=20	→	3×4=12	12
1349	Ability to deliver ultrasound services at WGH	Carruthers, Andrew	Safety - Patient, Staff or Public	6	N/A	5×4=20	New risk	3×4=12	16
1432	Risk to the delivery of the Health Board's draft interim Financial Plan for 2022/23	Thomas, Huw	Finance inc. claims	6	N/A	5×4=20	New risk	2×4=8	21
1352	Risk of business disruption and delays in patient care due to a cyber attack	Thomas, Huw	Statutory duty/inspections	8	4×4=16	4×4=16	→	3×4=12	25
1406	Risk of insufficient skilled workforce to deliver services outlined in Annual Plan 22/23 & deliver UHB strategic vision by 2030	Gostling, Lisa	Workforce/OD	8	N/A	4×4=16	New risk	3×4=12	30
1407	Risk to delivery of Annual Recovery Plan & achievement of WG Ministerial Priorities for the reduction in elective waiting times	Carruthers, Andrew	Safety - Patient, Staff or Public	6	N/A	4×4=16	New risk	3×4=12	35
684	Lack of agreed replacement programme for radiology equipment across UHB	Carruthers, Andrew	Service/Business interruption/disruption	6	4×4=16	4×4=16	→	3×4=12	38
129	Ability to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda patients	Carruthers, Andrew	Service/Business interruption/disruption	6	3×4=12	4×4=16	↑	3×3=9 Accepted	41
1439	Risk of delays of specialist wound management advice resulting in deep tissue damage, vascular disorders and sepsis	Carruthers, Andrew	Safety - Patient, Staff or Public	6	N/A	4×4=16	New risk	3×3=9	44
1340	Risk of avoidable harm for HDUHB patients requiring NSTEMI pathway care	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×4=16	4×4=16	→	1×4=4	47
813	Failure to fully comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO)	Carruthers, Andrew	Statutory duty/inspections	8	3×5=15	3×5=15	→	1×5=5	51
1337	Risk of reputational harm if the health board is found to have not managed the Llwynhendy TB outbreak as well as it could have	Kloer, Dr Philip	Adverse publicity/reputation	8	3×4=12	3×4=12	↓	2×4=8	57
1433	Inability to maintain routine and emergency services in the event of a severe pandemic event	Shakeshaft, Alison	Service/Business interruption/disruption	6	N/A	3×4=12	New risk	2×4=8	60
1350	Risk of not meeting the 75% waiting times target for 2022/26 due to diagnostics capacity and delays at tertiary centre	Carruthers, Andrew	Quality/Complaints/Audit	8	3×4=12	3×4=12	→	3×2=6	63
1328	Security Management	Rayani, Mandy	Safety - Patient, Staff or Public	6	4×3=12	4×3=12	→	3×2=6	66
1335	Risk of being unable to access paper patient records at the correct time and place in order to make the right clinical decisions	Carruthers, Andrew	Quality/Complaints/Audit	8	4×3=12	4×3=12	→	2×3=6	69

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 (< 1 day).	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.
			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.
Health Inequalities/ Equity	Minimal or no impact on our attempts to reduce health inequalities/improve health equity	Minor impact on our attempts to reduce health inequalities or lack of clarity on the impact we are having on health equity	Moderate impact on our attempts to reduce health inequalities or lack of sufficient information that would demonstrate that we are not widening the gap. Indications that we are having no positive impact on health improvement or health equity	Major impact on our attempts to reduce health inequalities. Validated data suggesting we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity

RISK MATRIX

	LIKELIHOOD →				
IMPACT ↓	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.

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

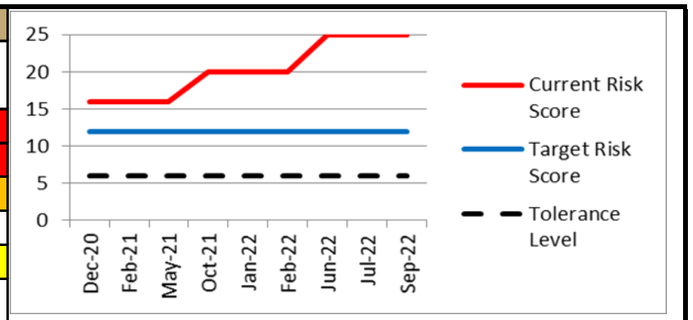
Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective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

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jul-22
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Aug-22

Risk ID:	**1027**	**Principal Risk Description:**	There is a risk to the consistent delivery of timely and high quality urgent and emergency care. This is caused by significant fragility across the urgent and emergency care (UEC) system (acute, primary care, community and social care services), related to workforce compromise and increasing levels of demand and acuity. This is not related COVID-19 per se but is driven by post-pandemic demand and the broader impacts of COVID -19. 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 and overcrowding at Emergency Departments 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?		1406, 1210, 750, 205, 86, 820, 232, 1298, 1281, 906, 1380, 1116, 878, 839, 1167, 1223, 111, 114, 199, 523, 136, 200, 1115, 1078, 572, 1295, 1231, 966, 967, 565, 852, 1295	

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):	5×5=25
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
Levels of emergency demand continue to increase significantly. This is not related to COVID-19 per se but is driven by post pandemic demand and the broader impacts of COVID -19. Workforce deficits, handover delays, 4 and 12 hour performance and bed occupancy rates are all demonstrating significantly worrying trends. The indirect impact of COVID-19 has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. The situation remains at high levels of risk escalation across our acute sites on a daily basis.

Rationale for TARGET Risk Score:
There is a significant challenge across the Urgent and Emergency Care system. The combined impact of the multi-faceted pressures which underpin this risk have led to an incremental increase in the overall level of pressure as reflected in deteriorating delays for ambulance handover, access to urgent and emergency care and delayed discharges. The extent to which these combined pressures impact upon the timeliness and quality of care provided is related to the overall availability of staffing resources on a daily / weekly basis, which in turn is influenced by increasing levels of staff sickness/absence.

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 which include efficient handover from WAST into ED. # 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. # 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 and specifically reviews COVID-related absence and forward forecast. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites. # Regular advice 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. # 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. # Domiciliary Care Risk and Escalation Policy approved by Integrated Executive Group and implemented across Health Board # 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, urgent and emergency care plan agreed. # Establishment of a Discharge to Assess (D2A) Group which reports to the Unscheduled Care group.	# Fragility of Care Home Sector exacerbated by COVID related issues such as financial viability, staffing deficits, recruitment and retention of workforce. # Significant paucity of domiciliary care/social care availability due to recruitment and retention of staff # Nurse staffing availability to ensure safe levels of care as a consequence vacancies. # Post-COVID-19 fatigue is exacerbating workforce capacity and availability of bank and agency staff who would be available. # COVID-19 incidence continues to further exacerbated workforce capacity and availability of bank and agency staff who would be available. # Inability to offload ambulances to release them back for use within community. # Increased pressures at ED as a result of WAST ambulance response policy resulting in very poorly patients self-presenting. # Better understanding of ED presentations to ensure development of alternative pathways in primary care / community to prevent ED attendance # Effective and timely communication to the public at times of pressure but also of safe alternatives to hospital admission / ED presentation that will contribute to changing public mind set / expectation and culture in terms of use of NHS resource and 'Home First' # Education and training for best practice in frailty management mandated to effect culture of 'unsafe to admit' for our very / severely frail	To consider alternative models of medical oversight i.e service level agreement with local GPs and HB salaried community GPs	Dawson, Rhian	Completed	Pending confirmation indemnity for the local GPs to deliver.
		Refer CRR 1406 detailing actions to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	31/03/2023	Ref CRR 1406 for detailed progress.
		Explore service provision in the community for people pending ambulance conveyance, and where conveyance is not possible to manage ambulance handover delays	Dawson, Rhian	Completed	Completed.
		Recruit additional workforce in line with safe staffing requirements for 28 beds in Amman Valley Hospital	Dawson, Rhian	Completed	Completed.
		Development of enhanced Bridging Service and to actively recruit HCSWs to support domiciliary care services	Lorton, Elaine	Completed	Completed.
		Create live UEC performance dashboard.	Dawson, Rhian	Completed	UEC live performance dashboard in place.
		Recruitment to UEC Programme Management Office	Dawson, Rhian	~~31/01/2022~~ ~~31/03/2022~~ 30/09/2022	Recruitment process underway.

# 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 # To optimise step down bed capacity in the community across care homes and community hospitals # SRO in place to lead agreed Urgent and Emergency Care (UEC) programme # Supernummery HCSWs aligned to the acute response teams to support failing community care capacity # Support for complex discharge caseload management tool (SharePoint) appointed # Reminders issued to management on importance of robust management of staff sickness and the use of COVID-19 Risk Assessment to help manage staff absences. # SDEC models continuously reviewed and refined to maximise impact on admission avoidance. # Staff are encouraged to participate in the UHB's ongoing COVID-19 vaccination programme. # Alternative models of medical oversight i.e service level agreement with local GPs and HB salaried community GPs. # Service provision in the community for people pending ambulance conveyance, and where conveyance is not possible to manage ambulance handover delays. # Increased bedding capacity in community hospitals. # UEC live performance dashboard in place. # Local streaming hub. # Direct referral into SDEC in WGH and GGH. # Operational joint meeting with WAST to identify and taking forward key action to help address conveyance.	# Supporting staff to be able to better manage family dispute relating to expectation eg home of choice, transfer pathways to short term placement in care home pending home care availability # Development of a 'tool' that supports staff to assess risk across the whole system to support decision making when discharge appears to be 'risky' to the individual patient. This includes decision making for 'further rehabilitation required in the acute environment' (why not at home?), further blood analysis to confirm medically fit to discharge, home care not available but family happy to take in the interim. # For all patients with LOS > 21 days the need for escalation and 'senior think tank' # If there is a paucity of home care to the extent that we are unable to provide > 28 hours per week (calls four times per day) - why are we advocating this level of commissioning? # Clarity regarding roles and responsibilities for discharge planning and coordination # The availability of live data at Cluster, County and Site level with sufficient analytical support # the ability to risk stratify for people at moderate to high risk of admission in the community to implement proactive anticipatory care plans to support avoidance of exacerbation / decompensation and hence increased risk of hospital admission # Optimising our bedded facilities in the community i.e we should aim for 'step up' from community and from 'front door' hospitals (within 72 hours) rather than as a 'step down' from acute hospitals after long length of stay. LOS should be no more than 10 days # Bespoke recruitment targeted at critical posts that will deliver improvements in UEC eg ANPs, APPs, PAs etc. and accept risk to permanently fund such posts i.e should not be temporarily funded. # Frailty screening by staff in ED and	Implementation of 111 First and local streaming hub as well as enhancing Same Day Emergency Care (SDEC) provision to reduce conveyance and conversion	Dawson, Rhian	31/03/2023	Recruitment underway. £3.4m awarded by WG for UEC Programme.
		Explore and gain approval for funding for 2wte COTE consultants	Dawson, Rhian	Completed	Completed
		To implement the Standard for Discharge to Assess in accordance with the WG Disharge Guidance	Dawson, Rhian	Completed	Plan to be developed.
		Review ambulance handover procedure in conjunction with WAST and HB Review Escalation Policy	Passey, Sian	~~31/03/2022~~ 31/10/2022	Senior level discussions with WAST have been undertaken in respect of ambulance handovers. All sites endeavour to comply with Red Release policies wherever possible. The policy is still in draft however HDUHB have been asked to share the policy with an all Wales group which has been established following the recent HIW WAST Review with the aim of setting developing a shared set of principles and policy, with each HB developing local SOPs.
		Review Escalation Policy	Jones, Keith	Completed	HB Escalataion Policy reaffirmed. Sites regularly operating at Red (Level 4) status with limited non-urgent elective surgery undertaken at the four sites due to urgent and emergency care pressures.

reporting into WPAS to support risk stratification of patient cohorts who should spend no more than 10 days in hospital. Majority should be turned around in 12 hours and < 72 hours. # Frailty screening and reporting into WPAS of inpatients who either have formal care in place on admission or whose level of frailty on admission suggests a need for care and support on discharge. This will support risk stratification to support discharge planning and coordination. # Consideration of workforce development for existing staff but also bespoke opportunities for non clinical roles that releases clinical time for 'clinicians to only do what they can do' # Reduce service duplication across sites # Development of 24/7 urgent primary care service that integrates urgent primary care service in the day and GPOOH and provides timely information, advice and assistance to patients and clinicians to provide safe alternatives to hospital admissions.	Review nursing models to support increasing capacity and environments for patients	Passey, Sian	Completed	Continuous discussions with Heads of Nursing and regular operational consideration given to scoping patient profile and pathways. In conjunction with primary care colleagues additional capacity in Amman Valley Hospital.
	To undertake a quality improvement project to map flow across GGH unscheduled system supported by Improvement Wales.	Perry, Sarah	~~31/12/2022~~ 31/12/2023	Work has started.
	To codesign schemes with Local Authorities that put urgent capacity into the system to reduce bed occupancy rate for frail, complex patients	Lorton, Elaine	31/10/2022	First meeting scheduled on 18/05/22.
	Review extant Escalation Policy to incorporate the whole UEC system	Jones, Keith	31/12/2022	HB Escalation Policy reaffirmed. Sites regularly operating at Red (Level 4) status with limited non-urgent elective surgery undertaken at the four sites due to urgent and emergency care pressures.

Incorporate and deliver actions that will address control gaps into the Health Board's UEC Plan.	Dawson, Rhian	31/03/2025	Launch of the UEC Improvement Programme on 16/06/22 to galvanise a collective approach to improvement.
Review wider nursing establishment requirements across 25A wards (outside of NSLA) to support increasing capacity and environments for patients.	Passey, Sian	30/09/2022	Continuous discussions with Heads of Nursing and regular operational consideration given to scoping patient profile and pathways. In conjunction with primary care colleagues additional capacity in Amman Valley Hospital (completed). A review has been completed of nursing models within EDs which will be submitted to Executive Team for discussion.
To review the West Wales Care Partnership Regional Discharge 2 Assess policy and develop action plan to ensure effective implementation of Policy Goal 5 (optimal hospital care following admission)	Passey, Sian	31/10/2022	Work is underway.

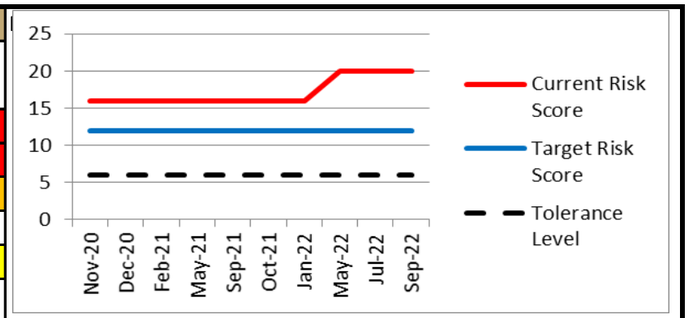
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance indicators. 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 SDOPC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	IPAR Performance Report to SDOPC & 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:**	Aug-22
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Sep-22

Risk ID:	**1032**	**Principal Risk Description:**	There is a risk that the length of time MH&LD clients (specifically ASD and psychological services) are waiting for assessment and diagnosis will continue to increase. This is caused by an increase in referrals and increasing DNA rates (c25%). There is also difficulty in recruiting suitably trained staff as well as sustainability of key posts as they are fixed term. 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?		138, 140, 1249, 1286, 1287, 1392	

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):	5×4=20
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
The service were experiencing significant waiting times as a result of increasing demand levels which are now back to pre-pandemic levels, compounding the backlog due to Covid restrictions. Due to increasing DNA rates (c25%), ongoing recruitment challenges and increasing demand there is an impact on the services' ability to see the same volume of service users as they were previously able to. Some posts continue to be 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 prioritising implementation of WPAS in key areas within MHLD and this will enable improved reporting and waiting list management and enable forward trajectories of improvement in waiting times to be determined. The target risk score 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 mainstream/Tier 0 support, wellbeing 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. Papers have been presented at the Quality Safety and Experience Assurance Committee with a further update paper provided for the December 2021 meeting outlining control measures to manage the waiting times that the Directorate have at present. A paper was presented at Board Seminar in June 2022 to provide assurance on current waiting times and control measures. Service Delivery Manager appointed and in place. Continual review of vacancies via MHLD QSE meetings resulting in the consideration of alternative staffing models when recruitment drives do not materialise. Workforce Redesign Group has been established.	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 and SCAMHS client group. Reliant on locally held data until reporting available via WPAS team. Currently with Software Development Team since go-live in April 2022.	Identify alternative venues/space to hold clinics.	Carroll, Mrs Liz	Completed	These actions have become control measures.
		Outcome measures to be in place to measure effectiveness/quality of services provided.	Marshall, Selina	~~30/06/2020~~ 31/03/2023	New action allocated to Service Delivery Manager.
		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	Action assigned to individual service leads.
		Funding for Interim Clinical Psychologist lead post to assist with the waiting lists and service development has been identified fixed term for 12 months and will work in conjunction with the new ASD Service Delivery Manager (in post 6 March) to address waiting lists.	Carroll, Mrs Liz	Completed	Interim Clinical Psychologist due to take up post by end of July 2022.
		To complete an impact assessment on the recommendations of the Autism Code of Practice.	vaughan, Catherine	~~30/04/2021~~ 31/12/2022	New action.

Trajectories have been identified for Memory Assessment Services and S-CAMHS and there are systems in place to monitor waiting lists at service level, through IPAR and Directorate performance meetings. Regular meetings with Estates to look at accessing/leasing/enhancing the current MH estates with a view to increase MH estate footprint. Within the service there is progress in terms of identifying clinical space due to the challenges experienced in accessing additional accommodation outside of the Directorate. Linking with wider Health Board, including corporate teams/Local Authority use of hubs. Works completed in Bro Cerwyn and staff have now returned. Units within the MH&LD footprint have been repurposed. IT are updating infrastructure to enable most efficient use of available space. Service Leads have been tasked with identifying alternative estate options for their areas. Work underway across all services who have waiting times, be they intervention or assessment. Use of HB Third Party Contractor has begun and initial letters sent to those waiting appointments with the Memory Assessment Service, Integrated Autism Service and Adult ADHD. Public facing webpages with QR codes are also being developed to give further guidance and support whilst individuals are waiting. Template letters being developed within further areas. Monitoring of this process will be the responsibility of individual service leads. Service Leads are exploring opportunities for outsourcing for CAMHS ASD and Psychological Therapies.			
Directorate has funded 12 month fixed term post to accelerate the transition of the entire Directorate on to WPAS with a view to this improving waiting list management and demand and capacity planning. A further two posts have been funded within the Informatics service.	Amner, Karen	Completed	Mapping work continuing for IAS service with the new Service Delivery Manager, MAS, Admiral Nursing and Perinatal. Data migration of Integrated Psychological Therapies spreadsheets completed 10.4.22 and service now inputting data at source. Training sessions continue to be available.
Request to be made for additional IT kit to support agile working.	Carroll, Mrs Liz	Completed	Request submitted 23.10.21.
Explore opportunities for outsourcing for CAMHS ASD and Psychological Therapies.	Carroll, Mrs Liz	Completed	Action included on service level risk register.
Directorate is working with the Health Board Performance Team to provide a more detailed report as to the current actions being taken by the Directorate.	Carroll, Mrs Liz	31/03/2023	This work is aligned to the migration of services to WPAS on a priority basis.

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
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			Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC (Oct21) MHLD progress update on Planning Objective 5G - Board (Mar22)	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.
	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd								
	MH&LD QSE Group overseeing patient outcomes	2nd								
	Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC	2nd								
	W-PAS Internal Audit (reasonable assurance(	3rd								
	An update was requested by the Chair and provided for the August Quality, Safety, Assurance Committee.									

Date Risk Identified:	Feb-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care

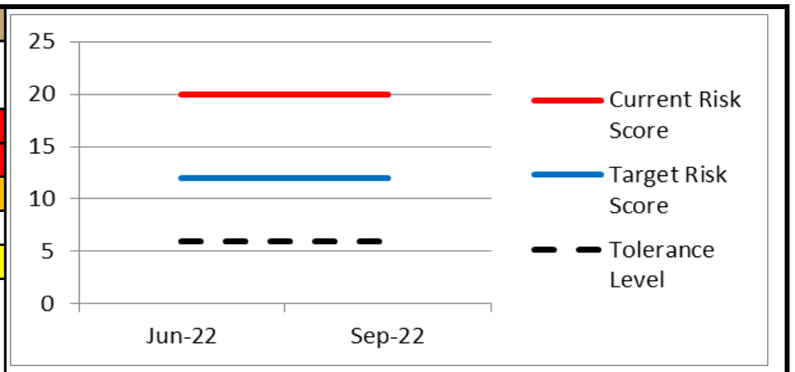
Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jul-22
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Aug-22

Risk ID:	**1349**	**Principal Risk Description:**

There is a risk of failing to deliver the ultrasound service at WGH. This is caused by a lack of appropriately trained obstetric staff, with no additional capacity on site to absorb displaced patient slots. The obstetric ultrasound examination unit operating at reduced capacity due to:
*Lack of robust plan to replace sonographers who have now retired.
*National shortage of radiographers within the general area.
*Staff working arrangements changing, with several now going part time
*Increased obstetric demand - specifically for 3rd trimester scans in line with the WAG targets of reducing still birth rates.
*The loss of a general ultrasound scan room due to air exchange fears and the pandemic, therefore further reducing capacity to undertake scans. This could lead to an impact/affect on increasing routine ultrasound waiting lists (which is already breaching 40 weeks in some cases), adverse peri-natal outcomes, failure to provide routine obstetric screening nuchal translucency (NT), and anomaly scans, failure to provide growth scans (the HB is not working in line with Growth Assessment Protocol (GAP) grow guidelines), non-adherence to RCOG and NICE guidelines, increased stress for staff creating a negative working culture, increased risk of staff developing Repetitive Strain Injury (RSI) and reduction in confidence from stakeholders.

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):	5×4=20
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	⟺



Rationale for CURRENT Risk Score:

Service failure has already occurred with a likelihood of recurrence due to a lack of trained obstetric sonographers, particularly post March 22 due to staff retirements. The service remains fragile despite being granted a locum for 2 months. In-sourcing an ultrasound service as at July 2022, with staff due to commence in post August 2022 for a rolling three month period, therefore a temporary solution due to funding.

Rationale for TARGET Risk Score:

The actions below will not in themselves reduce this risk significantly. Support is required to undertake the demand and capacity and the current establishment reviews. It is likely that these reviews will lead to a need for further investment and additional funding to establish a sustainable service model to include a robust perpetual training programme, that will enable the Health Board to met expected diagnostic waiting times targets.

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**
*Continual recruitment campaigns *Ability to request assistance from other sites when peak staff shortages experienced at WGH *Review of current workforce issues by senior management, and SBARs drafted for relevant Bronze and Silver * Met with recruitment to improve advertising of posts. * Outpatient referrals are being sent to other sites. * Some weekend working in place during Apr22 where there are gaps in service during the week. * In addition to the Site Lead Superintendent Radiographer, it has been agreed that sonographers from other sites will provide cover when possible, and a locum for 2 months has been agreed. * Insourced ultrasound service commenced August 2022. This has helped the provision of services considerably.	National shortage of sonographers. Inability to attract people to work in West Wales. Inability recruit locum sonographers to provide short term respite. Ability of other sites to release capacity when required. Ceasing in enhanced payments for staff for additional shifts	Approach PHW about the possibility of the Health Board failing to provide an obstetric screening service	Lingwood, Gill	Completed	Discussions with obstetrics service have taken place to agree that they will have this discussion with PHW.
		Explore the possibility of sending obstetric patients to other sites.	Lingwood, Gill	Completed	Radiology Staffing Task and Finish Group met on 31/03/22 and it was established that it is not currently practical to send obstetric patients to other sites. In addition to the Site Lead Superintendent Radiographer, sonographers from other sites providing cover, a locum for 2 months has been granted, however the service is still fragile due to sickness and annual leave. Update- Locum will end her contact with us on 31/05/22 due to uncertainty of continued employment as she has to take a six month break due to previously being an employee within the HB. This locum will therefore take her 6 month break from this point which has placed additional pressures on the service

Train midwives to be able to scan obstetrics	Lingwood, Gill	31/03/2023	It takes a year to complete sonography training in obstetrics and a further year for general ultrasound. Currently we have one midwife training who will qualify in January 2023 and follow a period of preceptorship. A Radiographer will commence training in January 2023. We are unable to train any further midwives at Withybush until at least January 2024, however Glangwili may be able to support the training of a midwife sonographer in January 2023 to bolster the service cross site.
Convert existing sonographer vacancy to backfill the release of radiographer to train in ultrasound from Jan23	Lingwood, Gill	31/03/2023	Post is at vacancy approval stage on Trac. However it takes a year to complete sonography training.
An update paper to written for OPDP to inform of the plan to sustain services in the short to medium term.	Roberts-Davies, Gail	Completed	Initial update paper presented to OPDP on 11th May 2022. Verbal update to be given at OPDP on 25th May and ongoing. Discussion with Head of Radiology confirmed that the initial action has been completed, and ongoing discussions now a control for the risk as it's an ongoing process.

Developing a mini competition document to test the market for insourcing ultrasound company for at least 12 months	Roberts-Davies, Gail	~~30/04/2022~~ 31/10/2022	The mini-competition doc was approved and advertised. The closing date for submissions was 12:00 on 25/05/2022. Unfortunately no companies on the Welsh framework responded. One company on the Crown framework has been engaged via a direct award. A rolling three month programme for insourcing has been approved as at July 2022 and commenced Aug 2022. This is progressing well and early indications are promising
Seek support to undertake a demand and capacity (D&C) review and detailed establishment review of the radiology service.	Roberts-Davies, Gail	~~30/06/2022~~ 30/11/2022	Initial meeting with Lightfoot to take forward D&C work, with further meetings planned. Initial contact made with workforce planning team re establishment review work. However the outputs of both reviews will likely lead to a need to invest/additional funding. Lightfoot will not be supporting this work due to contact end. Work is beginning with informatics to create a Radiology dashboard and we are currently reviewing our staffing establishment and structure. With the lack of project support with this work, the timelines have been revised. Radiology have been informed that the contract with Lightfoot has been extended, however Radiology have not been included in any ongoing work. Project support from the Commissioning Team in Finance has been obtained in relation to the demand and capacity work. This has been discussed in the Radiology Use of Resources Meeting and further discussions are taking place in regard to establishing a Radiology Planning and Delivery Group to bring together all pieces of work with the necessary expertise.

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
Non-Obs ultrasound - currently >over 40 weeks	Management review of sonography and SCP diagnostic waiting times	1st			Sonography Report to Acute Bronze and Operation Planning and Delivery Programme meeting					
	Monthly review of USC performance undertaken monthly (currently 42% of USC breaching), included in the IPAR & reported to WG	1st								
	IPAR overseen SDODC & Board	2nd								

Date Risk Identified:	Aug-22
Strategic Objective:	

Executive Director Owner:	Thomas, Huw	**Date of Review:**	Aug-22
Lead Committee:	Sustainable Resources Committee	**Date of Next Review:**	Sep-22

Risk ID:	**1432**	**Principal Risk Description:**	There is a risk to the delivery of the Health Board's draft interim Financial Plan for 2022/23. The draft financial plan for 2022/23 was re-submitted in July 2022, and based on a revised forecast of £62m which is currently not approved by Welsh Government (WG). This is caused by the re-submitted draft financial plan as at July 2022, based on a revised forecast of £62m not being approved by Welsh Government, with initial feedback being that the plan is unsupportable and unacceptable. The draft financial plan includes WG funding assumptions which have yet to be confirmed, namely: • the Plan currently assumes WG funding to meet the planned costs of addressing our continued local COVID-19 activities, however this funding has not yet been secured centrally by WG; and • the Plan currently assumes WG funding to meet the planned costs of addressing specific exceptional costs from FY23, namely energy costs, the impact of the increase in National Insurance (Health and Social Care Levy) and the increased cost in commissioned services driven by the Real Living Wage. However, this funding has not yet been secured centrally by WG and therefore poses a risk to the position if funding is not fully available. This could lead to an impact/affect on the Health Board's cashflow requirements and its ability to meet its payments as they fall due, currently expected to impact in March 2023. Urgent mitigating actions are required to significantly reduce the Health Board's current expenditure trajectory, whilst maintaining patient services.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)		**No trend information available.**
Domain:	Finance inc. claims	
Inherent Risk Score (L x I):	5×4=20	
Current Risk Score (L x I):	5×4=20	
Target Risk Score (L x I):	2×4=8	
Tolerable Risk:	6	
Trend:	*New risk*	

Rationale for CURRENT Risk Score:

Financial planning assumptions have been assessed assuming up to 12 months of "Low" COVID-19 prevalence (defined as COVID-19 circulating in the community, perhaps at levels of Summer 2021, but lower severity (equivalent to Omicron variant)). Whilst the operational responses and corresponding financial impact of the pandemic during 2020-2022 has provided a sound basis for modelling scenarios, it should be acknowledged that this "Low" scenario may not be the case throughout the year, which may have resource implications. WG funding streams are partly confirmed, however there will be a reliance on the success of bids for specific funding to support the specific exceptional costs, transitional COVID-19 support in response to the pandemic and in the acceleration of the Health Board's Strategy. A strategic transformation of our operating model is required to make the shift in services that are required to deliver workforce and finance sustainability - this is a medium term outlook, but will impact the in-year position.

Through our revised planning process, operational plans to address the financial savings gap and operational variation have not provided sufficient assurance to mitigate the current financial trajectory.

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. The current draft Financial Plan does not provide sufficient assurance of this and urgent management actions are required to address this.

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, including: Local Health Board funding arrangements; Funding arrangements through the Regional Partnership Board and Local Authority partners. Funding from WG's own sources or from HM Treasury via WG. 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. Linked to Target Operating Model (TOM) workplan, which will be shaped by the Health Board's strategy, “A Healthier Mid and West WalesÃ¢â‚¬Â, and align to the design assumptions set out in that. 7. Accountability statements in relation to the Opening Directorate Budgets underpinning the draft interim Financial Plan for 2022/23 will issued to all budget holders in April 2022. 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 decisions are made. 8. Performance against plan monitored through System Engagement Meetings with Services, including Performance, Quality and Financial information. To be improved through Improving Together. 9. Implementation of systems for efficiency (Malinko, WellSky, Nurse Documentation system) are driving financial systems for control	The costs of addressing the Health Board's local needs may exceed available funding or the organisation my fail to deliver the required level of transformational change during the year through which the opening cost base is expected to be rationalised. This is in relation to the continuation of core and other services, the direct and transitional response to COVID-19, specific exceptional costs and the delivery of Recovery and Sustainability Plans.	Feedback/clarity from WG as to levels of additional revenue and capital funding available	Thomas, Huw	31/08/2022	WG feedback is awaited
		Finance Delivery Unit have been invited in to work closely with the Finance and Performance team to translate the Planning Objectives that relate to our Target Operating Model into the financial and performance impacts we should expect to see.	Thomas, Huw	31/08/2022	Letter to Director General requesting support has been sent.
		The Delivery Unit and Improvement Cymru have been invited to undertake a desk top review with our Planning Team of all the Planning Objectives we are progressing this year in relation to implementing our Target Operating Model (including a review of the underpinning plans for each) to provide the Board and Welsh Government with assurance that the actions we are taking are sufficient in their scope and ambition to achieve what we have set out in our plan and that the underlining action plans are sufficiently robust.	Davies, Lee	31/08/2022	Letter to Director General requesting support has been sent.
		We will establish a monthly meeting with the Welsh Government Planning, Performance, Quality and Finance Teams to review and challenge our progress on delivery that will involve me and all appropriate members of the Executive Team here. I will be guided by you on the relationship between this meeting and the more routine IQPD meetings although it may be sensible to merge them or have a two-part agenda.	Moore, Steve	31/08/2022	Letter to Director General requesting support has been sent.

(Symbiotics, Caf M in Facilities and Estates, Allocate), alongside the Digital Strategy improving grip and control. 10. Weekly financial reporting to Executive Team, tracking week-on-week progress against key metrics.		Our normal scrutiny and assurance arrangements as a Health Board will continue and Chair's agreement will be sought to re-establish regular informal update meetings with the Health Board's Independent Members to keep them informed of progress.	Thomas, Huw	31/08/2022	In progress - series of meetings are being established
		The weekly Executive Team meeting chaired by the CEO will be the internal group that monitors and drives progress, focusing on: a) delivery of our Planning Objectives and the subsequent financial benefits; b) efficiency and productivity opportunities (based on our Opportunities Framework); c) corrective actions identified through our regular Executive-led Directorate Use of Resources meetings to reduce current expenditure trajectories.	Moore, Steve	31/08/2022	The process is in place, however the cycles are yet to identify corrective actions leading to an in-year financial improvement.

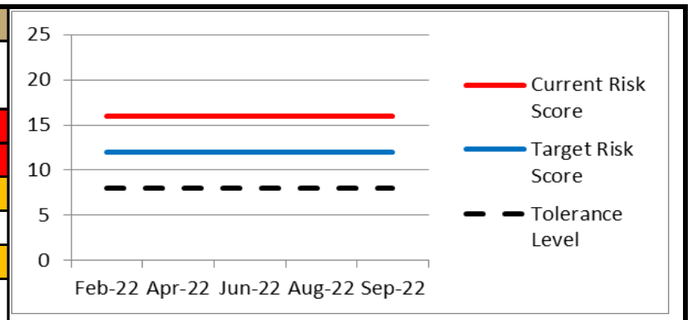
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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 Use of Resources Meetings.	1st			* Mth 2 Finance Report Sustainable Resources Committee, June 2022 * Mth 3 Finance Report Board, July 2022	None	Shift in financial reporting to Board and SRC so that it is clearly aligned to core cost drivers.	Thomas, Huw	31/08/2022	On track
	Sustainable Resources Committee oversight of current performance	2nd					New weekly pack developed for ET to support rapid decision making.	Thomas, Huw	31/08/2022	On track
	Transformation & Financial Report to Board & SRC	2nd					Cash management strategy and forecast cashflows to be developed and reported to ET, SRC and Board	Thomas, Huw	31/08/2022	On track
	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 process	3rd								

Date Risk Identified:	Jan-22
Strategic Objective:	6. Sustainable use of resources

Executive Director Owner:	Thomas, Huw	**Date of Review:**	Aug-22
Lead Committee:	Sustainable Resources Committee	**Date of Next Review:**	Sep-22

Risk ID:	**1352**	**Principal Risk Description:**	There is a risk of business disruption and unacceptable delays in patient care (particularly radiology, pharmacy, laboratories and Cancer Care) and in some instances misdiagnosis. This is caused by unavailability of data, inability to share data, corruption of data or malfunctioning of clinical devices and systems due to a cyber-attack, and a lack of resources to implement Information Assurance and/or a poor Cyber Security culture. This could lead to an impact/affect on positive patient outcomes and threat to life, reputational damage, loss of patient trust, severe financial impact to Hywel Dda through regulatory fines and individual litigation (UHB's finances and reputation - ICO fines of up to 4% of Budget/Revenue for GDPR/DPA 2018, Welsh Government fines of up to £17m for NISR). In addition, a loss of clinical technologies and systems would result in extreme pressure on limited clinical resources.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Statutory duty/inspections
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	8
Trend:	⇔



Rationale for CURRENT Risk Score:
There are daily threats to systems which are managed by UHB and Digital Health Care Wales . Cyber attacks against the healthcare sector have become more prevalent. There was a 44% increase in ransomware attacks against the UK healthcare sector during the height of the COVID-19 pandemic with a 20% rise year on year. The recent attack on HSE Ireland highlighted the real possibility of NHS Wales being attacked and, given the similarity in infrastructure, a demonstration of what a cyber attack could look like and the challenges it would present to service operations, clinicians and digital staff. 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.

Rationale for TARGET Risk Score:
Increased diligence, and monitoring of the cyber incidents will limit the impact upon the organisation. However this work is continuous and is dependent on obtaining the appropriate level of resources to undertake the patching of servers, control of boundary devices and firewalls, hardening of laptops and workstations, updating of anti-virus libraries and segmentation of networks and infrastructure work at pace.

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**
Hywel Dda's Corporate Risk Register (CRR) and Board Assurance Framework are reviewed 3 times a year. Cyber Security Risks are owned by an Executive Director, Finance Director and SIRO and delegated to Director of Digital and Deputy SIRO. Process in place to review and manage all critical cyber security risks in line with existing risk management framework. There is an Independent Board Member for Digital. The Deputy SIRO chairs an Information Governance Sub Committee and the Information Asset Owners Group. IG Risks are captured, well documented and reviewed monthly. Mandatory IG Training . IG policies and processes including DPIA and Privacy Notices in place (These are due for review and uplift to include data security and NISR requirements). The following technologies are utilised in ensuring that the threat of a cyber attack is reduced: - Defender for Endpoint - SolarWinds and Kaseya - Email Phishing - Sophos - National Tools Funding allocated to Cyber Security and Information Governance Service Business Continuity Plans with fall back to manual and administrative processes.	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. Lack of business continuity and disaster recovery plans for key clinical systems	Establish and publish an Organisation of Cyber Security with clearly defined roles and escalation points to the business that include Board members.	Tracey, Anthony	~~30/06/2022~~ 30/09/2022	On track - a number of programmes of work have been drafted and will be approved at the first meeting of the Cyber Resilience Sub-Group of IGSC.
		Build and deliver a communications plan on Cyber Security to the Hywel Dda workforce.	Tracey, Anthony	~~31/07/2022~~ 30/09/2022	The plan has been completed and discussed at the Cyber Security Assurance Group. It will be signed off at the next IGSC for rollout in September.
		Train all Hywel Dda Board Members in Cyber Security including current threats to NHS Wales. The National Cyber Security Centre (NCSC) recommend their Board Toolkit https://www.ncsc.gov.uk/collection/board-toolkit	Tracey, Anthony	~~31/08/2022~~ 31/10/2022	On track - a formal training programme (e-learning) is being explored for Board members
		Restate the Board's intent on cyber security to the Hywel Dda workforce.	Tracey, Anthony	~~31/08/2022~~ 31/10/2022	On track - as above. Following a successful adoption by the Board, the eLearning package will be rolled out across the Health Board. Discussions around the mandating of such training still require to be completed.
		Carry out a yearly table top exercise to practice the Hywel Dda's response to a National Cyber Security Incident and a Major Cyber Security Incident	Tracey, Anthony	31/03/2023	On track. It has been agreed that a national exercise will be developed which will run across all Health Boards and Trusts. However, guidance will be sent to all departments of the Health Board requesting that they review their Business Continuity Plans, given the increase risk of a Cyber Attack as a result of the current Ukraine situation. A recent table top exercise was run at UHB with the Radiology Team in which lessons are being taken forward.

Implement an Information Security Management System (i.e. ISO27001).	Tracey, Anthony	31/12/2022	On track
Conduct cyber security risk and vulnerability assessments of critical systems and supporting network infrastructure to capture and remediate risks to business continuity.	Tracey, Anthony	~~30/06/2022~~ 30/12/2022	A number of vulnerabilities have been identified and reported to IGSC, and the digital team are working through the mitigation of said vulnerabilities.
Include cyber security (Secure by design) in all maintenance, new digital and clinical initiatives (including procurement) to ensure confidentiality, integrity and availability within the maximum tolerance of the services business continuity plans and resourcing constraints.	Tracey, Anthony	30/09/2022	On track
Implement a robust supply chain security process with controls appropriate to risk including financial penalties for clinical and business impact and appropriate insurances (public liability and indemnity, business continuity, cyber etc.).	Tracey, Anthony	31/10/2022	On track
Ensure that contracts are clear on cyber security and business continuity requirements and standards for products and services (GDPR/DPA 2018, NISR 2018, CIW Regulations and NHS Wales Standards 3.1 and 3.4).	Tracey, Anthony	~~31/07/2022~~ 30/09/2022	A full review of all historic contracts is underway to ensure that cyber security is included and at the forefront. All new contracts are assessed for cyber assurance before awarding.
Review all business continuity plans in light of COVID-19, new ways of working, resourcing constraints, operational targets/KPIs and reliance on networked devices and digital (inc Cloud) technologies.	Tracey, Anthony	30/06/2023	On track - A work programme has been developed and will be discussed with the Emergency Planning Team to ensure that all systems comply. Where the system is under the direct management of Digital Services, a formal update to the business continuity plans will be produced and adopted.
Review all Connections, Firewalls, Web Proxies, Switches, VLANS and implement technical segregation to minimise business impact as a result of a cyber security incident .i.e Radiology, Pharmacy, Labs, Cancer Care.	Tracey, Anthony	~~31/07/2022~~ 31/12/2022	On track

Review relative responsibilities for cyber security across the Health Board	Tracey, Anthony	30/11/2022	On track
Update the Corporate Risk Register on cyber security to include risks around data theft, lack of data integrity leading to clinical safety risk, business disruption including risk to clinical safety and patient care and regulatory fines under GDPR/DPA, NISR, CIW and PCI-DSS. Consider the impact to Revenue/Budget, Reputation, Regulation and Health and Safety.	Tracey, Anthony	Completed	New corporate risk on cyber security approved by Executive Risk Group on 02Mar22.

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. Number of staff trained in Cyber Awareness	Department monitoring of KPIs	1st			Cyber Assurance Framework (CAF) - IGSC (Monthly) Cyber Resilience and Security (SRC) Apr22					
	Cyber Security Assurance Group to monitor recommendations and actions required in securing our infrastructure from cyber threats and improving cyber awareness across the organisation	2nd								
	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	3rd						
Audit reviews (Internal / Cyber Resilience Unit (CRU) / Wales Audit Office (WAO)	3rd						

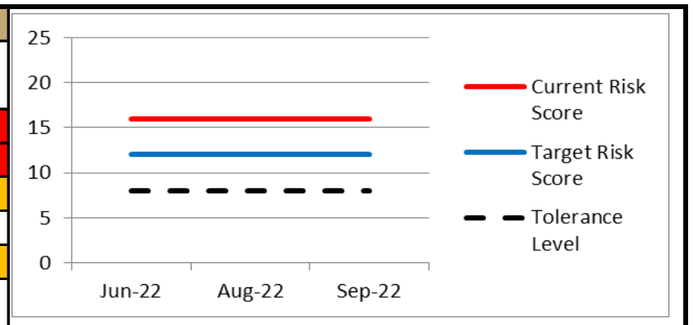
Date Risk Identified:	Apr-22
Strategic Objective:	N/A - Operational Risk

Executive Director Owner:	Gostling, Lisa	**Date of Review:**	Aug-22
Lead Committee:	People, Organisational Development and Culture Committee	**Date of Next Review:**	Sep-22

Risk ID:	**1406**	**Principal Risk Description:**	There is a risk there will be insufficient skilled workforce available to deliver services required for "Recovery" and the continued response to COVID and other respiratory infections, as outlined in the UHB's annual plans 2022/23, and activities to future proof workforce solutions are not taken within 2022-2025 time frame for the development and delivery of the UHB's strategic ambitions to 2030. This is caused by possible new variants of COVID, increases in the severity and dispersal of respiratory viruses within the population (in children and adults) which could mean an increase in infections and outbreaks within acute, community and social care facilities, and due to increased knowledge of workforce requirements and an inability to foresee risks, realign funding and create new workforce models of delivery of service provision. This could lead to an impact/affect on the UHB's ability to staff pathways for COVID, surge capacity and new models of care within general hospitals, community hospitals, delivering the respiratory vaccination programme and the delivery of planned care, as well as increased sickness absence directly, and increased self-isolation of staff, and limiting the ability to recruit and train staff quickly to provide additional support in the short, medium and long term.

Does this risk link to any Directorate (operational) risks?	205, 86, 820, 232, 1298, 1281, 906, 90, 632, 525, 1223, 1083, 111, 114, 199, 523, 136, 1238, 200, 180, 1245, 1224, 1309, 1152, 1211, 565, 105, 119, 118, 928, 1305, 852, 1295, 1292, 1377, 842, 138, 371, 153, 156, 939, 940, 1409, 1419, 628, 1316, 1317

Risk Rating:(Likelihood x Impact)	
Domain:	Workforce/OD
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:	8
Trend:	⟷



Rationale for CURRENT Risk Score:

This risk has been scored as 16 (the likelihood has decreased to "likely" and has the potential to have a "major" impact) as the number of key staff unavailable for work from staff sickness and self-isolation is still as high, although there has been a slight improvement. The reasons for which may also impact on staff resilience and ability to maintain performance. Staffing levels (acute & community) continue to operate well below established levels due to both vacancies and sickness/absence with the nurse staffing escalation policy applied. There is still a significant risk of workforce misalignment with activity and required competence levels. Further work needs to be undertaken to understand the level of risk across each staff group, specialty and site to fully comprehend the level of risk the organisation as a whole. Further work will be undertaken to understand the level of risk across each staff group, specialty and site to fully comprehend the level of risk the organisation as a whole.

Rationale for TARGET Risk Score:

The Target Risk score indicates the likelihood of the risk occurring (COVID-19 absence continues to be high at c9% but lower than peak at 12% but has not returned to pre-pandemic levels of c5%). Other intelligence leads as to be alert to workforce issues as evidence suggests that patient acuity is increasing and therefore workforce requirements will increase by proxy until new models/methods to reduce or manage complexity can be identified. Also, it may be that there could be concerns for the re-start of services or more specifically of a winter surge developing when recovery activity has fully commenced. Therefore, the probability sits between 75-90% when taking account of multiple factors - respiratory infections, increased patient acuity, the longer term impacts of COVID-19 on the population i.e. inability to access services needed, and workforce resilience. We hope we will be able to take mitigate actions noted below predominantly through our interventions under the Regeneration Framework in the short term and for the medium to long term begin to realign available workforce to new service design and models of care. This risk is wider than a 12 month period as actions taken or not taken today will have a long term legacy on our available future workforce and capacity/capability to manage the associated challenges of service & workforce redesign.

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**
Organisational Governance Structure People, Organisational Development and Culture Committee (PODCC) Workforce Conscious Group (to change to Workforce Planning and Education Assurance Group in 22/23) Workforce Professional Planning Groups (Nursing, Medical and Therapies and Health Care Sciences Planning Groups and the Team around the Patient Group in place) Workforce Planning Team acting in strategic & tactical capacity; development of the Workforce Regeneration Intervention Framework to align operational, tactical and strategic activity. Organisational Gap Analysis based on a 10 year profile developed Inter-Workforce and Corporate Team & Planning Objectives Establishment Control Agency usage Bank Utilisation & ongoing onboarding of supply Efficient Rostering practice Roll out of new rostering system Overview of organisation and service wide risks (assessment of each service area based on workforce availability)	An organisational wide escalation assessment in place identifies gap but not detailed in year solutions (working through Recovery Plans and workforce requirements, set against an escalation plan for service developments). Workforce planning groups need time to mature and develop focus. Insufficient capacity/capability in workforce planning within team and across organisation. Establishment control cannot be relied on as one source of truth for information as a) partially due to temporary changes linked with COVID-19 and pathways, b) 9 sources of information not all feed into the establishment control tool and c) data management issues in ESR, eg, single employer status for our medical workforce. Tools to enable modelling in short	IMTP Plan Workforce Technical document has been drafted and further details required by June 2022 to include specifics on 1)Recovery Plan & Workforce Requirements 2) Ongoing COVID Response Planning & Workforce Requirements 3) Phased Plan for COVID-19 escalation - considered business as usual 4) New Programmes & Projects Timelines & Workforce Requirements explored for alignment to Recovery & COVID Plans. 5) Linked to the Target Operating Model 6) Maintain alignment between emergency, operational, tactical, regional and strategic plans related to workforce	Walmsley, Tracy	~~31/07/2022~~ (NB Workforce Technical Document Review complete - gaps in knowledge reference Target Operating model). Other papers aligned also being shared with PODCC).	Workforce Plans to be reviewed based on Target Operating Model. Baseline IMTP (gap analysis) complete by end of Mar22. Full plan to be developed by Jul22. Service engagement required. Link in to professional planning groups. Review of groups, meetings & attendances to manage capacity to engage to enable alignment on critical aspects & higher risks. Update July 2022: Target Operating Model in development; Workforce Technical Document & MDS to be sent to PODCC committee in August for update on progress to date.
		Implementation of the nursing workforce plan (Buy (Resourcing), Build (Development) & (Retention) delivery within year with monthly check of progress against actions assured by the Nursing Workforce Planning Group	Gostling, Lisa	31/03/2023	Plans are in place and actions being developed to support retention. Development of a Workforce Planning & Education Assurance Group to embed ongoing work. Detailed plans in place and currently on track, with specific focus on areas of concern i.e. resourcing.

service area based on workforce availability) Continuous process of assessment of services to be stood down and deployment options based on service needs (ODPD) Targeted prioritisation of recruitment/onboarding of new employees to the highest areas of risk in terms of maintaining service delivery (WFOD Strategic Group) Temporary Workforce Utilisation reports shared regularly to monitor levels of supply.	tools to enable modelling in short medium and long term to enable alignment of population health, labour market, internal labour market, activity & performance analysis aligned to financial constraints (work arounds utilised but gaps/issues exist). Linked with service pressures increased demand is placed in terms of workforce which has not been planned for delivery in year. Critical analysis of workforce alignment to priorities for delivery within financial considerations for short medium & long term. A robust framework of competency based workforce planning and related training to underpin the Team around the Patient initiatives and new model development of care.	Development of professional led workforce plans to align to in year tactical & operational plans linked to the overarching Strategic 10 year Workforce Plan.	Walmsley, Tracy	31/03/2023	TOR for Overarching Workforce Planning & Education Assurance Group and specific groups previously established to feed in i.e. Nursing Workforce Planning and Team around the Patient. Groups and alignment of work for: medical (inc Psychology) & associated medical professionals workforce; AHP/HCS inc Pharmacy group; Ancillary & Estates; and Digital & Administrative. Workforce Regeneration Framework to provide alignment of work streams.
		Engagement with HEIW & Universities on Medical, Nursing, AHP/HCS & Pharmacy programmes to include work linked to the Strategic Workforce Planning & Education Group and specific discussions with HEIW on entrenched commissioning issues due to provision or rurality. Regular contact with HEIW on all matters related to workforce planning & education based - monthly & quarterly.	Walmsley, Tracy	31/03/2023	Education & Commissioning response for 2022 shared in Mar22 with HEIW, follow up actions where issues have presented in relation to outturn being explored i.e. Psychology. Ongoing plan & specifics based on a critical analysis of IMTP by professional leads and service plans over a 5 year time frame.
		Development of community workforce model (quarterly monitoring will be embedded to feedback on progress).	Walmsley, Tracy	31/03/2023	Linking with County Directors and HEIW on primary & community workforce infrastructure and design methodology.

Analysis, design and development of the infrastructure to develop the a new model of care i.e. OBC and Social Model of Health i.e. resource requirements, alignment to current structure and service design programmes (workforce planning for workforce, planning/project management, communications & engagement, clinical oversight)	Williams, Paul	31/03/2023	Resource identification has been reviewed and a phased plan of implementation agreed by Executive Team. Requires alignment of new resources within current operating model/infrastructure to make best use of resource and manage risks.
Digital support with workforce planning to support speed in decision making at local, regional & national levels. (Regeneration Framework adopted as a national model). Interdependent need to link population health, external labour market analysis, activity modelling, internal labour market analysis to pathway design, patient outcomes and staffing models based on appropriate assumptions, scenario planning and financial models.	Walmsley, Tracy	31/03/2023	Mapping of resources required, reprioritising work to enable development (may impact on other work priorities if additional investment not possible). Working with Chair of Team around the Patient Group to facilitate. Discussed with LG (12/01/22)as QSEAC, PODCC and SURC all have links to workforce planning implications. Workforce Planning Conscious Assurance group in place acting as "oversight". group. National, regional and local (strategic and operational) WFP Groups emerging supported by WFP Team eg MH, LD,CYP, UEC, etc. Draft TOR in place to be reviewed corporately as per controls. A number of strands of work need to be drawn together as per actions above as control measures & gaps.

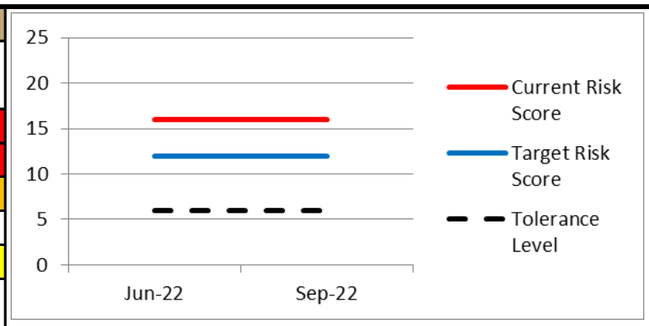
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Monitoring of workforce SIP and gaps in establishment control	1st				Continuous development mechanisms	Develop & utilise maturity matrix to continue to assess capacity & capability needs & evaluate work	Walmsley, Tracy	31/03/2023	Scoping previously complete to develop further.
	Workforce Planning Conscience Group to be developed in the Workforce Planning & Education Assurance Group (22/23)	1st								
	Workforce levels monitored at Professional Groups for Workforce Planning Group and Operational Delivery Group	2nd								
	PODCC - IMTP Plan, and process mapped through Planning Sub Group	2nd								
	Workforce Planning Internal Audit (Substantial Assurance) 2021/22	3rd								

Date Risk Identified:	Jun-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Sep-22
Lead Committee:	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Oct-22

Risk ID:	**1407**	**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 and achievement of WG Ministerial Priorities for the reduction in elective waiting times to target levels during 2022/23. This is caused by the impact of urgent and emergency care pressures (as reflected in risk 1027) and a continuing significant deficit in available staffing and financial resources to support green pathways for urgent and cancer pathway patients. 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:

The combined impact of urgent and emergency care pressures (as reflected in risk 1027) and a continuing significant deficit in available staffing and financial resources continues to limit available capacity for elective, urgent and cancer pathway patients and, as a consequence, represents a risk to delivery of Ministerial Measures for the reduction in waiting lists/times during 2022/23.

Limits to staffing resource both in theatre, and post operatively, was a challenge before the COVID pandemic. As we continue efforts to progress recovery following the pandemic, significant staffing deficits with the Health Records service (impacting on the volume of outpatient activity delivered) and Anaesthetic medical team (limiting the volume of elective operating sessions undertaken) continue to limit progress in expanding overall activity levels to match/exceed pre-pandemic levels. The impact of increasing unscheduled care pressures continues to limit capacity to be dedicated to elective & surgical pathways.

An elective care recovery plan has been developed which seeks to increase outpatient and treatment capacity beyond levels delivered prior to the pandemic. However, the capacity required during the 2022/23 year to enable achievement of the Ministerial Measures exceeds that currently available. Whilst outsourcing programmes are continuing supported by Recovery funding provided by WG, the additional capacity required exceeds the level currently being commissioned and reflected with the UHB's Annual Recovery Plan.

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 pandemic. The target score of 12 is based on the realistic assessment of the level of planned care work which can be achieved both internally across the UHB and via maximum utilisation of capacity available within the independent sector, should available resource levels support commissioning of activity to the level required.

Whilst efforts to make further progress towards the Ministerial Measures continue, the Health Board has signalled through its Annual Recovery Plan that full achievement of both the Stage 1 and Total pathway measures by the respective target dates is unlikely.

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 dedicated elective beds on 3 sites. # 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. # Robust sickness absence management arrangements in place. # Comprehensive programme of outsourcing of planned care volumes in place utilising capacity available via independent sector providers # Weekly review of outsourcing volumes and further opportunities progressed jointly by Planned Care and Commissioning teams. # Planned Care Recovery Programme for 2022/23 in place.	# Limited impact to date of the wider urgent and emergency care plan in reducing capacity pressures on acute sites and the ability to protect sufficient elective pathway capacity for elective patients. # Theatre staffing availability to support expansion of theatre capacity at required pace and level. # Timeliness of the All Wales Commissioning Framework to support rapid decision making and commissioning of independent sector activity levels when supported by non-recurrent funding released part-way through the year. # Sufficiency of Health records service capacity to support planned expansion of outpatient activity. # Sufficiency of Anaesthetic medical staffing capacity to support planned expansion of required operating lists.	Revised elective care delivery plan developed for inclusion within refreshed Annual Delivery Plan to be submitted June 2022.	Jones, Keith	Completed	Plan complete and submitted within refreshed Annual Recovery Plan.
		Opportunities to enhance dedicated elective pathway capacity across sites is dependent upon successful delivery of the transforming urgent and emergency care plan.	Jones, Keith	31/03/2023	Dedicated elective capacity in place at PPH, BGH and WGH (day surgery until December 2022) sites. Planning continues to establish dedicated elective pathway capacity at Glangwili Hospital to support sufficient internal capacity for Urology & ENT surgery - progress dependent on successful impact of TUEC programme and recruitment of ward nurses to support required capacity.
		Workforce development and recruitment plan jointly developed between Planned Care & Workforce Team	Hire, Stephanie	31/03/2023	Some progress achieved in recruitment of theatre staffing resources. Further progress to be achieved through Q3 in 2022/23. Limited progress to date in recruiting additional anaesthetic capacity. Locum and permanent post recruitment efforts continue. Responses to most recent adverts due 01/09/22.
		Targeted review of Health Records service vacancies and recruitment plans, led by Health Records service and supported by Planned Care & Workforce teams.	Rees, Gareth	~~31/07/2022~~ 30/09/2022	19 WTE vacancies identified. Recruitment priorities subject to escalated review. Steady progress achieved to date with anticipated fill rates at each site by end September 2022 as follows: PPH (94%) / WGH (77%) / BGH (88%) / GGH (92%).
		Modular Unit to enable enhanced day surgical provision awaiting completion at Prince Philip Hospital.	Jones, Keith	~~31/03/2023~~ 17/10/2022	Commissioning period delayed due to ongoing engineering issues with air handling units. Latest forecast handover date 26Sep22 with anticipated date of opening 17Oct22.

ASSURANCE MAP	Control RAG	Latest Papers	Gaps in ASSURANCES

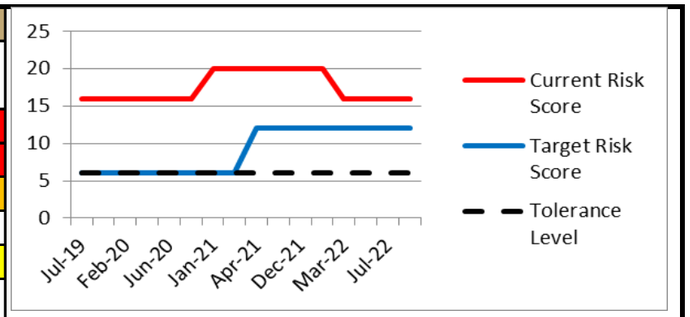
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level	Rating (what the assurance is telling you about your controls	(Committee & date)	Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to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

Date Risk Identified:	Jan-19
Strategic Objective:	N/A - Operational Risk

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jul-22
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Aug-22

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 Radiologists) 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):	4×4=16
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. 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. 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). The risk score has been reduced to 16 reflecting that some equipment has been installed and is operational. A costed plan along with a rolling programme for the installation of additional equipment is in place. The next batch of equipment for replacement has been prioritised and identified, however no funding has yet been secured (for FY 2023/24). A paper has been prepared for the August Capital Sub-Committee meeting to discuss this programme further.

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) - now installed # Additional CT secured in the form of a mobile van in December 2020. # Newly created National Imaging and Capital Priorities Group ensures there is a robust governance process to support a national, sustainable clinically focused capital equipment programme across Wales. This will ensure that all HB's in Wales agree to a prioritisation process which will allow for timely equipment procurement and delivery to support healthcare demands across Wales.	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.	Roberts-Davies, Gail	Completed	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. 21/12/2021 - discussion with the Head of Radiology has confirmed that all relevant funding has been sourced, with ongoing work to install equipment / updates to be made alongside the Estates time. Action complete with regards to funding.
		Installation of CT Scanner at Withybush General Hospital	Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise. As of 25/05/2022 the installation of this equipment is currently running to schedule.
		Installation of scanner at Prince Philip Hospital	Roberts-Davies, Gail	31/10/2022	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise.
		Installation of CT Scanner at Bronglais General Hospital	Roberts-Davies, Gail	28/02/2023	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise.
		Installation of DR room in Prince Philip Hospital	Roberts-Davies, Gail	31/10/2022	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise.
		Installation of DR room in Glangwili General Hospital	Roberts-Davies, Gail	30/11/2022	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise.

Installation of DR room in Withybush General Hospital	Roberts-Davies, Gail	31/12/2022	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise.
Installation of fluoroscopy room in Bronglais General Hospital	Roberts-Davies, Gail	28/02/2023	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise.

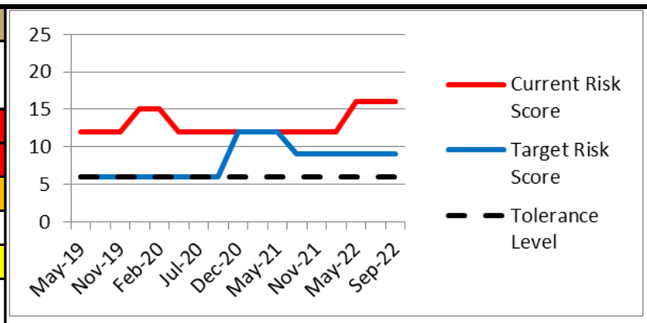
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**			**Identified Gaps in Assurance:**	**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 Feb20 Further updates CEIMT Sep20	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:	Apr-17
Strategic Objective:	N/A - Operational Risk

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Sep-22
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Oct-22

Risk ID:	**129**	**Principal Risk Description:**	There is a risk of the inability to deliver the statutory requirement to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda patients This is caused by outdated and unsustainable GP dominant workforce model as GPs near retirement age and pay rate differentials (50% reduction over last 5 years) across Health Boards in Wales that impact the UHB's ability to recruit in the mid-long term. This could lead to an impact/affect on a detrimental impact on patient experience, as patients would need to go to an ED/MIU to receive treatment for a primary care complaint to be managed. The inability to provide an out of hours service would also add to day to day GP demand, delayed care for patients and over-reliance on other services such as district nursing and ART teams. The unscheduled care pathway including WAST/primary care could continue to suffer ongoing disruptions due to unmet demand for the OOH service seeking alternative management. This risk may also result in the unforeseen deterioration of an unmanaged condition in a patient, thus becoming more complex to resolve if not dealt with in a timely manner.
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):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	3×3=9
26/11/2020 - Board 'Accept' Target Risk	
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
Fragility of out of hours service delivery continues. Rotas continue to be fragile, particularly at weekends and holiday periods. The inability to recruit GPs (caused by aging workforce and a reluctance of new GPs taking on out of hours roles), combined with increased demand for face-to-face, longer complex consultations, and increasing pressures in day-to- day primary care which is impacting the ability of GPs to be available for OOH shifts. In addition, some clinicians may preferentially work in other urgent emergency care initiatives such as 111 First or SDEC, as they are potentially much lighter (as reported by SBU OOH service). Any further absence on out of hours provision is likely to rapidly result in further deterioration of the current position. Availability of day time work, potentially leading to less availability of locums available for OOH. The Health Board currently have approximately 49 GPs (down from 100, 5 years ago) who regularly work the rotas, and an additional 10-20 who only work bank holidays rotas due to enhanced rates. ANP staff have reduced from 4 to 1 which covers 4 hours over a weekend period (0.1 WTE).

Rationale for TARGET Risk Score:
Service rota positions remain variable with continued shortfalls in clinical cover variably affecting service provision. Generally the rotas continue to be unstable, particularly at the weekends and holiday periods, and this is further compounded by the need for salaried staff to take annual leave and sessional staff to have time off to rest. 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 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 are being considered which will take into account the findings of the recent peer review. There are concerns regarding the future stability of the service, and a need for a greater workforce development plan from central government is really required. TCS must include a more realistic workforce plan to future proof the whole Health Board.

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 and using Rosta master to identify gaps in shifts and cover # Dedicated GP Advice sessions in place at times of high demand (mostly weekends and bank holidays). # Remote working telephone advice clinicians secured where required. # Health Professional feedback form in use between clinicians, service management and 111 (WAST) leads. # WAST Advance Paramedic Practitioner (APP) resource in place. # Rationalisation of overnight bases in place since March 2020, now subject to service review. # Workforce and service redesign requirements flagged as part of IMTP. # Deputy Medical Director meetings on a weekly/bi-weekly basis, helps to ensure governance of the service. # Regular review of risk register with Assurance & Risk Officer. # Agreed pathway for PPH Minor Injury Unit in place. # GP Hub in place where locum sessions can be accessed centrally to support service provision - however there are issues/delays with onboarding in Hywel Dda therefore this has not benefitted Hywel Dda. # Ongoing recruitment campaigns in order to bolster the MDT model and maintaining service stability. # Use of telephone consultations for service delivery alongside remote working, which has increased by 60% due to the pandemic.	The ability to influence workforce participation remains limited due to the lack of contractual agreements (reliance on sessional staff). Difficulties in the recruitment and retention of staff. Competing with other services for same staff, eg SDEC. Concerns regarding the future stability of the service and wider impact on other services such as A&E and admissions and daytime services, GP practice and district nursing, and a need for a greater workforce development plan from central government is really required. TCS must include a more realistic workforce plan. Need for formalised workforce plan and redesign is still required - reflected in IMTP submission. In relation to service demand, activity has increased a little over the summer 2021, but still have the same % of referrals to A&E and 999, with no increase in % of admissions. Covid continues to influence the risk-position with frequent short notice absences and limited opportunity to find cover in these circumstances. The focus on delivery of care via the telephone advice method is the significant factor in stabilising the risk at this time however there is a slow return to seeing more patients face to face with calls completed as telephone advice now reduced to 60-70%. Any reduction in capacity remains likely to require an increase in the risk level as the service delivery will be adversely affected.	Develop a sustainable out of hours service aligned to TCS and the Urgent Emergency Care (UEC) Programme taking into consideration the the findings of the internal service review and the recent Peer Review (when received).	Richards, David	31/10/2023	Awaiting final Peer Review report. Meeting scheduled with UEC Programme lead.
		Implementation of the recommendations of Out of Hours Peer Review undertaken in Jul22	Richards, David	31/10/2023	Awaiting final Peer Review report.
		Educate GPs on importance of incident reporting to improve the quality of service	Archer, Dr Richard	31/01/2023	A journal club session will be used to address this with GPs.
		Develop a streamlined process to onboard GPs from the All Wales GP Hub with workforce colleagues	Archer, Dr Richard	31/01/2023	Ongoing discussion following the publication of internal and likely action in peer review (when available).

Low levels of incident reporting and feedback to improve understanding of quality of service. Onboarding of GPs in Hywel Dda from GP Hub Peer review identified cultural issues within the service.	Work with the workforce relationship team to improve the relationship between management, clinical staff and GPs	Richards, David	31/10/2023	Have met with relationship managers and are working on developing structures.

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. (Monthly updates to IPAR including areas of concern and statistics). 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			OOH Paper - QSEC (Oct21)					
	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								
	QSEC monitoring	2nd								
	Issues raised, and performance Matrix reviewed, at National OOH forum (bi-monthly, attended by WG)	3rd								
	WG Peer Review Oct 19	3rd								
	Peer Review Jul-22 (awaiting final report)	3rd								

Date Risk Identified:	Jul-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Sep-22
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Oct-22

Risk ID:	**1439**	**Principal Risk Description:**	There is a risk that specialist wound management advice is delayed, and as such causes serious harm to patients potentially resulting in deep tissue damage, delays in vascular disorder diagnosis, and on occasion, sepsis. This is caused by the under-resourcing of the specialist tissue viability service to provide advice, oversight and monitoring of wound management across the Health Board. This could lead to an impact/affect on the quality of patients care and delay appropriate treatment in community would result in avoidable admissions, increased length of stay in hospital, and inappropriate treatment plans.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)		**No trend information available.**
Domain:	Safety - Patient, Staff or Public	
Inherent Risk Score (L x I):	4×5=20	
Current Risk Score (L x I):	4×4=16	
Target Risk Score (L x I):	3×3=9	
Tolerable Risk:	6	
Trend:	*New risk*	

Rationale for CURRENT Risk Score:
This is a fragile service which has been extensively considered at Executive level and funding has been agreed on a recurrent basis for the Tissue Viability Nurse (TVN) service.

Rationale for TARGET Risk Score:
Funding has been agreed and service model developed which when in place will reduce this risk to the target risk score of 9. Education throughout the Health Board needs to take place to reduce the risk to a tolerable level.

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**
Centralised referral route. Reinforced referral route across health board - Each team member to have time allocated to manage centralised referral route and triage referrals received from the Acute services only Tissue Viability Team to triage the referrals to the service - Standard procedure for all staff to follow when triaging referrals. Tissue Viability and Wound Management guidance policy. Maintaining attendance to essential meetings such as pressure damage scrutiny and MDTs. To continue with essential training across Health Board to encourage all staff to attend to promote best practice in wound care. Workforce: • Weekly Team meeting. • Daily contact with team member on the Complex referrals • Ongoing clinical supervision to new member of the Tissue Viability Team. Agreed funding to strengthen existing service model. Working with external company to develop and implement effective data collection which will support monitoring through the development of robust outcome measures. Service is currently operating in business continuity mode - extra hours offered to part time staff within the team and to work across different sites when required. Close working with heads of nursing in community and long term care.	Availability of specialist nurses Availability of specialist advice and IT infrastructure to support community and primary care staff in wound management Capacity of operational staff to attend wound management training across the health board (acute, community and primary care)	Appointment of staff with varying skill mix to the service	Dawkins, Helen	31/03/2023	Job descriptions are being developed to support skill mix requirements.

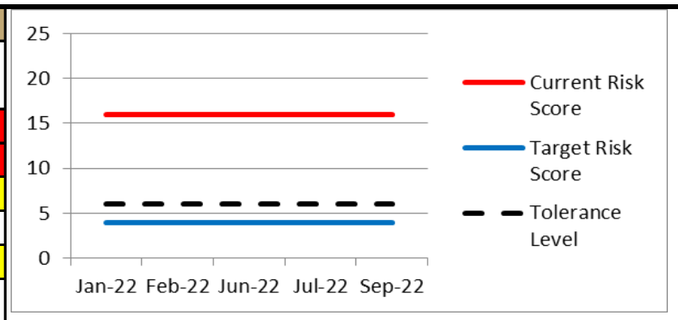
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Datix incident reports monitored by scrutiny meetings	1st				Ability to record outcome measures Base assessment required to understand the skills and knowledge of the workforce in wound management	To work with external company to develop and implement effective data collection which will support monitoring through the development of robust outcome measures.	Dawkins, Helen	31/12/2022	Memorandum of Understanding currently being reviewed.
	No of wound management incidents monitored by QSEC	2nd					Develop virtual clinics to support access for providing advice to community and primary care staff	Dawkins, Helen	12/12/2022	Infrastructure being reviewed to ensure safe governance of uploading personal data.
	National Tissue Viability Group attended by HDUHB Senior Specialist Tissue Viability Nurse	3rd								

Date Risk Identified:	Jan-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Aug-22
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Sep-22

Risk ID:	**1340**	**Principal Risk Description:**	There is a risk of avoidable harm (death and serious deterioration in clinical condition and outcomes) for HDUHB patients requiring NSTEMI pathway care. This is caused by a combination of delayed pathway referral from HDUHB to SBUHB and Cardiac Catheter Laboratory capacity constraints at Morrison Hospital, which is further compounded by transport and logistical challenges in transferring patients in a timely manner, particularly from WGH and BGH. This could lead to an impact/affect on delayed NSTEMI 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 Morriston Hospital resulting in cardiology/unscheduled care flow pressures within HDUHB acute sites. NSTEMI pathway inadequacy is also resulting in poorer patient experience due to anxieties associated with delayed treatment/prolonged hospitalisation, together with poorer staff work experience/satisfaction given associated clinical and outcome risks for patients.
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):	1×4=4
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
NICE guidelines for Acute Coronary Syndromes (NG185) recommend 'coronary angiography (with followâ€˜on PCI if indicated) within 72 hours of first admission(presentation) for people with unstable angina or NSTEMI who have an intermediate or higher risk of adverse cardiovascular events' (recommendation 1.1.6). In support of this recommendation/target, we aim to identify and refer patients to Morriston Cardiac Centre for angiography within 24 hours of admission/presentation. For 2021 the median wait between admission/presentation and angiography for HDUHB patients was 213.5 hours (8.9 days) and the median time between admission/presentation and referral was 39.5 hours. For context, the 2021 position is a deterioration from that maintained in 2019 where the PPH Treat and Repatriate Service supported a median admission/presentation to angiography wait of 120 hours (5 days) - this service was suspended at the outset of COVID-19 due to PPH site pressures. Comprehensive review of Jan-June 2022 performance data scheduled for July 2022 - 'current risk score' will be reviewed at that point.

Rationale for TARGET Risk Score:
The former PPH Treat and Repatriate Service achieved significant improvements for this pathway by a reduction in the median admission/presentation to angiography waiting time from 312 hours (13 days) to 120 hours (5 days) between January 2019 and April 2019. As a service we are aiming to deliver a NICE-complaint pathway and comply with the 72 hour recommendation/target. HDUHB Cardiology Pathway Transformation Project has identified 4 key areas for improvement in the NSTEMI pathway, these are: 1. Reduce length of time from presentation to referral to a median time of 24 hours (potential workforce and system/process solutions) 2. Re-instate NSTEMI Treat and Repatriation service and/or identify steps to improve patient transportation and logistics 3. Increase regional capacity at Morriston Cardiac Centre to meet the 72 hour NICE guidelines 4. If point 3 above is not realised, explore options to commission NSTEMI pathway angiography service from an alternative provider/s across Wales

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 HDUHB Teams on assessment and referral onto NSTEMI pathway. # 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. # 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. # 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. # Bi-monthly operational meeting with Swansea Bay UHB (SBUHB) to monitor activity/patient flow and address associated risks/issues. # Reporting arrangements in place to monitor emergency and elective waiting times. # NSTEMI Pathway Improvement workstream within HDUHB Cardiology transformation project # NSTEMI Pathway Improvement workstream within ARCH Cardiology Programme	Continuing delays in referring HDdUHB patients to Morriston Cardiac Centre for angiography Compromised logistics and patient pathway flow (particularly for BGH and WGH) due to absence of a Treat and Repatriation service and/or effective patient transportation Inadequate Cardiac Catheter Laboratory capacity at Morriston Cardiac Centre	Introduce a number of system and process solutions to reduce presentation to referral to a median time of 24 hours: 1: Staff awareness and education initiative to highlight urgency and timeliness of NSTEMI patient pathway management - ACTION CLOSED; 2: A Clinical Decision Tool to aid early patient identification and referral; 3: Pilot of daily HDdUHB/SBUHB Teams call to review/prioritise patient referrals and need for HDdUHB Cardiologist/SBUHB Interventionist telephone referral - - ACTION CLOSED; 4: Pilot of a weekend HDdUHB Cardiologist on-call advice line to support referral process; 5: Pilot of Chest Pain Nurse NSTEMI patient review and processing of referrals at GGH and PPH between September ’22 and March ’23.	Smith, Paul	~~31/08/2022~~ 31/03/2023	Service and NSTEMI Project group are progressing additional risk actions required: 1: NSTEMI/ACS awareness update presented at HDUHB-wide Grand Round Medical Meeting in April ’22 - ACTION CLOSED; 2: A Clinical Decision Tool to aid early patient identification drafted and for approval at ARCH ACS Meeting in September ’23 - PROGRESSING; 3: Pilot of daily HDdUHB/SBUHB Teams call to review/prioritise patient referrals in discussion - decision taken by ARCHACS Group not to progress - ACTION CLOSED; 4 Pilot of a weekend HDdUHB Cardiologist on-call advice line running during April and May ’22. Report of outcomes due September ’22 - PROGRESSING; 5: Pilot of Chest Pain Nurse NSTEMI patient review and processing of referrals at GGH and PPH currently in development, to initiate September ’22 - PROGRESSING.
	Introduce workforce solutions to support the reduction of presentation to referral to a median time of 24 hours: 1 Consultant Cardiologist 3 Band 8a ANPs 1 Band 4 Pathway Coordinator		Smith, Paul	~~31/08/2022~~ 31/03/2022	Indicative investment highlighted in IMTP - HDdUHB detailed business case development presented at ARCH Regional Recovery Group on 17th March '22. Re-fresh due to re-presentation at September '22 ARCH Regional Recovery Group.

Re-instate of NSTEMI Treat and Repatriation service and/or identify steps to improve patient transportation and logistics.	Smith, Paul	31/12/2022	PPH NSTEMI/ACS Treat & Repatriate Pathway SBAR re-submitted to PPH Triumvirate in April ’22. PPH Cardiology Workstream currently reviewing scope to re-operationalise the NSTEMI/ACS Treat & Repatriate pathway at PPH - progress delayed to need for £500k Capital funding to support Ward4/CCU ward reconfiguration, which would include NSTEMI/ACS Treat & Repatriate bay.
Increase regional capacity at Morriston Cardiac Centre to meet the 72 hour NICE guidelines.	Smith, Paul	31/12/2022	Supported by ARCH, SBUHB submitted SBAR outlining plans for increased capacity and delivery of 7 day Cardiac Cath Lab service at ARCH Regional Recovery Group on 17th March '22. Re-fresh business case for presentation at September ‘22 ARCH Regional Recovery Group.
Explore options to commission NSTEMI pathway angiography service from an alternative provider/s across Wales	Smith, Paul	Completed	ARCH Regional Cardiology Project Group and HDdUHB ACS Working Group currently pursuing a plan that will see the required Cardiac Cath Lab service from Morriston Cardiac Centre. HDUHB Commissioning and Contracting Team have approached Cardiology NSTEMI/ACS centres/facilities across Wales and on the Wales/England borders and there is no available capacity to support HDUHB NSETMI/ACS pathway.

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
	Daily/weekly/monthly/ operational monitoring arrangements by management	1st			Cardiac Waiting Lists - QSEC (Feb22)	None Identified.				
	Audit of NSTEMI pathway undertaken by Cardiology Clinical Lead/SDM on monthly basis	1st								
	IPAR Performance Report to SDOPC & Board	2nd								
	Monthly oversight by WG	3rd								

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Jul-22
Lead Committee:	Health and Safety Assurance Committee	**Date of Next Review:**	Aug-22

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: The age, condition and scale of physical backlog, circa £20m (+) relating to fire safety (i.e. non compliant fire doors, compartmentation defects and general fire safety management issues) across our estate significantly affects our ability to comply with the requirements of the RRO in every respect.

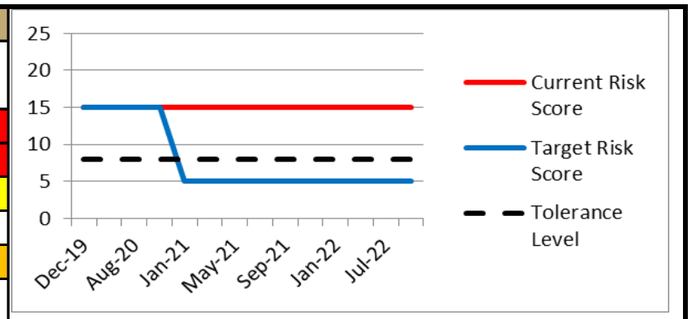
2:Difficulties managing the actions within the current fire safety risk assessment system - to enable complete transparency and ongoing management of actions assigned to responsible persons. The new Boris system will address this issue.

3: Management responsibilities for fire safety not fully understood by all responsible managers.

4: Fire safety training attendance figures are not reaching HB agreed targets. This could lead to an impact/affect on the safety of patients, staff and general public, HSE investigations and further fire brigade enforcement (already served on Withybush and Glangwili General Hospitals), 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:
In addition to completing all actions following an internal governance review initiated by the CEO. The HB has now embedded a fully resourced fire safety management team, with 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, as a result of further fire brigade inspections across the organisation and the need to address these findings within the timescales expected. 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. Phased fire safety improvement works are ongoing across our sites, with significant investments being made to address the recommendations in the MWWFRS letters. All programme dates have been agreed with the HB, WG and MWWFRS senior inspecting officers. We intend to review the progress of our completed actions to determine the risk score as we progress with these works.

Rationale for TARGET Risk Score:
Further improvements in culture and ownership for fire safety. It is the scale of physical backlog for fire safety compliance (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. It is anticipated that when training attendance levels specifically for L2 training have reached > 80% targets and are sustained at this level continuously, coupled with the completion of key fire safety investment programmes and phases across our acute sites (completing in circa April 2025), the HB will then be in an informed position to look at the reduction of risk score for risk 813. This decision will be reviewed regularly.

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. Extensive fire safety improvement works are being undertaken at WBH, GGH and at BGH from WG agreed funding (EFAB bids for BGH and funding and From submitted business cases), with phased timelines fully agreed with MWWFRS. Regular communications and dialogue is taking place between HB and MWWFRS. 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. 9. Works already completed following issue of Enforcement Notices and LoFSM at various sites. For EN sites (WBH and GGH) - Advanced Works to vertical escape routes now completed. Also further improvements under LoFSM at Tregaron, Bronglais, Glangwili and Withybush Hospitals.	Despite significant investments already in place following enforcement notices and letters of fire safety matters, additional investment is required to address fire safety defects at other sites within the UHB, which are being inspected by MWWFRS. We have firm plans in place to address a range of fire safety projects over the coming years and these are all fully identified as actions within this risk with anticipated timelines. 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. Staff fire training attendance figures are below targeted figures set by the HB at 85% for all levels - inability to undertake face to face training has impacted (Covid). Despite making improvements to the culture of fire safety management and ownership, the HB does need to ensure this is organisational wide and embedded within it's workforce and cascaded by management.	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	Completed	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 trial on site by July 2021. System now being tested on site on a few Fire Risk Assessments, we plan to go fully live in Nov/Dec 2021.
		Implementation of a new software system to manage the content of the HB's fire risk assessments. Boris software has now been purchased and is currently being implemented. Date agreed as part of internal fire safety governance review.	Evans, Paul	Completed	Boris software now purchased Dec 2020, initial implementation planned for March 2021. Implementation of risk assessments will now be planned for July 2021. System now supports the use of mobile technology therefore risk assessments can be completed live on the system. System now being tested on site, fully operational by Jan (now Feb) 2022
		Additional fire surveys are required across various sites to obtain costs for all fire compartmentation defects, doors, fire alarm systems and other associated items.	Evans, Paul	31/03/2023	fire safety team and compliance team are working with site operations to determine what the gaps are and to agree what surveys will be required.

Introduce new innovative ways of improving fire training attendance across the HB to increase the percentage figures agreed and set by the HB. As part of the next risk review the fire team intend to split this action into individual sections so we can track and close off action as and when completed.	Evans, Paul	31/03/2023	The fire safety team have been trialing the use of MS teams for L2 Fire training, which has proved to be very successful. We are planning to roll this out to other areas of fire training levels, such as L5/L4 & L3. This will have a positive impact on staff being able to attend the session. We will need to improve communications on this and to ensure staff are made fully aware of the sessions taking place and the dates.
To introduce ways to help improve the culture and ownership of fire safety across the HB. Although management training is taking place at the "Managers Induction Programme" and this is well received. The HB still needs to do more to avoid areas of poor practice that is sometimes identified.	Evans, Paul	Completed	To look at improving the current training content and programme that's currently on offer for management. Regular global communications of do's and don'ts. Having a fire safety share point system, with links to interesting info on effective fire safety management.
Now the new Boris fire safety system is being implemented across the HB (training planned for June 22 for staff), fire risk assessment actions from this need to be monitored by those responsible. These actions need to be communicated at all fire safety sub groups and fed to the HB wide FSG for complete transparency.	Evans, Paul	31/03/2023	System now live in the HB and staff training is planned for end of June 22, from this point all fire risk assessment actions will be closely monitored using this system.
Establish a teams training platform to deliver the level 3 and level 4 fire safety training programmes. Although this will also be supported by face to face sessions. Ensure that management cascade the need for staff to attend fire safety training, appreciating the service pressures and availability of staff. The Fire team have adequate capacity (and flexible training platforms) for staff to attend all levels of training. The fire team will also look to implement a regular training global e-mail as a reminder for staff on when and how to book a session.	Evans, Paul	30/09/2022	We have already implemented teams sessions for L1 and L2 training, the fire team wish to extend this to cover both level 3 and level 4. Level 5 is already implemented.

WBH - Completion of Phase 1 works - For all remaining horizontal escape routes.	Elliott, Rob	31/01/2023	January 2023, remains the currently approved programme for these works.
WBH - Completion of Phase 2 works - For all departments, ward areas and risk rooms.	Elliott, Rob	30/04/2025	Phase 2 works remain on programme to be completed by April 2025.
GGH - Completion of Phase 1 works - For all remaining horizontal escape routes.	Elliott, Rob	28/04/2023	The current forecast completion date is April 2023, however this will need to be closely monitored and reviewed as the project progresses
GGH - Completion of Phase 2 works - For all departments, ward areas and risk rooms.	Elliott, Rob	30/04/2024	Phase 2 remains on programme to be completed by April 2024 (subject to the full due diligence work needed as part of the Business Case development).

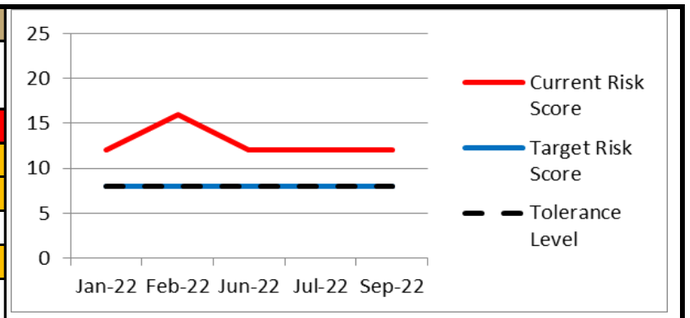
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Maintain a zero or as low as possible number of outstanding fire risk assessments.	Bimonthly review of outstanding actions from fire risk assessments	1st			IA Fire Precautions Report - ARAC Jun18 SBAR submitted to each HSAC meeting, which includes themes of all fire safety risks.	General site management checks/walkarounds on all sites				
	Site Fire wardens reporting fire safety issues	1st								
	Annual Online Fire Audit Self-Assessment submitted to NWSSP	1st								
	Review of compliance through fire safety groups	2nd								
	SBAR 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:	Oct-21
Strategic Objective:	3. Striving to deliver and develop excellent services

Executive Director Owner:	Kloer, Dr Philip	**Date of Review:**	Jun-22
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Aug-22

Risk ID:	**1337**	**Principal Risk Description:**	There is a risk of reputational harm if the health board is found to have not managed the TB outbreak in Llwynhendy as well as it could have. This is caused by the potential findings of the forthcoming HB and PHW commissioned external review into the outbreak and its management since 2010, and whether each stage was conducted in accordance with best practice guidance in place at the time of each phase of the outbreak. This could lead to an impact/affect on stakeholder confidence in the Health Board's ability to manage future outbreaks, local and national media interest, and additional scrutiny from key stakeholders such as WG.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Adverse publicity/reputation
Inherent Risk Score (L x I):	5×4=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:

The outbreak investigation has been re-opened four times in response to new cases of TB, leading to a rapid internal review carried out by PHW in 2019, to identify immediate actions and to make recommendations for the ongoing management of the outbreak. One of the key recommendations of the review was to commission, jointly with PHW, an external review of the outbreak and its management, to inform the approach to the management of TB disease in Wales. The Board agreed to proceed with the external review, the start was delayed by COVID-19. The review commenced in April 2022 with an anticipated completion during Autumn 2022. The risk score has been reduced as no significant findings have been reported to date.

Rationale for TARGET Risk Score:

The development of a cohesive TB database to enable cross-referencing of contacts is also key requirement to mitigate 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**
PHW Health Protection support supporting outbreak and contacting Paediatric cases who previously not attended All contacts have been contacted at least once and families of the deceased have been formally communicated with advising of the review Treatment plans put in place where required A Project team has been established to support the review panel, led by a Project Manager and include administrative support, Communications and Information and Communications Technology Health Board commitment to be open about the findings from the Review with stakeholders and the public and ensure these are addressed. Public Service Ombudsman for Wales (PSOW) kept informed on progress of review Communication strategy agreed through the TB Joint Oversight Group to support the publication of the final report in the Autumn of 2022	Ability to identify everyone as a contact from TB outbreak from different sources Having an agreed effective response to TB aligned to PHW to ensure that management of an outbreak is within an agreed process	Development of TB Database to enable cross-referencing of contacts	Tracey, Anthony	~~31/03/2022~~ 30/09/2022	A system has been developed however further work is required to enable is cross-reference contacts.

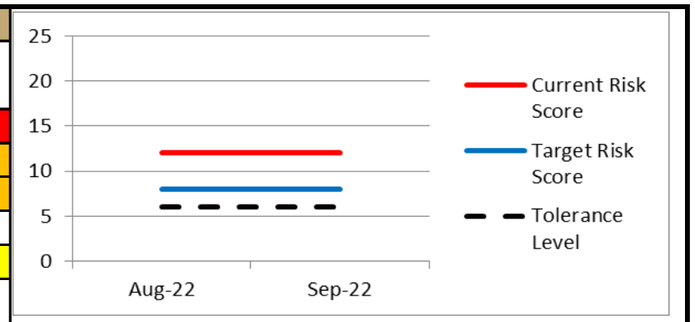
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	TB Operational Task & Finish Group facilitating the external review	1st			An External Review of the Llwynhendy Tuberculosis Outbreak - Board (Sep21)	External review of TB outbreak and management to inform the approach to the management of TB disease in Wales	To commission, jointly with PHW, an external review of the outbreak and its management, to inform the approach to the management of TB disease in Wales.	Kloer, Dr Philip	~~31/05/2022~~ 31/12/2022 (TBC)	In response to the COVID-19 pandemic, a decision was taken early in 2020 to pause the review. Professor Mike Morgan has recently been appointed as the chair of the external review panel and has been formally commissioned, on 16Aug21, to oversee the review. The review has commenced with anticipated completion in autumn 2022.
	TB oversight group for operational response co-chaired by HB and PHW Medical Directors	2nd								
	Internal review presented to an In-Committee Board meeting in Nov19	2nd								

Date Risk Identified:	May-22
Strategic Objective:	4. The best health and wellbeing for our individuals and families and our communities

Executive Director Owner:	Shakeshaft, Alison	**Date of Review:**	Aug-22
Lead Committee:	Health and Safety Assurance Committee	**Date of Next Review:**	Oct-22

Risk ID:	**1433**	**Principal Risk Description:**	There is a risk the Health Board being unable to maintain routine and emergency service provision across the organisation in the event of a severe pandemic event. This is caused by a novel virus (or emerging variant or mutation of concern) causing a pandemic as declared by the World Health Organisation (WHO) and the subsequent ability of the Health Board to respond to the scale and severity of the outbreak. This could lead to an impact/affect on patients being able to access appropriate and timely treatment, the UHB being able to maintain safe and effective levels of staffing, financial loss, adverse publicity/reduction in stakeholder confidence, increased mortality and ill-health across our population.
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):	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:	*New risk*



Rationale for CURRENT Risk Score:
Currently Pandemic Flu is the highest risk on the UK National Risk and Threat Register. This is due to be reviewed imminently when the definition is likely to be expanded to cover any infection rather than just influenza that could cause a pandemic. Current likelihood scored at a 3 to reflect the risk of the Health Board being unable to respond to the scale and severity of the pandemic - not the likelihood of the pandemic actually occurring.

Rationale for TARGET Risk Score:
A Cabinet Review of Influenza Preparedness was due just prior to COVID-19 which delayed publication. This workstream has now recommenced and together with outcomes and learning points from COVID-19 will inform our future planning approach for pandemic response. It is hoped to reduce either the likelihood and/or impact score following consideration and implementation of these reviews/recommendations and subsequent review of internal planning arrangements.

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**
# Major Incident Plan # Well established command and control structures for managing pandemic response both nationally and locally # Continuation of current COVID-19 national vaccination programme until at least March 2023 # Future service model for contact tracing and testing in place until March 2023 # Extensive knowledge across Health Board in managing a pandemic event # COVID-19 response measures which can be adapted to respond to any future pandemic event # Local Resilience Forum (LRF) multi-agency plans for managing pandemic influenza (approved by Strategic LRF 14/11/18 now under review) # LRF Excess Deaths Plan (which supports the LRF multi-agency pandemic influenza management arrangements) developed as a recommendation from Exercise Cygnus. Plan was ratified by the LRF Strategic Group on 11/07/2018. Will be reviewed imminently via LRF Health Group. # Health Board Pandemic Influenza Response Framework and associated plan(currently outdated awaiting review) # Quality assurance process via national & local exercise programmes. # Access to national counter measures stockpile # Surge Plans in place to enable HB to respond to future spikes/waves of infection requiring recommencement of contact tracing, testing & vaccination # Continuous learning from COVID-19	# Current Health Board pandemic framework will need to be updated to incorporate new Cabinet Office review implications/ recommendations and broaden remit to generic pandemic response rather than be influenza specific. # Current response measures, especially around contact tracing, testing and vaccination are time limited and currently in the process of being stood down. Will need to be re-established to respond to future pandemic situation.	Reinstate Health Board Pan Flu Group with a wider remit to consider future pandemic response arrangements within the HB and to enact Cabinet Office Influenza Review implications when publicised.	Hussell, Sam	31/12/2022	Awaiting publication.
		The Wales Cancer Network are employing Single Cancer Pathway (SCP) Project Managers for each health board across Wales to support the SCP work and the optimisation of the National Optimal Pathways	Humphrey, Lisa	31/03/2024	Project Manager appointed and took up post in Apr22. This will be a 2 year fixed term appointment to run alongside the optimisation project.
		Work with newly appointed Head of Radiology to: 1) explore outsourcing opportunities and internal solutions to increase capacity to appointments and reporting utilising non recurrent recovery money. 2) Investigating current capacity for diagnostics to ensure a 7-day turnaround as per the National Optimal Pathways.	Humphrey, Lisa	31/03/2023	Initial Meeting with Head of Radiology 09Mar22 to scope schedule of work for demand & capacity (C&D) plan for radiology and explore short term opportunities to increase capacity. A draft C&D has been carried out by the Radiology service in collaboration with the Delivery Unit. An SBAR that contains the cost of associated gaps in service provision has been developed in draft and presented to Cancer Delivery Board. Next step is to present to the Executive Team October 2022.
		Review access to green surgical pathways across all sites to include access to green critical care.	Humphrey, Lisa	~~30/04/2022~~ 30/09/2022	BGH & WGH Green elective pathway has been re-established. A plan for pre COVID theatre capacity to return for all hospital sites by end Sep 22.

Introduce a central point of contact for navigator as a pilot to coordinate radiology USC appointments and reporting from Mar22	Humphrey, Lisa	Completed	The Radiology Navigator took up post in April 22.

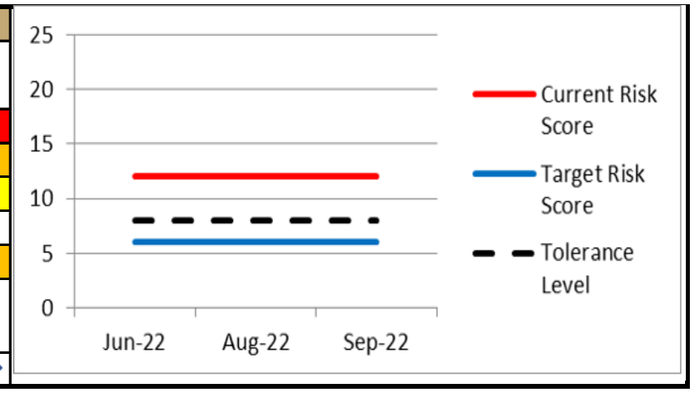
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES			
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Planning via Emergency Preparedness, Resilience & Response (EPRR) inc LRF workstream reports to Health & Safety Assurance Committee	1st			TTP Updates to Board on a regular basis. Vaccination Delivery Programme Update - Board (Jul22) Major Incident Plan - Board (Jul22)	None identified.				
	Operational pandemic reporting structures from HB to WG	2nd								
	National, regional & local command & control structures	2nd								
	National groups operational for vaccination programme planning & delivery	3rd								
	Emergency Planning Advisory Group (EPAG) Wales meetings re Pandemic response and future planning	3rd								

Date Risk Identified:	Feb-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Sep-22
Lead Committee:	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Nov-22

Risk ID:	**1350**	**Principal Risk Description:**	There is a risk of the UHB not being able to meet the 75% target for waiting times in the ministerial measures for 2022/26 for the Single Cancer Pathway (SCP). This is caused by the reduced capacity due to the impact of COVID-19 on our ability to meet the expected 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 which could potentially lead to poorer outcomes and patient experience, adverse publicity/reduction in stakeholder confidence and increased scrutiny/escalation from Welsh Government.
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):	3×2=6
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:

The impact of COVID-19 has increased the risk of being unable to meet the target. The delays are caused by diagnostic capacity issues across the health board in line with the infection control guidance that still remains in place. The main area of concern is Radiology. A decrease in capacity for appointments and results reporting within radiology, due to COVID-19 related sickness, current vacancies and planned annual leave within two of the four health board sites. Patients have been offered alternative appointments on other sites, however some patients have not agreed to attend and have requested an appointment close to home.

Cancer performance has been variable since quarter 3 2021/22. This was due to the increase in COVID related sickness, management of COVID related flows and the overall impact on diagnostic and critical care. The consequence of which resulted in short term planned and unplanned step down of activity within outpatients and planned surgery. This has led to an increase in the backlog of patients waiting in excess of 63 days. Performance since April 2022 has shown a small but steady improvement in line with forecast trajectories and is now at 54% (June 22). Whilst the trajectory for the remainder of the year indicates further overall improvement , in-month performance through the summer period is expected to be variable until the backlog of patients waiting is further reduced.

Rationale for TARGET Risk Score:

The aim is to treat patients within target waiting times, which has now been confirmed as 75% non-adjusted 2022-2026.
The tolerance level will be met if plans to increase diagnostic capacity, utilising allocated recovery funding are realised. Publication of performance data by WG recommenced in Feb21 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**
# A SCP Diagnostic Group with all the relevant service managers is in place to look at the capacity & demand for diagnostic services, looking at what capacity is required for a 7 day turnaround diagnostic service. # Fully established cancer tracking team in place to allow patients to be proactively tracked through their pathways. # A new cancer dashboard has now been developed by Informatics with the support of Business Intelligence (BI) SCP funding from the Wales Cancer Network. This is now live with accesses for Cancer Services staff and Service Managers. This will allow MDTs to actively monitor tumour site specific patients on a SCP. # A Rapid Diagnosis Clinic (RDC) has been launched within the health board. Currently 1 clinic per week being held in PPH. Funding has now been secured and plans are being discussed to role this service out across all 3 counties. # As per the Wales Bowel Cancer Initiative, a successful FIT10 screening in the management of USC patients on a colorectal pathway was implemented in Jun20. This initiative is due to be rolled out to primary care by the endoscopy service by April 2023. # Digital Delivery of Care was implemented during the first wave of the pandemic, resulting in two thirds of patients receiving virtual appointments and only a third requiring face to face appointments. # Virtual appointments are being undertaken via digital solutions e.g. Attend Anywhere. # Weekly Cancer Watchtower meetings where services managers are in attendance. The function of this group is to monitor and address service demand, capacity and risk issues. # Monthly performance meetings with Welsh Government. Trajectory performance plans are currently being developed for each tumour site by the relevant services, with regards to improving performance. This also includes Backlog Trajectory plans on how these improvements will be achieved. # Cancer Pathway Review Panel has been implemented to identify any risk for those patients who have not received their treatment within 146 days.	Anticipated significant gaps within key diagnostic services to address required levels of activity to support SCP. Key diagnostic information systems do not support effective demand / capacity planning. Need for the implementation of new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment pathways. Access to green pathways and tertiary centres fluctuates depending on COVID-19.	The Wales Cancer Network are employing Single Cancer Pathway (SCP) Project Managers for each health board across Wales to support the SCP work and the optimisation of the National Optimal Pathways	Humphrey, Lisa	31/03/2024	Project Manager appointed and took up post in Apr22. This will be a 2 year fixed term appointment to run alongside the optimisation project.
		Work with newly appointed Head of Radiology to: 1) explore outsourcing opportunities and internal solutions to increase capacity to appointments and reporting utilising non recurrent recovery money. 2) Investigating current capacity for diagnostics to ensure a 7-day turnaround as per the National Optimal Pathways.	Humphrey, Lisa	31/03/2023	Initial Meeting with Head of Radiology 09Mar22 to scope schedule of work for demand & capacity (C&D) plan for radiology and explore short term opportunities to increase capacity. A draft C&D has been carried out by the Radiology service in collaboration with the Delivery Unit. An SBAR that contains the cost of associated gaps in service provision has been developed in draft and presented to Cancer Delivery Board. Next step is to present to the Executive Team October 2022.
		Review access to green surgical pathways across all sites to include access to green critical care.	Humphrey, Lisa	~~30/04/2022~~ 30/09/2022	BGH & WGH Green elective pathway has been re-established. A plan for pre COVID theatre capacity to return for all hospital sites by end Sep 22.
		Introduce a central point of contact for navigator as a pilot to coordinate radiology USC appointments and reporting from Mar22	Humphrey, Lisa	Completed	The Radiology Navigator took up post in April 22.

# Process in place that improves time for patients to first outpatient appointment to improve the 28 day performance target (all patients to be informed...etc). # Deep dive pathway review for poorest performing tumour sites - urology, lower GI, gynaecology. # Continue to escalate concerns regarding tertiary centre capacity and associated delays.		Each MDT to review and adopt recommended optimal tumour site specific pathways	Humphrey, Lisa	~~31/03/2023~~ timescales may change depending on COVID	The Macmillan Cancer Quality Improvement Manager is working with the teams with regards to implementing the new pathways. Due to the pandemic, the services have not been able to implement the new pathways in full, due to the restrictions around services and staff

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**		
Internal targets - Looking at the performance per tumour site individually concentrating on those tumour sites under 50% ie Gynae, Lower GI and Urology. Monitoring the 28 day performance and overall performance for each tumour site.	Daily/weekly/monthly/ monitoring arrangements by management	1st			* Implementation of Single Cancer Pathway Report - BPPAC - Feb20 * COVID-19 Impact on Cancer Services - Board - May20 * Cancer Updated to QSEAC Jun20 & OpQSESC Jul20 * Risk 633 QSEAC - Feb21 & Aug21 * IPAR Report - Board - Jan22
	Monitor outpatient appointments booked beyond 10 days to identify common themes	1st			
	Service plans in response to COVID-19 overseen and agreed by Bronze Acute & Gold (when instigated)	2nd			
	IPAR Performance Report to SDODC & Board	2nd			
	Monthly oversight by Delivery Unit, WG	3rd			

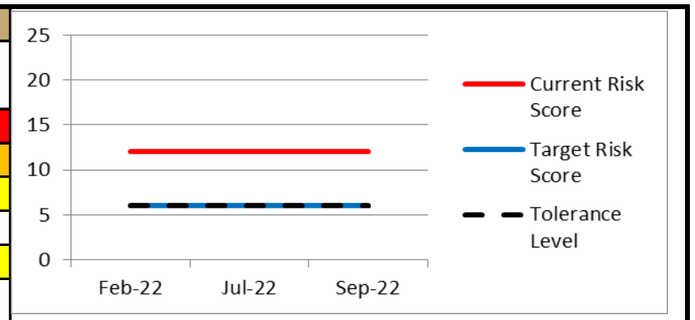
Gaps in ASSURANCES				
Identified Gaps in Assurance:	**How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
None identified.				

Date Risk Identified:	Dec-21
Strategic Objective:	1. Putting people at the heart of everything we do

Executive Director Owner:	Rayani, Mandy	**Date of Review:**	Aug-22
Lead Committee:	Health and Safety Assurance Committee	**Date of Next Review:**	Oct-22

Risk ID:	**1328**	**Principal Risk Description:**	There is a risk that the ability to protect staff, patients and critical assets is compromised by the current vulnerabilities in our security management arrangements and infrastructure. This is caused by insufficient physical security measures to protect staff, patients, services and equipment. This could lead to an impact/affect on staff injury from physical assault, unauthorised access to hospital departments, placing vulnerable patients at risk, theft of HB and personal assets, increased demand on police resources, increase in complaints and claims, and non-compliance under the Protect Duty under CONTEST Cyrmu.
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):	4×3=12
Target Risk Score (L x I):	3×2=6
Tolerable Risk:	6
Trend:	⟺



Rationale for CURRENT Risk Score:
Security reviews have identified inability to lockdown sites effectively. There is no dedicated security guard force to discourage criminal activity or respond to demands and manage security systems. There is also variation in the standard of coverage and quality including evidential standard required of CCTV systems across the Health Board.

Rationale for TARGET Risk Score:
A planning objective has been agreed by Board which recognises the Board's commitment to strengthening security arrangements within Hywel Dda, investment will be required to reduce the level of risk to the 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**
Certain external doors are fitted with automated locking. Access Control in certain departments CCTV in place across Health Board with Aberaeron and Cardigan having good examples of more robust security management arrangements. Communication systems (2-way radio) in use in certain departments Porters have been trained in de-escalation and restraint skills. Use of external security teams in vaccination centres and when deemed appropriate, eg potential high risk situation at acute sites. Planning objective to undertake a review of the existing security arrangements within the Health Board agreed by Board in Jan22. Support and pursue police prosecutions of incidents relating to theft and issuing of anti-social behaviour disorders (ASBO) Information sharing exists with Police in relation to safeguarding/Prevent, Controlled drug loss/theft (Local Intelligence Network), incident data from A&E BGH and WGH have improved external door security on a number of doors during Mar22	Not all doors are fitted with automated locking systems therefore require manually locking Inability to efficiently lockdown sites or departments quickly if required. Variation in coverage and quality of CCTV provision across sites Lack of dedicated day-to-day management and resource of security systems. Lack of a dedicated security guard force to respond to incidents, management of CCTV, response to violence and aggression incidents, act as a visible deterrent, ID badge issue, management of access control systems, perform a key role in the event of emergencies or when lockdown is required.	A review of external door security to be undertaken.	Harrison, Tim	Completed	External door review completed in Mar22 however capital bid was unable to be submitted in time for financial year end due to equipment availability. However BGH and WGH have improved external door security on a number of doors during Mar22.
		Undertake a review of security arrangements within Hywel Dda (linked to new PO agreed by Board in Jan22)	Harrison, Tim	Completed	Internal review completed and will be discussed at Task and finish Group on 19/05/22. Police have undertaken a review of security of residences at WGH and aim to roll this out across the Health Board residences.
		Additional electronic lock doors to be fitted at BGH.	Harrison, Tim	Completed	Additional priority doors fitted with access control
		Develop a risk based proposal which identifies the schedule of works and investment required to address any deficits and/or enhancements required by the security review (this links PO 3L)	Harrison, Tim	30/09/2022	Task and finish Group established with first meeting on 19/05/22. Next step will be to set up workstreams for each element listed under PO 3L (eg CCTV, Access Control, Security Guardforce)
		CCTV system review currently being undertaken - Completed WGH, GGH and PPH	Harrison, Tim	11/11/2022	Security Manager leaving HB so this work is temporarily being reviewed by V&A Case Manager

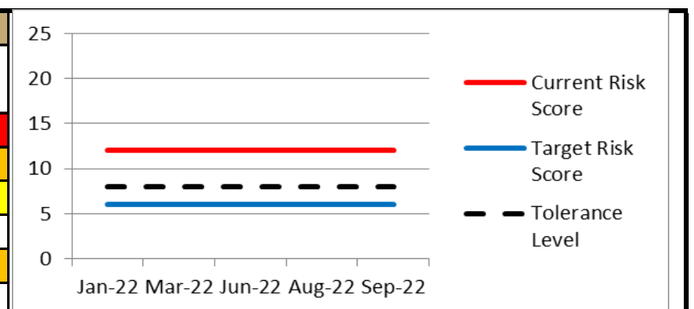
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Security incident breaches are reported via Datix and investigated	1st			Premises and Security Update Deep Dive - HSC (Nov21)	Review of high risk areas to improve mitigations	Establish Health Board Security Management Group	Harrison, Tim	Completed	Terms of reference produced and first meeting arranged for May 22.
	Reports on security arrangements and related incidents are provided to Health and Safety Committee	2nd								
	Mass vaccination Centres were reviewed by the Counter-terrorism Security Advisors (CTSA)	3rd								
	CTSA External Review in 2017 advised of areas that required addressing	3rd								

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Aug-22
Lead Committee:	Sustainable Resources Committee	**Date of Next Review:**	Oct-22

Risk ID:	**1335**	**Principal Risk Description:**	There is a risk of clinical services being unable to access paper patient records, at the correct time and place in order to make the right clinical decisions and provide effective patient care. This is caused by not having a fit for purpose records management infrastructure along with organisational management arrangements which are insufficient in capacity and scope. This could lead to an impact/affect on the interruption to clinical services, ability to provide effective patient care including compliance with and attainment of nationally agreed Cancer, RTT and Stroke targets, review and fine by the ICO (<£17.5m - £35m fine per episode), increased litigation and negligence claims, complaints and possible redress, non-compliance with GDPR in regards access to patient information, underutilisation of clinical staff, outpatient facilities and day case areas and theatres, inappropriate disclosure of confidential information, missing patient information and confidential documentation, and non-compliance with nationally agreed retention timescales.
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):	4×3=12
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:
Currently across the Health Board there is a considerable variance in both practice and process, operationally when utilising and dealing with the various types of records in use throughout directorates, services and departments. The current records management methodology, results in a non-standardised approach to delivering effective records management arrangements. With a lack of agreed criteria in terms of managing the record during its life cycle from creation, during retention and to disposable. There is a requirement for an investment in a modern day solution and an alteration to culture and attitude that will embrace change and technology associated with a digital health record (DHR), to manage the risk. The Health Board has selected its electronic document management system (EDMS) supplier.

Rationale for TARGET Risk Score:
The implementation of a full DHR will support and resolve a number of issues currently being experienced across the Health Board. Prior to making a record digital all services and identified IAO's will have to undertake a full review of their records management arrangements and work in conjunction with a robust criteria to ensure processes follow a standardised approach. A DHR resolves any issues we may currently be experiencing with regards the lack of storage capacity, provision of records in line with GDPR requirements, the ability to facilitate additional clinical requests, the transition to a virtual world, cost benefits, as well as many others. To assist implementation a requirement for adaptation to working practice and a considerable change in culture for future success.

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**
Health Board Information Asset Register Identified Information Asset Owners (IAOs) Health Records Policies, Procedures and SOPs Some digitalisation projects commenced, eg, physiotherapy, A&E cards Health Board e-nursing documentation implementation Electronic systems including: WPAS (Welsh Patient Administration System), WCP (Welsh Clinical Portal), PACS (Radiology), LIMS (Pathology), WAP e-referrals (Welsh Admin Portal), CANIS (Cancer), Diabetes 3, Selma Acquired additional storage facilities to both accommodate excess paper records and establishing a scanning bureau Reduced understanding or records types (across various services) and those appropriate for scanning, long term storage or destruction, leading to a non-consistent criteria for records management during the records life cycle from creation, to retention and ultimate destruction. With the requirement to implement and standardise health records protocols across all services. Acquisition of a electronic document management system (EDMS). Lease of a second storage facility Scanning of 227,500 non active patient records	An absence of a sustainable long term solution for records management and storage In its paper form, the health record is not under the accountability of any one Executive and hence the degree of influence is potentially compromised. Reduced understanding or records types (across various services) and those appropriate for scanning, long term storage or destruction, leading to a non-consistent criteria for records management during the records life cycle from creation, to retention and ultimate destruction. With the requirement to implement and standardise health records protocols across all services.	Acquisition of a electronic document management system (EDMS) suited to receive the management document retrieval on an searchable basis.	Tracey, Anthony	Completed	Complete - Civica Cito has been selected as the Health Boards EMDS supplier.
		Develop and implement scanned health record solution over the next 5-7 years depending on the split between determination of scanning and deep storage (DHR).	Carruthers, Andrew	31/03/2028	£300k per annum for three years made available to prime the project to include acquiring premises to facilitate a scanning bureau along with appointment of a project manager. A paper outlining the direction of travel and key steps to be taken was presented to executive team 28 July 2021 and this was broadly supported. A project implementation plan along with specification for acquiring scanners is being progressed.
		Review current records management arrangements for records that are not within the scope and responsibility of the Central Health Records function. This will require agreement on future record management arrangements, required resources and project support going forward as an essential precursor to the delivering the scanning phase of the project plan. This will be largely driven by individual information asset owners providing comprehensive schedules of information assets under their responsibility.	Carruthers, Andrew	~~30/04/2022~~ ~~30/06/2022~~ 30/09/2022	Draft proposal has been completed and ready for submission to the Executive Team. Some minor alterations are required and the Health Records Manger has been on leave for a sustained period of time. The paper will be updated and ready for submission in August 2022.

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
	Information Asset Owner Registers Group	1st			Records Storage SBAR - Executive Team (Jul21)		Agree formal reporting arrangements with Head of Corporate Governance	Rees, Gareth	Completed	Following Mar22 Board where the 3 year Annual Plan 2022/25 was agreed, the planning objectives are in the process of being aligned to Committee Workplans for 2022/23. 5M has been aligned to SDODC.
	Digital Health Records Project Group to oversee delivery of enabling work	2nd								
	SDODC overseeing delivery of Planning Objective 5M	2nd								
	IA Records Management Report (limited - follow up (reasonable) in Health Records only	3rd								