Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	31 March 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

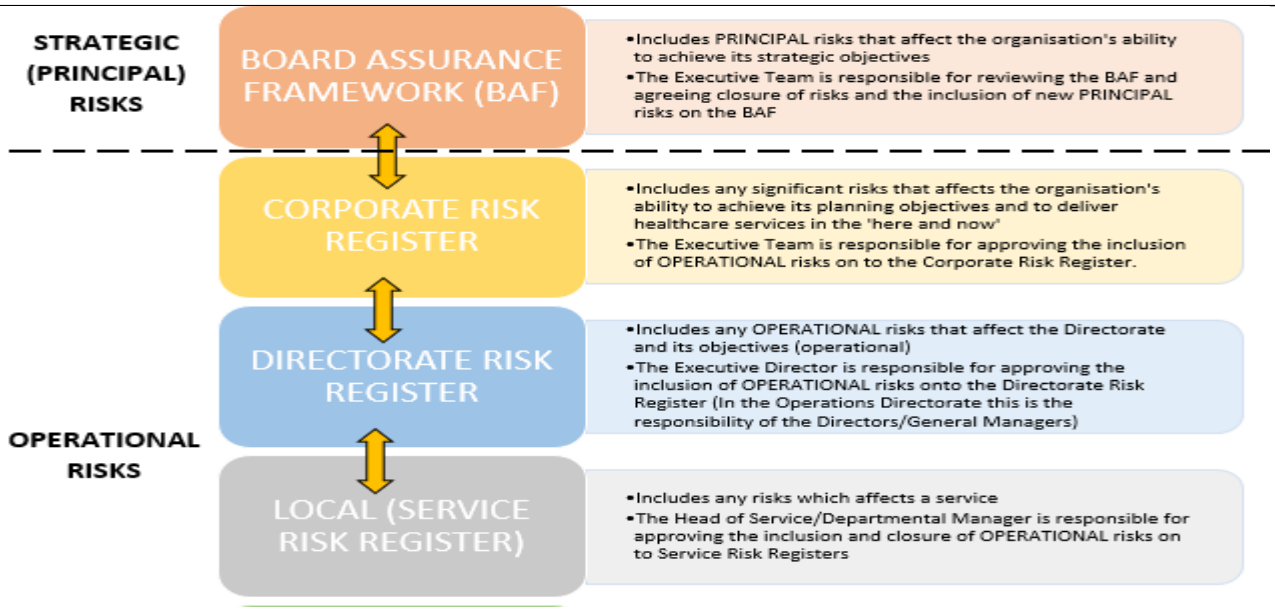
The Corporate Risk Register (CRR) is presented to the Board to advise of the corporate risks of Hywel Dda University Health Board (HDdUHB) and provide assurance that these risks are being assessed, reviewed and managed appropriately/effectively.

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 November 2021, 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. Recent examples of this have taken place at the Quality, Safety and Experience Committee where a deep dive was undertaken into risk 1032 (Mental Health and Learning Disabilities timely access), and risk 684 (Radiology). The risks have also been reviewed on a monthly basis at the Executive Risk meetings.

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 Board meeting.

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

Total Number of Risks	18	
New risks	10	*See note 1*
De-escalated/Closed	4	*See note 2*
Increase in risk score ↑	0	
Reduction in risk score ↓	2	*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 18 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		1016	813		
MAJOR 4			1307 (NEW) 1350 (NEW)	684 (↓), 1032, 1048 (↓), 1219, 1296 (NEW) 1337 (NEW) 1340 (NEW) 1352 (NEW)	1027 1297 (NEW)
MODERATE 3				129 (→) 1328 (NEW) 1335 (NEW) 1342 (NEW)	
MINOR 2					
NEGLIGIBLE 1					

Note 1 – New Risks

Since the previous report in November 2021, 10 new risks have been added to the CRR:

Risk	Lead Director	New/ 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	New	23/11/21	This risk was approved by Chair's Action ahead of the Sustainable Resources Committee in December 2021 and replaced, in part, the previous corporate risk 1163 (Risk to the delivery of the Health Board's draft interim Financial Plan for 2021/22 of a £25.0m deficit). The levels of Welsh Government (WG) funding for the Health Board's response to the COVID-19 pandemic and Elective Recovery plans have been issued, largely at fixed values from Month 6 and 8 in line with the forecast continuation of costs incurred and Recovery bids.

1297 - Risk that the Health Board's underlying deficit will increase to level not addressed by additional medium term funding	Director of Finance	New	23/11/21	This risk was approved by the Executive Risk Group via Chair's Action ahead of the Sustainable Resources Committee in December 2021 and replaced, in part, the previous corporate risk 1163 (Risk to the delivery of the Health Board's draft interim Financial Plan for 2021/22 of a £25.0m deficit). Issues have previously been raised over the ability of the Health Board to plan at a strategic and operational level. The Health Board's performance over the last year has demonstrated a significant improvement in the ability to operationally plan and a developing maturity within the organisation. However, the Health Board's financial deficit has deteriorated and workforce constraints remain. The Health Board's Roadmap to Sustainability is largely predicated on a reduction to, or repurposing of, acute bed capacity; however, in the current climate of unprecedented pressures within Unscheduled Care and delivery of challenging Recovery Plans, the implementation of schemes to reduce the number of acute beds is exceptionally challenging. The medium term financial impact of COVID-19 on the underlying position is currently informed by modelling intelligence due to the fluid nature of the pandemic and the multitude of unknown variables inherent in such a situation. WG funding for the medium term impact of the Health Board's response to COVID-19 and Recovery has been confirmed, and there is currently a significant gap between the level of funding and expenditure trends and/or plans.

1307 - Risk to achieving the Capital Resource Limit 2021/22	Director of Finance	New	23/11/21	This risk was approved by the Executive Risk Group via Chair's Action ahead of the Sustainable Resources Committee in November 2021. Significant uncertainty lies in the delivery of the Capital Programme in 2021/22 due to a number of factors which lie outside of the control of the Health Board. Whilst previous years demonstrate that the Health Board has been able to meet its statutory duty to breakeven against the capital resource limit, there is an increased likelihood in 2021/22 that it will not be able to do so. The Health Board has received capital funding for a demountable theatre at Prince Phillip Hospital (PPH) totalling £19.937m in December with planned completion by the 31st March 2022. Given the scale of spend required before the end of March 2022, any slippage in programme would be likely to be a significant financial value. Longer lead times for medical and digital equipment mean that opportunities to re-prioritise 2022/23 replacement programmes as capital scheme slippages are identified are reduced.
1328 - Security Management	Director of Nursing, Quality and Patient Experience	New	02/11/21	This corporate risk was approved by the Executive Risk Group on 2nd November 2021. On average, across the Health Board, 85 violence and aggression incidents are reported each month. There is no dedicated security guard force and here is also variation in the standard of coverage and quality including evidential standard required of CCTV (closed circuit television) systems across the Health Board.

1335 - Risk of being unable to access patient records, at the correct time and place in order to make the right clinical decisions	Director of Operations	New	05/01/22	This risk was approved by the Executive Risk Group on 5th January 2022. 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.
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	New	05/01/22	This risk was approved by the Executive Risk Group on 5th January 2022. The outbreak investigation has been re-opened four times in response to new cases of Tuberculosis (TB), leading to a rapid internal review carried out by Public Health Wales (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.

1340 - Risk of avoidable harm for HDUHB patients requiring NSTEMI pathway care	Director of Operations	New	02/02/22	This risk was approved by the Executive Risk Group on 2nd February 2022 and replaced the previous corporate risk 117. The new risk is focused specifically on the NSTEMI pathway as NICE guidelines for Acute Coronary Syndromes (NG185) recommend 'coronary angiography (with follow-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 target, the Health Board aims 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 HDdUHB 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.

1342 - Inability to plan and respond effectively to the pandemic due to changes in COVID testing and reporting policy	Director of Operations	New	02/02/22	This corporate risk was approved by the Executive Risk Group on 2nd February 2022. The change of testing policy during the latest wave of the pandemic made it challenging for the Health Board to fully understand where it is on the pandemic curve, and make accurate decisions in stepping up and down services at the right time. Whilst the Health Board is utilising other proxy data, this may not provide a full picture of activity, and may contradict the public data on COVID-19 cases in the local community. The level of risk has reduced from 20 when it was first identified to 12 as the peak of the 4th wave has passed.

1350 - Risk of not meeting the 75% waiting times target for 2022/26 due to diagnostics capacity and delays at tertiary centre	Director of Operations	New	02/03/22	This corporate risk was approved by the Executive Risk Group on 2nd March 2022 following an in-depth review of corporate risk 633 which related to the Health Board's ability to meet the 75% target for waiting times in 2020/21 for the new Single Cancer Pathway (SCP). The new risk reflects the current context and issues and the new ministerial measure in respect of the SCP, with new actions identified. 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 remain 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 on a downward trajectory for quarter 3 during 2021/22. This is due to the increase in COVID-19 related sickness, management of COVID-19 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. Performance since September 2021 has been steadily deteriorating and is now at 53% (December 2021).

1352 - Risk of business disruption and delays in patient care due to a cyber attack	Director of Finance	New	02/03/22	This corporate risk was approved by the Executive Risk Group on 2nd March 2022 following an in-depth review of corporate risk 451 (cyber security breach) and external assessment. There are daily threats to systems which are managed by Digital Health Care Wales and HDdUHB. Cyber attacks are becoming more prevalent, and previously hackers were not targeting health bodies, but the recent attack in Ireland, means that the possibility of an attack is ever present. Impact score is 4 as a cyber-attack has the potential to severely disrupt service provision across all sites for a significant amount of time, however the processes and controls in place have reduced the likelihood due to the improvements in patching.

Note 2 - De-escalated/Closed Risks

Since the previous report to Board in November 2021, the following 4 corporate risks have been closed/de-escalated:

Risk	Lead Director	Close/De-escalated	Date	Reason
1218 - Significant pressures expected from RSV and other respiratory viruses on Paediatric Services	Director of Operations	De-escalated to Directorate level	05/01/22	The Executive Risk Group agreed to de-escalate the risk to Directorate level as the anticipated peak in November 2021 had not been realised, the agreed actions have been taken and the situation was managed. The Service has since closed this risk as RSV have remained within expected levels.
117 - Delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery	Director of Operations	Closed	02/02/22	The Executive Risk Group agreed to close the risk following a detailed review by the Service Delivery Manager. This risk which related to generic delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery was replaced by a specific risk (ref 1340) which relates to the significant risk to patients on the NSTEMI pathway (see above section).

451 - Cyber Security Breach	Director of Finance	Closed	02/03/22	The Executive Risk Group agreed to close this risk following a review of the risk by the service. The new risk (1352) reflects the current context and issues following an external review (see above section).
633 - Ability to meet the 75% target for waiting times for 2020/21 for the new Single Cancer Pathway (SCP)	Director of Operations	Closed	02/03/22	The Executive Risk Group agreed to close this risk following a review of the risk by the service. The new risk (1350) reflects the current context and issues and the new ministerial measure for the single cancer pathway (see above section).

Note 3 – Increase/decreases in Current Risk Score

Since the previous report to Board in November 2021, there have been changes to the following 2 risks:

Risk	Risk Owner	Previous risk Score	Risk Score Nov-21	Date	Reason
684 - Lack of agreed replacement programme for radiology equipment across UHB	Director of Operations	5x4=20	4x4=16 ↓	03/03/22	The Health Board's stock of imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites which has a significant impact on the UHB's ability to meet its RTT target and impact to patients can include delays in diagnosis and treatment. Presently equipment downtime is frequently up to a week which can put significant pressures on all diagnostic services. Whilst activity has decreased due to COVID, scanning of COVID patients requires more time than non-COVID patients, which will become an issue as requests for diagnostics for non-COVID patients increase as other services resume. 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.

1048 - Risk to the delivery of planned care services set out in the Annual Recovery Plan 2021/22	Director of Operations	**5x4=20**	**4x4=16** ⬇	07/11/21	The prevalence of COVID-19 has increased in recent months and this has had an impact of inpatient pathways which has led to a number of temporary ward closures across all sites associated with COVID-19 outbreaks and the impact of wider urgent and emergency care pressures on the planned care patient pathway. Limits to staffing resource both in theatre, and post operatively, was a challenge before COVID-19. The additional factors of providing separate staffing teams for red and green areas, is an added challenge and has shaped the model of provision suggested on each site. It is evident that our realisable capacity in the short term will not match that available prior to March 2020. The outline plans do however reflect the maximum capacity that can be achieved within the footprint of our existing hospital sites. Whilst the plan for increased delivery of elective work (outlined within the HDUHB Annual Plan) is progressing in accordance with the plan outlined, challenges and risks around availability of supporting bed and theatre capacity remain which limits the ability of our clinical teams to expand activity delivery to pre-COVID-19 levels, and further waves of the pandemic. There is a significant challenge across the Urgent and Emergency Care system which continues to impact upon planned care pathways.

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.

Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Mar-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	**5×4=20**	**5×4=20**	→	**3×4=12**	6
1297	Risk that the Health Board's underlying deficit will increase to level not addressed by additional medium term funding	Thomas, Huw	Statutory duty/inspections	8	N/A	**5×4=20**	*New risk*	**2×4=8**	9
1032	2021/22 Operating Plan Delivery - Timely access to assessment and diagnosis for Mental Health and Learning Disabilities clients	Carruthers, Andrew	Safety - Patient, Staff or Public	6	**4×4=16**	**4×4=16**	→	**3×4=12**	13
1048	Risk to the delivery of planned care services set out in the Annual Recovery Plan 2021/22	Carruthers, Andrew	Safety - Patient, Staff or Public	6	**5×4=20**	**4×4=16**	↓	**3×4=12**	17
1352	Risk of business disruption and delays in patient care due to a cyber attack	Thomas, Huw	Statutory duty/inspections	8	N/A	**4×4=16**	*New risk*	**3×4=12**	20
684	Lack of agreed replacement programme for radiology equipment across UHB	Carruthers, Andrew	Service/Business interruption/disruption	6	**5×4=20**	**4×4=16**	↓	**3×4=12**	24
1219	Insufficient workforce to deliver services required for "Recovery" and the continued response to COVID-19	Gostling, Lisa	Workforce/OD	8	**4×4=16**	**4×4=16**	→	**3×4=12**	27
1296	Risk that the Health Board will not deliver a financial out-turn position in line with our original plan of £25m deficit	Thomas, Huw	Statutory duty/inspections	8	N/A	**4×4=16**	*New risk*	**2×4=8**	34
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	N/A	**4×4=16**	*New risk*	**2×4=8**	37
1340	Risk of avoidable harm for HDUHB patients requiring NSTEMI pathway care	Carruthers, Andrew	Safety - Patient, Staff or Public	6	N/A	**4×4=16**	*New risk*	**1×4=4**	40
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**	44
1342	Inability to plan and respond effectively to the pandemic due to changes in COVID testing and reporting policy	Carruthers, Andrew	Quality/Complaints/Audit	8	N/A	**4×3=12**	*New risk*	**3×3=9**	48
1307	Risk to achieving the Capital Resource Limit 2021/22	Thomas, Huw	Statutory duty/inspections	8	N/A	**3×4=12**	*New risk*	**2×4=8**	51
129	Ability to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda patients	Carruthers, Andrew	Service/Business interruption/disruption	6	**4×3=12**	**4×3=12**	→	**3×3=9**	54
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	N/A	**3×4=12**	*New risk*	**3×2=6**	60
1335	Risk of being unable to access patient records, at the correct time and place in order to make the right clinical decisions	Carruthers, Andrew	Quality/Complaints/Audit	8	N/A	**4×3=12**	*New risk*	**2×3=6**	63
1328	Security Management	Rayani, Mandy	Safety - Patient, Staff or Public	6	N/A	**4×3=12**	*New risk*	**3×2=6**	66
1016	Increased COVID-19 infections from poor adherence to Social Distancing	Rayani, Mandy	Safety - Patient, Staff or Public	6	**2×5=10**	**2×5=10**	→	**2×5=10**	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

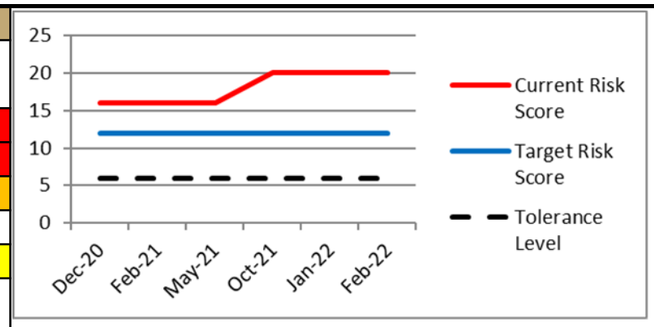
Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective 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:**	Feb-22
Lead Committee:	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Mar-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 increasing fragility within the urgent and emergency care (UEC) system, increasing levels of demand above staffed capacity, the impact of COVID-19 on available whole system bed and staffing resources and delays in discharges across the care system which are beyond the direct influence of the Health Board. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increased incidents of a serious nature relating to ambulance handover delays 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?		yes	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	5×4=20
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. The case incidence of COVID-19 (Omicron) has increased within the community across West Wales which has led to an increase in the proportion of staff having to self isolate as outlined in national guidance. COVID-19 cases have also increased in hospitals and care home facilities. This has a direct impact on acute and community care bed availability alongside a reduced workforce. This has led to increasing delays in the discharge pathway and increasing delays for patients needing access to urgent and emergency care services due to reduced 'flow' and hence capacity within our Emergency Departments. Available staffing resources continue to be challenged and supply of short term and locum staffing resources remains variable. 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 fluid and changeable 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 as the winter period has progressed.

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. # 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 # LFT testing introduced for staff # Reminders issued to management on importance of robust	# Data has demonstrated that targeted improvement is required across our UEC system to reduce conveyance, conversion and discharge levels to facilitate improvements in the management of our Complex frail population, maximise enhanced 'front door' turnaround within max 72 hours and improved discharge coordination. # Fragility of Care Home Sector exacerbated by COVID related issues such as financial viability, staffing deficits, recruitment and retention of workforce. # Significant paucity of domiciliary care/social care availability due to recruitment and retention of staff exacerbated by increased staff absences due to the TTP process. # Nurse staffing availability to ensure safe levels of care as a consequence vacancies and COVID 19 related absence across acute and community care. # Reduced acute bed availability due to impact of COVID-19 outbreaks and reduced staffing availability. # COVID-19 has further exacerbated workforce capacity and availability of bank and agency staff who would be available. # 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. # No live dashboard demonstrating UEC performance. # Insufficient programme management to support delivery of UEC programme. # Clinical Lead for Care of the Elderly (COTE) has indicated need for additional clinical leadership in GGH (2WTE Consultants)	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 1219 detailing actions to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	31/03/2022	Ref CRR 1219 for detailed progress.
		To encourage and support staff to participate in the UHB's Covid-19 vaccination programme.	Jones, Keith	Completed	Undertaken through general communications and line management.
		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	~~31/12/2021~~ 31/03/2022	UEC Dashboard 'mock up' available. Pending approval.
		Recruitment to UEC Programme Management Office	Dawson, Rhian	~~31/01/2022~~ 31/03/2022	Recruitment process underway.
		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	31/03/2022	Scoping underway
		To implement the Standard for Discharge to Assess in accordance with the WG Disharge Guidance	Dawson, Rhian	31/03/2025	Plan to be developed.
		Review ambulance handover procedure in conjunction with WAST and HB Review Escalation Policy	Passey, Sian	31/03/2022	Senior level discussions with WAST have been undertaken in respect of ambulance handovers. All sites endeavour to comply with Red Release policies wherever possible.
		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.

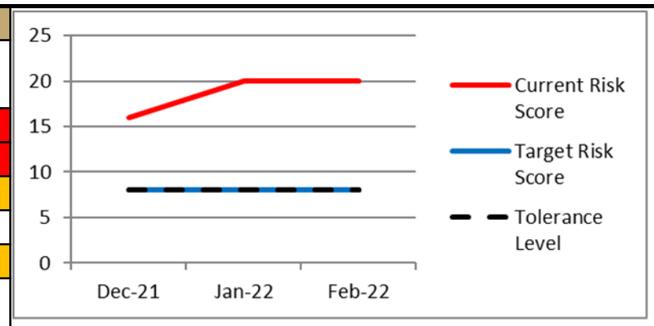
management of staff sickness and the use of COVID-19 Risk Assessment to help manage staff absences. # Staff visiting restricted to those 'who have purpose' # SDEC models continuously reviewed and refined to maximise impact on admission avoidance. # Staff are encouraged to participate in the UHB's ongoing COVID-19 vaccination programme.	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.

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-21	**Executive Director Owner:**	Thomas, Huw	**Date of Review:**	Feb-22
Strategic Objective:	6. Sustainable use of resources	**Lead Committee:**	Sustainable Resources Committee	**Date of Next Review:**	Mar-22

Risk ID:	**1297**	**Principal Risk Description:**	There is a risk that the Health Board's underlying deficit will increase to a level which is not addressed by additional medium term funding. This is caused by insufficient data or intelligence driving theoretical opportunities which cannot be practically delivered by Operational Teams; change programmes are not sufficiently resourced or well-managed; or changes made to services or the acute bed base which are contrary to current unprecedented acute demand. This could lead to an impact/affect on our inability to deliver financial sustainability which could lead to a resumption of financial turnaround with consequences for retention of the workforce, staff morale, poor patient experience and poorer value healthcare with a reduction of confidence from our stakeholders.
Does this risk link to any Directorate (operational) risks?		1296	

Risk Rating:(Likelihood x Impact)	
Domain:	Statutory duty/inspections
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:	8
Trend:	*New risk*



Rationale for CURRENT Risk Score:

Issues have been raised over the ability of the Health Board to plan at a strategic and operational level for a number of years. The Health Board's performance over the last year has demonstrated a significant improvement in the ability to operationally plan and a developing maturity within the organisation. However, the Health Board's financial deficit has significantly deteriorated and significant workforce constraints remain. The Health Board's Roadmap to Sustainability is largely predicated on a reduction to, or repurposing of, acute bed capacity; however, in the current climate of unprecedented pressures within Unscheduled Care and delivery of challenging Recovery Plans, the implementation of schemes to reduce the number of acute beds is exceptionally challenging.

The medium term financial impact of COVID-19 on the underlying position is currently informed by modelling intelligence due to the fluid nature of the pandemic and the multitude of unknown variables inherent in such a situation. WG funding for the medium term impact of the Health Board's response to COVID-19 and Recovery has been confirmed, and there is currently a significant gap between the level of funding and expenditure trends and/or plans.

Rationale for TARGET Risk Score:

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

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

Given the challenge in delivering the savings required in FY21 of £32.4m, a further gap of £11.5m in FY22, and the implications of this in the medium term, further work is ongoing to manage this risk.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Understanding the underlying deficit and Opportunities Framework. A pre-COVID-19 assessment has been completed, which will need to be refined as part of the Roadmap to Sustainability. Very high level base-case long term financial model. A Planning Steering Group is in place to co-ordinate activities across key corporate functions. The Planning Team are embedded within the operational management structures across the organisation. A Strategic Enabling Group is in place to co-ordinate improvements to the Health Board's key systems to improve systems and processes across the organisation, including: Improving together - a programme to embed a quality management system to ensure consistency of approach in addressing quality and service improvement throughout the organisation. Agile Digital Business Group - a Group which reports into the Finance Committee which scrutinises business cases on digital investment to allow a rapid allocation, allocate resources promptly, learn from previous business case implementations and disinvest if appropriate. Value Based Health and Care Group: which ensures that the Health Board's roll out and deployment of VBHC is in line with plans and will facilitate the shift of resources over time.	It has now been confirmed that the Health Board will not receive funding from Welsh Government in response to the brought forward underlying position from FY21 (due to unidentified savings) of £32.4m for 2022/23. It has also been confirmed that WG funding for the direct response to the pandemic will not be received beyond 2021/22, with a need to balance Recovery and the COVID-19 response within the issued allocation. The Health Board's Roadmap to sustainability has been drafted at a strategic level, with further work needing to be undertaken from a detailed operational planning perspective.	WG validation review of the brought forward underlying position to be undertaken, as directed by the FDU.	Thomas, Huw	31/03/2022	Progress to be reported in next review.
		WG assessment of draft funding request in response to COVID-19 in the medium term to be concluded, with confirmation of the level of funding available to the Health Board. The Health Board will continue to refine the prioritisation of responses to determine the Value of each COVID-19 response workstream and if that resource could be better re-purposed.	Thomas, Huw	31/03/2022	WG level of funding now confirmed, with Executive led prioritisation now required to assess value of existing COVID-19 responses against Recovery and Other activities. This will be conducted as part of the financial planning workstreams.
		Further work to be undertaken on the Roadmap to Sustainability from a detailed operational planning perspective to provide assurance over deliverability to both the Board and Welsh Government.	Carruthers, Andrew	31/03/2022	Feedback had been received from WG regarding the level of operational detail and clarity required; further work is underway.
		Develop the capability for the routine capture of PROMS and implement in all clinical services within 3 years. Establish the required digital technology and clinical leadership and engagement to facilitate pathway redesign based on these insights and put in place impact measurement processes to evaluate changes at a pathway level (PO 6D)	Thomas, Huw	31/03/2024	Core digital infrastructure in place and progress in roll out in multiple conditions has been achieved, with many more planned over next two years. First formal service reviews have taken place with Cardiology and Executive leads to determine next steps. Work underway to both support taking action from insights and the visualisation of the high volume of new data this will create to clinically and operationally inform services.

Implement a VBHC pathway costing programme for all clinical services that is capable of being completed within 3 years, and prioritised based on the likelihood of generating change.	Thomas, Huw	31/03/2024	Objective developed for year ahead as we move into next phase of this three year objective: - Through engagement at each project inception to offer a financial consideration of Value Based Healthcare to all potential projects. - Then prioritising and implementing costing projects with reference to furthering organisational strategy and the likelihood of producing intelligence and evidence that supports operational and clinical change. - Exploring further innovation and development in the application of this costing approach.
By September 2021 develop a plan to achieve, as a minimum, the design assumptions set out in “A Healthier Mid and West Walesâ€ related to the new hospital build on the current health board acute hospital sites. The aim will be to achieve these measures fully by March 2023 and the plan should set out expected trajectories towards this over 2021/22 and 2022/23 (PO 6K)	Thomas, Huw	31/03/2022	Progress to be reported at next review.
To be completed by the end of 2021/22 undertake a full analysis of our supply chain in light of the COVID-19 pandemic to assess the following: - Length and degree of fragility - Opportunities for local sourcing in support of the foundational economy - Carbon footprint - Opportunities to eliminate single use plastics and waste The resulting insights will be used to take immediate, in-year action where appropriate and develop proposed Planning Objectives for 2022/23 implementation (PO 6H)	Thomas, Huw	31/03/2022	Resource has been allocated to begin this analysis and opportunities will be fed into the Opportunities Framework as they are identified.

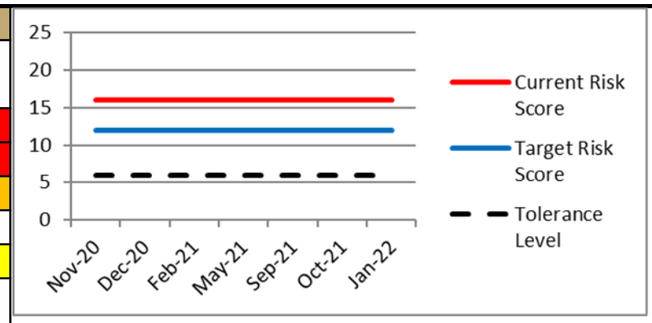
		Rapid deployment of digital solutions to support with better intelligence allowing better local decision-making based on evidence.	Thomas, Huw	31/03/2022	Refer to the Digital Strategy for actions and delivery timelines.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Operational agreement to underlying deficit assessment. Welsh Government accepting of impact of COVID-19 on underlying deficit. Plan in place to develop a long term financial plan. Financial assessment of A Healthier Mid and West Wales in place, linked to the Roadmap to Sustainability.	Reporting to Sustainable Resources Committee	2nd			Month 10 Finance Report Sustainable Resources Committee, February 2022 Month 9 Finance Report Board, January 2022	None				

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Feb-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Mar-22

Risk ID:	**1032**	**Principal Risk Description:**	There is a risk that the length of time MH&LD clients (specifically S-CAMHS, ASD, memory assessment and psychology services for intervention) are waiting for assessment and diagnosis will continue to increase during 2021/22. This is caused by new environmental (due to social distancing measures) constraints to undertake required face-to-face assessments and patients' reluctance to attend clinics due to the risk of COVID, as well as certain elements of some assessments being restricted due to other agencies, such as education, providing limited services at present. Difficulty in recruiting suitably qualified staff and increasing demand. 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	

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



Rationale for CURRENT Risk Score:

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

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

Rationale for TARGET Risk Score:

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

Key CONTROLS Currently in Place:
(The existing controls and processes in place to manage the risk)

Gaps in CONTROLS				
Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**

Use of IT/virtual platforms such as AttendAnywhere when appropriate. Clinical prioritisation regarding assessment and treatment of service users by engaging in a dynamic process of reviewing waiting lists in line with any other referrals that may be received in respect of that service user. Additional funding provided for recruitment however national shortage of required skills - 3 new staff have been recruited into the ASD team. Services are in contact with individuals to provide information regarding community support, well being at home and guidance should their situation deteriorate. Regular meetings with Women and Children's Service to strengthen interdepartmental working. Process in place to ensure individuals on waiting lists are being contacted periodically through the wait for assessment/treatment to monitor any alteration in presentation. 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. 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.	Social distancing measures reducing the available space/offices that can be used to meet clients face-to face. Certain elements of some assessments also being restricted due to other agencies, such as education, providing limited services. Continued lack of IT impacts on staff who have to work from home not having full accessibility. Estates issues ongoing with no access to clinical areas in some localities to see CYP and unable to access GP or LA sites thus restricting clinical sessions. Telephone assessments ongoing, virtual assessment offered but uptake not good for ASD client group.	Assess and source further IT requirements.	Carroll, Mrs Liz	Completed	Some further IT equipment has been received and distributed on a priority basis. The Directorate will now need to rationalise working from home/agile working in order to maximise the potential office/clinical space.
		Identify alternative venues/space to hold clinics.	Carroll, Mrs Liz	~~31/03/2021~~ 31/12/2021 31/03/2022	Working with the Estates Department and exploring options with external partners. Regular meeting with Estates to look at accessing/leasing/enhancing the current MH estates with a view to increase MH estate footprint. 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. This has been made more difficult due to the withdrawal of Bro Cerwyn due to extensive unforeseen building damage. The Directorate are continuing to extend and fund the use of alternative venues until the work at Bro Cerwyn has been completed.
		Head of Service to operationalise	Carroll, Mrs Liz	~~31/12/2020~~ 31/03/2022	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. Service specific template letters have been developed in some areas and the directorate has used the HB Third Party contractor to send letters to those waiting for appointments with the Memory Assessment Service. Public facing webpages with QR codes are also being developed to give further support and guidance to individuals waiting to be seen.

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	~~31/03/2022~~ 30/06/2022	Work underway across all services who have waiting times, be they intervention or assessment. Use of HB Third Party Contractor has begun, focussing on those waiting appointments with the Memory Assessment Service. Public facing webpages with QR codes are also being developed to give further guidance and support whilst individuals are waiting.
Identify funding for Interim Clinical Psychologist lead post to assist with the waiting lists and service development.	Carroll, Mrs Liz	~~31/03/2021~~ 31/03/2022	Appointment has been made and waiting for new staff member to take up post.
Health Board is engaging in work with WG to benefit from additional support re waiting lists, demand and capacity planning and service mapping to meet the national standards and new Autism Code.	Carroll, Mrs Liz	~~30/04/2021~~ 31/03/2022	Health Board will be early pilot site providing an early offer for children and young people and their families, who otherwise would be referred for direct support to the NHS. Awaiting an update on this work.
Dedicated Psychologist for Autistic Spectrum Disorders commencing a fixed term appointment from July 2021 with a specific focus around demand and capacity.	Lodwick, Angela	Completed	Psychologist in post and commenced assessments with focus of reducing waiting lists
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.	Amner, Karen	31/12/2022	Awaiting final location codes for Integrated Psychological Therapies Services. Mapping work continuing for IAS/ASD service and initial documents being developed for MAS.
Directorate to rationalise working from home/agile working in order to maximise the potential office / clinical space	Carroll, Mrs Liz	31/03/2022	Due to Omicrom variant greater numbers of staff have been working from home. An increase in DNA rates were experienced during this time. Directorate is awaiting delivery of additional IT kit to support home/agile working. Directorate continues to seek regular updates from Digital Services in relation to delivery timeframe.

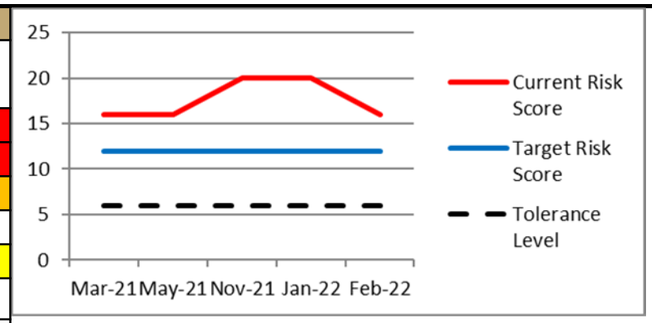
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES			
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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)	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								
	An update was requested by the Chair and provided for the August Quality, Safety, Assurance Committee.									

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

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

Risk ID:	**1048**	**Principal Risk Description:**	There is a risk there will be disruption to the delivery of planned care services set out in the Annual Recovery Plan 2021/22. This is caused by the impact of urgent and emergency care pressures (as reflected in Risk 1027) and a continuing significant deficit in available staffing 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 prevalence of COVID-19 has increased in recent months and this has had a further impact of inpatient pathways which has led to a number of temporary ward closures across all sites associated with COVID outbreaks and the impact of wider urgent and emergency care pressures on the planned care patient pathway.

Limits to staffing resource both in theatre, and post operatively, was a challenge before COVID. The impact of increasing unscheduled care pressures during the Autumn/Winter period has further reduced available capacity to be dedicated to elective & surgical pathways. In January 2022, the Health Board approved the application of additional measures under the WG Local Choices Framework to reduce non-urgent elective Outpatient (OP) and In-patient (IP) pathways to enable the further prioritisation of physical and staffing resources to support unscheduled care pathways. This was a temporary arrangement which was applied for 2 weeks, which resulted in the current risk score increasing to 20. Pathways that were affected have now been restored, reducing the current risk score back to 16.

Non-urgent elective surgical pathways was also temporarily suspended across all sites with urgent/cancer IP surgery continuing at Prince Philip and Glangwili hospitals only. The pathway in Bronglais Hospital has been restored and plans are in place to restart the pathway in Withybush Hospital by early March. Discussions are continuing in respect of re-establishing the orthopaedic pathway in Prince Philip Hospital.

Outsourcing programmes are continuing supported by Recovery funding provided by WG although activity rates are limited by staffing challenges at a number of independent sector locations.

There is a significant challenge across the Urgent and Emergency Care system which continues to impact upon planned care pathways.

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 latest wave of the pandemic. The target score of 12 is based on the realistic assessment of the level of planned care work which can be achieved across the footprint of the HB over the next 12 months and acknowledges this will not reflect levels achieved pre-pandemic due to the current staffing challenge and the impact on capacity and throughput of expected requirements to maintain social distancing and enhanced IP&C procedures.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage planned care risks on daily basis including multiple daily multi-site calls in times of escalation. # Prioritised review of patients based on an agreed risk stratification model. # Provision of 'green' pathway beds on 4 sites (where staffing allows). # Discharge lounge takes patients who are being discharged. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Escalation plans for acute and community hospitals (within limits of staffing availability). # Outpatient transformation programme in place with a continuing focus on alternatives to face to face delivery of outpatient care to enable increases in care volumes delivered. # Risk assessed establishment of AMBER post-operative critical care pathway as a more practical alternative to dedicated GREEN post-operative critical care pathway to increase the flow of appropriate patients. # Robust sickness absence management arrangements in place. # Comprehensive programme of outsourcing of planned care volumes in place utilising capacity available vis independent sector providers # Weekly review of outsourcing volumes and further opportunities progressed jointly by Planned Care and Commissioning teams. # Planned Care Recovery Programme for 2021/22 in place. # LFD testing rolled out across selected planned care wards and clinical areas.	# Limited impact of the wider urgent and emergency care plan in reducing capacity pressures on acute sites and the ability to protect sufficient 'green' pathway capacity for elective patients. # Nurse staffing availability to ensure safe levels of care as a consequence vacancies and COVID 19 related absence across ward, critical care and theatre areas # Reduced acute bed availability due to impact of COVID-19 outbreaks and reduced staffing availability # COVID-19 has further exacerbated workforce capacity and availability of bank and agency staff who would be available. # Limitations of the physical estate on hospital sites to enable protected/dedicated green pathway critical care facilities # 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. # Operational delivery challenges (staffing) experienced by independent sector providers which, to date, have compromised delivery of activity levels commissioned. # Services reminded of the need to undertake robust sickness management to ensure staff are able to return to work safely and promptly.	Plan for Q1-4 levels of capacity to be agreed via 2021/22 Annual Plan	Jones, Keith	Completed	Plan confirmed via Annual Recovery Plan.
		Opportunities to enhance dedicated green pathway capacity across sites are subject to continuous review and discussion between respective acute sites and Planned Care Directorate	Jones, Keith	Completed	Non-urgent elective surgical pathways have been temporarily suspended across all sites with urgent/cancer in-patient (IP) surgery continuing at Prince Philip and Glangwili hospitals only. Non-urgent outpatient pathways temporarily suspended for 2 weeks (Jan2022), recommenced 24Jan22. Plans to re-establish IP surgical pathways at Bronglais (early Feb22) and Withybush hospitals (end Feb22).
		Refer CRR 1219 detailing actions to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	31/03/2022	Ref CRR 1219 for detailed progress.
		Review of overall acute nurse staffing resource availability with support from acute site and directorate heads of nursing.	Passey, Sian	Completed	Staffing deficits confirmed. Current delivery progressing in accordance with available staffing.
		To remind services to of the need to undertake robust sickness absence management to ensure staff are able to return to work safely and promptly	Jones, Keith	Completed	Actioned however impact of updated shielding guidance continues to limit the return of affected staff.
		Planned Care Recovery programme (beyond Mar22) to be developed and agreed.	Jones, Keith	Completed	Plan for 2021/22 confirmed. Longer term recovery proposals (beyond Mar22) currently being reviewed via IMTP development. Extent and scope of delivery will be determined by agreed funding level.
		To support routine testing of staff	Carruthers, Andrew	Completed	LFT rolled out across selected planned care wards and clinical areas.
		Development of ward based post operative enhanced care pathways as an alternative to dedicated green critical care facilities.	Jones, Keith	~~31/05/2021~~ 31/03/2022	Implemented at PPH & BGH. Development plans continuing at other sites, timelines dependent on staffing availability.

		Development of plans to enhance capacity through consideration of demountable facilities and opportunities to develop regional solutions for key pathways (eg cataract surgery).	Jones, Keith	~~31/03/2021~~ 30/04/2022	Modular unit construction underway - expected to be operational in Apr22. Physical refurbishment work at Amman Valley Hospital in progress to enable release and dedication of day surgery theatre for cataract surgery.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**		
Performance indicators. A suite of planned care metrics have been developed to measure the system performance.	Activity volumes are reported daily on situation reports	1st			
	Daily performance data overseen by service management	1st			
	Delivery Plans overseen by Acute Services Triumvirate	1st			
	Bi-monthly reports to SDOPC on progress on delivery plans and outcomes (and to Board via update report)	2nd			
	IPAR Performance Report to SDOPC & Board	2nd			

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

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

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

Risk ID:	**1352**	**Principal Risk Description:**	There is a risk of business disruption and intolerable delays in patient care (particularly radiology, pharmacy, laboratories and Cancer Care) and in some instances misdiagnosis. This is caused by unavailability or malfunctioning of clinical devices and systems due to a cyber-attack, and resources to implement Information Assurance and a Cyber Security culture. This could lead to an impact/affect on 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 will result in extreme pressure on limited clinical resources.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)		**No trend information available.**
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:	*New risk*	

Rationale for CURRENT Risk Score:
There are daily threats to systems which are managed by Digital Health Care Wales and UHB. Cyber attacks are becoming more prevalent, and previously hackers were not targeting health bodies, but the recent attack in Ireland, means that the possibility of an attack is ever present. Impact score is 4 as a cyber-attack has the potential to severely disrupt service provision across all sites for a significant amount of time, however the processes and controls in place have reduced the likelihood due to the improvements in patching.

Rationale for TARGET Risk Score:
Increased 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 anti-virus 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	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	On track - this is a programme of work within the wider Cyber Programme which will be discussed at the first meeting of IGSC.
		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	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	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
		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	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

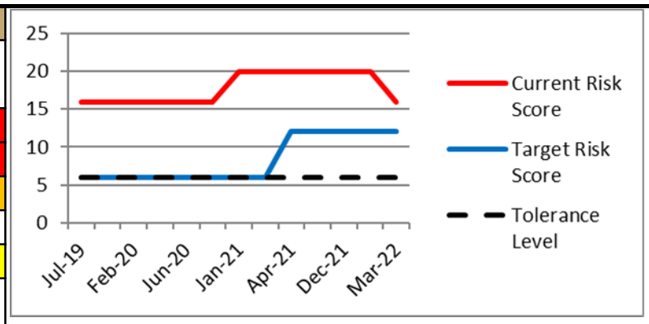
Implement a robust supply chain security process with controls appropriate to risk including financial penalties for clinical and business impact and appropriate insurances (public liability and indemnity, business continuity, cyber etc.).	Tracey, Anthony	31/10/2022	On track
Ensure that contracts are 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	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	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 Essentials	Department monitoring of KPIs	1st			Cyber Assurance Framework (CAF) - IGSC (Monthly)					
	IGSC monitoring of cyber security workplan addressing recent internal and external audits/assessments	2nd								
	IGSC monitoring of National External Security Assessment (2nd)	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:	Jan-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Mar-22
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Apr-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. Whilst activity has decreased due to COVID, scanning of COVID patients requires more time than non-COVID patients, which will become an issue as requests for diagnostics for non-COVID patients increase as other services resume. Commissioning of agreed equipment has also been delayed as a result of COVID and this remains dependent external factors. Radiology has been asked to increase its service provision to other Directorates which it is currently unable to provide due to limitations on current equipment, however the demountable CT-scanner will provide much needed resilience at GGH. 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.

Rationale for TARGET Risk Score:

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

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

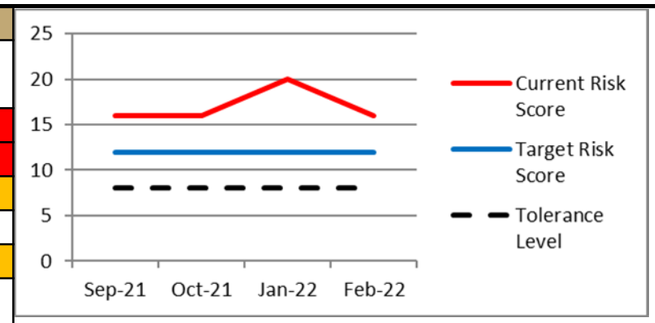
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports.Some funding has been secured from AWCP for some replacements but does not cover all outdated equipment nor the future requirements. # Escalation process in place for service disruptions/breakdowns. # WG Funding agreed for 2 x CT scanners (GGH & WGH) - to be commissioned by Dec21 and Mar22. # Additional CT secured in the form of a mobile van in December 2020. # 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.
		Monthly project meeting to discuss commissioning of agreed equipment with estates, planning and manufacturers.	Roberts-Davies, Gail	~~31/12/2020~~ 30/08/2021 31/03/2022 31/03/2024	The replacement schedule currently is to replace CT at WGH with a plan to replace a number of ultrasound systems and Image Intensifiers across the four hospital sites. There has been further funding agreed to replace 2 CT scanners, 3 DR radiography systems and 2 fluoroscopy systems across the Health Board by the end of the 2023/24 financial year.

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:	May-21	**Executive Director Owner:**	Gostling, Lisa	**Date of Review:**	Jan-22
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	People, Organisational Development and Culture Committee	**Date of Next Review:**	Feb-22

Risk ID:	**1219**	**Principal Risk Description:**	There is a risk there will be insufficient 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 2021/22. This is caused by new variants of COVID, increase 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. Further to this, a lack of alignment of information between service, workforce and finance on workforce requirements for unfunded service pathways could further jeopardise workforce availability in areas of need. This could lead to an impact/affect on the Health Board's ability to staff pathways for COVID, field hospitals, surge capacity within general hospitals, community hospitals, paediatric units effectively managing the impact from of outbreaks, delivering a mass 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 new staff quickly to provide additional support.
Does this risk link to any Directorate (operational) risks?		1186	

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 reduced to 16 (the likelihood has decreased "likely" and has the potential to have a "major" impact) since the previous report as the number of key staff unavailable for work from staff sickness and self-isolation has improved as the latest wave has abated. 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. Unfunded service provision could impact on understanding of workforce availability and create misalignment of workforce availability.

Rationale for TARGET Risk Score:
The Target Risk score indicates the likelihood of the risk occurring (to note there have been minor outbreaks of new variants in Wales) which depending on the efficacy of the vaccine against this, 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% as the recent out break of Omnicron has transpired. We hope will be mitigated by the actions noted below. What is known is that services do have unfunded pathways and any resourcing activity has the potential to divert resources away from these areas.

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 Planning Team Inter-Team & Professional Groups & 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) Continuous process of assessment of services to be stood down and deployment options based on service needs Continuous prioritisation of recruitment/onboarding of new employees to the highest areas of risk in terms of maintaining service delivery Temporary Workforce Utilisation reports shared regularly to monitor levels of supply.	An organisational wide escalation plan (based on a detailed assessment of Recovery Plans and workforce requirements, set against an escalation plan for COVID resurgence). Establishment control cannot be relied on due to temporary changes linked with covid and pathways. Linked with service pressures increased demand is placed in terms of workforce which has not been planned for delivery in year.	IMTP Plan addendum details - 1)Recovery Plan & Workforce Requirements 2) COVID Planning objectives & Workforce Requirements 3) Phased Plan for Covid escalation 4) New Programmes & Projects Timelines & Workforce Requirements explored for alignment to Recovery & COVID Plans. Monthly assessment of demand to be undertaken linked with service discussions in preparation for current demands and anticipated increased pressure in Winter.	Walmsley, Tracy	~~31/10/2021~~ 30/11/2021 31/01/2022 28/02/2022 31/07/2022	Workforce Plans to be reviewed with services. Baseline IMTP to be worked through by end of Mar22. Full plan to be developed by Jul22.
		Development of strategic recruitment strategy for delivery within year with monthly check of progress against actions	Thomas, Annmarie	Completed	Recruitment plan for bridging service actioned. Responding to specific requests for additional workforce requirements in a number of areas e.g. Family Liaison Officers, Facilities, Vaccination Service, TTP etc. Strategy in progress and will be linked to IMTP Workforce Planning Methodology (MDS for WG etc). .Strategy submitted to ET/Board 25/11/21. Further development ongoing linked to IMTP. Need to understand “additionalityâ€ required. Ongoing work to align to workforce plan demand. See not reference MVC Booster above.
		Assessment of services to be stood down and deployment options based on service needs.	Walmsley, Tracy	~~15/11/2021~~ 30/12/21 (review) 30/01/22 (review) 31/03/22 (review)	RSV Surge Plan completed by 31/10/21. Developing workforce plan for FH if reopening is required. No plans to open FH as at 13/01/22 communicated - demand & risk assessment undertaken alongside sources of workforce supply Please see note on Booster Vaccination Programme above. Local Options Framework in place and being enacted.

Maximise use of temporary workforce availability to include Bank, Overtime and Agency by undertaking monthly assessment of resourcing pipeline and continuous review of Bank HCSW recruitment	Thomas, Annmarie	31/03/2022	Temporary Workforce Utilisation maximised via a) continuous recruitment to bank b) engagement with additional agencies on the framework c) revisiting off-contract booking protocols d) ED level approval for temporary variation/increase in rates for agreed priority service areas. Flexible Incentive rate introduced for fixed period Aug-Dec21 to improve supply. NHS Wales Advance Notice incentive rates introduced Jan-Mar22. C. 125 finalising onboarding process to Bank HCSW roles during Quarter 3 and 4.
Align Funded Establishment & Unfunded posts to understand "workforce gap". Working with HON, CH on NSL levels alignment & HCSW gaps (funded & funded) with Finance colleagues.	Walmsley, Tracy	Completed	Completed assessment. Fed into Silver. Agreed to manage at risk for each service.
Develop team around the patient model. Group established and Plan on a Page developed. Band 4 roles being developed; will align to work above on funded and unfunded establishment.	Passey, Sian	~~31/10/2021~~ 30/01/2022 28/02/2022 31/03/2022	Work ongoing. Capacity to support development noted as a concern. Alignment of resources and support needed. Discussions ongoing on how to develop and support programme of work. Initial meeting to reflect support needed for Jan22. Meeting scheduled for Feb22.

Engagement with HEIW & Universities on Medical, Nursing, AHP/HCS & Pharmacy programmes to include work linked to the Strategic Education Group and specific discussions with HEIW on more Band 4 roles and medical workforce planning. Regular contact with HEIW on all matters related to workforce planning - monthly & quarterly.	Walmsley, Tracy	~~30/09/2021~~ 30/01/2022 28/02/2022	Met September will continue to connect with All Wales workforce planning network. Require support to access data on commissioning to align to locality and develop alignment to Education & Commissioning Work. Issues raised at All WF Network in December x 2 sessions dedicated to addressing feedback and closing loop on data with HEIW. Tool to link to Supply & Attrition in Progress. Meeting planned with HEIW for 24/01/22 aligned to planned E&C template to be completed by 31/01/22. NB This is adding pressure on services to complete in timely and accurate manner. All Wales WFP Network meetings scheduled for 18/01/22 - will raise there.
Medical workforce across USC being reviewed. Ensure baseline assessment is understood across UHB. Discussions on priority gaps/issues in Pembrokeshire progressing Further work in Carmarthen and Ceredigion being planned. (Also linked to appointments/approach to Physician Associates (PAs) in UHB.)	Walmsley, Tracy	31/03/2022	Work to be discussed further. PA work making progress - rotations of PA into Secondary & Primary Care being planned. 19 PA's will be in post in Hywel Dda HB in Nov21 - this will be one of the largest cohorts of PA's across Wales. EOI from PA's for 22/23 being developed - decision on corporate/local funding will be required. Capacity to progress work on medical workforce planning from all partners - assessing approach.
Review need and work with all Wales colleagues to develop incentivisation for bank work to support in times of increased demand. If Wales wide incentive not agreed then support organisation to develop own local scheme	Morgan, Steve	Completed	All Wales Advisory Notice received and HB proposal drafted. Document submitted to Execs for final approval 22nd December 2021. Proposal signed off by Execs on 22nd Dec 2021. Scheme now operational.

Focus on Workforce Plan alignment to predicted/possible scenario. Assess risk and develop mitigating actions for future plans utilising refreshed ECT/Allocate data in Temp Workforce Tool to update workforce plan and assess gaps. Iterative cycle to update monthly.	Walmsley, Tracy	~~31/10/2021~~ 15/11/2021 30/12/2021 * review again 31/03/22	Scenario of 925 beds being followed. Workforce gap is significant to meet need. Ongoing meetings with services to develop workforce plan and flag issues. Will feed into Workforce Planning Service Oversight Group when established. Link to IMTP, Governance. Developed scenario linked to IPC - exploring scenarios align to business as usual activity & recovery
Digital support with workforce planning to support speed in decision making	Walmsley, Tracy	31/03/2022	Immediate - Digital support access for absence monitoring reporting. Mid Term - accessing support from colleagues on future approach to tool based approach. Longer term - national all Wales approach may be instigated. Discussions at all levels taking place.

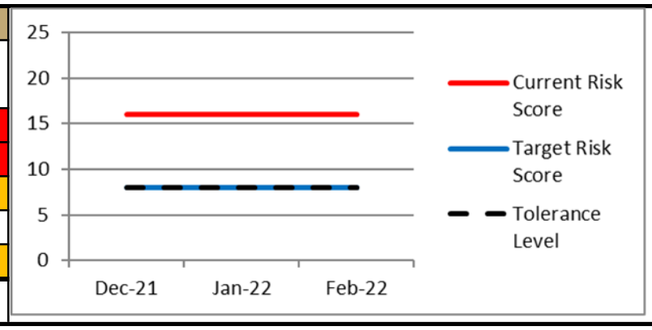
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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				Specific Workforce Planning group	Workforce Planning Assurance group to be established	Walmsley, Tracy	~~31/12/2021~~ 30/01/2022 28/02/2022	Discussed with LG (12/01/22)as QSEAC, PODCC and SURC all have links to workforce planning implications. Workforce "Conscience" group in place acting as "oversight" group with working TOR to be reviewed in line with concepts of emergency, tactical, operational and strategic workforce planning. A Framework for WFP in development for Health & Social Care requires alignment and clarity against internal organisational approaches. Local WFP Groups emerging within directorates supported by WFOD eg MHLD as part of IMTP. Draft TOR in place to be reviewed corporately. A number of strands of work need to be drawn together: Overseas RN programme, Grow Your Own and Retention as per Board paper 25/11/21. Draft framework to be confirmed by 28/02/22.
	Workforce levels monitored at Professional Oversight Group for Workforce Planning & Service Oversight Group for Workforce Planning	2nd					Re-develop workforce plan based on gaps present to Workforce Bronze	Walmsley, Tracy	Completed	Actions above feed into this activity/HCSW FTC COVID also reviewed
	PODCC - IMTP Plan, Planning Sub Group	2nd					Defined links to operational, tactical and strategic resources to align across all enablers - digital workforce, risk, QI, Service improvement to re-design workforce and embed significant service change to create workforce sustainability in short, medium and long term.	Walmsley, Tracy	~~31/01/2022~~ 31/03/2022	Meeting to be set up - diary availability is January 2022. Meeting held 11/01/22. Ongoing discussion.

Workforce Planning Internal Audit (Substantial Assurance)	3rd			Workforce Planning Internal Audit (24 Jan 2022) Population Health, Strategic & Engagement lenses on maturity of WFP being considered.	Walmsley, Tracy	28/02/2022	2nd and broader workforce planning audit in progress to be reviewed on 24/01/22. Any actions will follow if identified.

Date Risk Identified:	Nov-21	**Executive Director Owner:**	Thomas, Huw	**Date of Review:**	Feb-22
Strategic Objective:	6. Sustainable use of resources	**Lead Committee:**	Sustainable Resources Committee	**Date of Next Review:**	Mar-22

Risk ID:	**1296**	**Principal Risk Description:**	There is a risk that the Health Board will not deliver a financial out-turn position in line with our original plan of £25m deficit. This is caused by escalating pressures within Acute sites due to lack of access to Primary Care manifesting in A&E attendances and Domiciliary and Social Care fragility preventing the discharge of medically fit patients. This could lead to an impact/affect on a reduction in stakeholder confidence, reputational damage and increased scrutiny from WG.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Statutory duty/inspections
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	8
Trend:	*New risk*



Rationale for CURRENT Risk Score:
The levels of WG funding for the Health Board's response to the COVID-19 pandemic and Elective Recovery plans have been issued, largely at fixed values from Month 6 and 8 in line with the forecast continuation of costs incurred and Recovery bids.

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. 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.

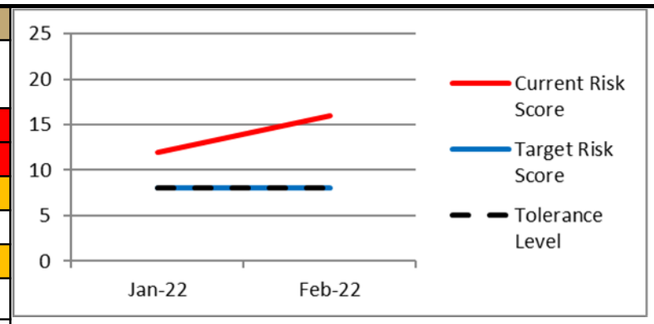
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**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, Sustainable Resources Committee, Board and Welsh Government on local costs incurred as a result of COVID-19 and Elective Recovery Plans 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. Accountability statements in relation to the Opening Directorate Budgets underpinning the draft interim Financial Plan for 2021/22 were issued to all budget holders in April 2021. The letters clarify that it is expected that all budget holders manage their services within their allocated budgetary envelope; that it is incumbent on all to ensure that expenditure, including the operational response to COVID-19, represents best value; and, that there is the expectation that these operational needs can be clearly demonstrated and that additional costs will reduce as and when decision making through the command structure allows. 6. Performance against plan monitored through System Engagement Meetings with Services, including Performance, Quality and Financial information. To be improved through Improving Together. 7. Use of Resources group is an added governance mechanism, for increased oversight of investment and disinvestment decisions.	The costs of addressing the Health Board's local needs may differ from the allocated funding envelope. The impact of the Winter months within Unscheduled Care services may further exacerbate the ability of the Health Board to resource both core and Recovery activity plans.	Confirmation from WG following the Accountable Officer letter issued in November 2021 regarding the treatment of £10.1m of Elective Recovery funding.	Thomas, Huw	Completed	WG feedback has now been received, with confirmation of acceptance of the Accountable Office letter.
		Refined prioritisation plans for Recovery schemes, factoring in latest market conditions in respect of Private Provider capacity and internal Workforce plans.	Carruthers, Andrew	Completed	Further work has been undertaken to assess the risk profile of plans, with YTD delivery being broadly in line with plans.
		Refine assessment of the feasibility of resilience and broader expenditure plans to deploy an element of Recovery funding to support the wider operational effectiveness of the Health Board, whilst ensuring delivery of value.	Carruthers, Andrew	~~17/12/2021~~ 17/02/2022	The planned accelerated profile of expenditure has been delivered in Month 10, with improved confidence in the continued delivery against plans in future months despite the challenges in managing a combination of market saturation within private providers, system resilience and workforce capacity constraints. The current forecast of £12.1m exceeds the Recovery funding by £0.6m with a likelihood of further over-commitment to prioritise patient access, which is being managed within the overall COVID-19 funding allocation.

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 Elective Recovery Plans Performance against planned direct response to COVID-19 In-month financial monitoring	Performance against plan monitored through System Engagement Meetings with Services	1st			Month 10 Finance Report Sustainable Resources Committee, February 2022 Month 9 Finance Report Board, January 2022	None				
	Sustainable Resources Committee oversight of current performance	2nd								
	Transformation & Financial Report to Board & SRC	2nd								
	WG scrutiny through monthly monitoring return	3rd								
	Audit Wales Structured Assessment 2021	3rd								

Date Risk Identified:	Oct-21	**Executive Director Owner:**	Kloer, Dr Philip	**Date of Review:**	Feb-22
Strategic Objective:	3. Striving to deliver and develop excellent services	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Mar-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 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):	4×4=16
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, and will now be completed by May22.

Rationale for TARGET Risk Score:
A sustainable TB service is required to support the ongoing outbreak management and ensure that all contacts are identified, screened and treated as appropriate. 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**
1 x permanent TB specialist nurse Current service provision is staffed to deal with TB incidences and outbreaks and not able to take on other work such as screening of overseas students to our universities as per current guidance Limited paediatric provision (6 months funding) PHW Health Protection support supporting outbreak and contacting Paediatric cases who previously not attended All contacts have been contacted at least once. Treatment plans put in place where required Provision to do BCGs Temporary phlebotomy provision in place A Project team will be established to support the review panel, led by a Project Manager and include administrative support, Communications and Information and Communications Technology.	Not having a sustainable TB service in place which will be exacerbated by a lack of consultant provision from Apr22 to undertake screening of oversees university students as per current guidance Additional TB specialist nurse to support outbreak Ability to identify everyone as a contact from TB outbreak from different sources High DNA rate from contacts	Implementation of sustainable TB Service plan submitted as part of IMTP 2022/25	Kloer, Dr Philip	31/03/2022	Submission to be considered as part 2022-25 IMTP process.
		Development of TB Database to enable cross-referencing of contacts	Tracey, Anthony	31/03/2022	A system has been developed however further work is required to enable is cross-reference contacts.
		Develop a communications strategy through the TB Joint Oversight Group	Evans, John	31/05/2022	Communications Officer to develop strategy to support the publication of the final report in May22.

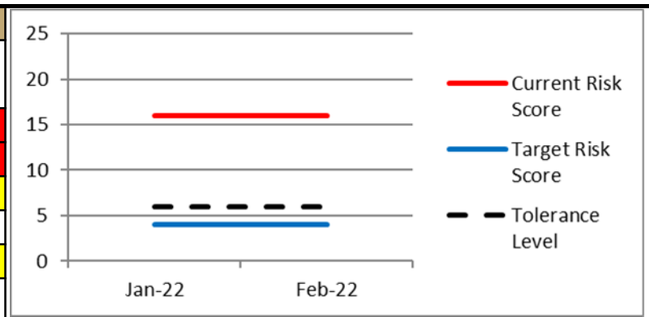
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	TB operational group operational response chaired by LPHD	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	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.
	Outbreak Control Team oversee the management of TB outbreak chaired PHW	2nd								
	Internal review presented to an In-Committee Board meeting in Nov19	2nd								
	TB Operational Task & Finish Group facilitating the external review	2nd								
	TB Joint Oversight Group chaired by Medical Directors of UHB and PHW	2nd								

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

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

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; 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; 4- Pilot of a weekend HDdUHB Cardiologist on-call advice line to support referral process.	Smith, Paul	31/08/2022	Service and NSTEMI Project group are progressing a) development of clinical proforma to support/expedite referral process - proforma for presentation/discussion at March '22 ARCH NSTEMI meeting; and b) development of medical NSTEMI pathway awareness/update for delivery at HDUHB Medical Grand Round session during Summer '22.
		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	Indicative investment highlighted in IMTP - HDdUHB detailed business case in development and scheduled for presentation at ARCH Regional Recovery Group on 17th March '22.
		Re-instate of NSTEMI Treat and Repatriation service and/or identify steps to improve patient transportation and logistics.	Smith, Paul	31/12/2022	Supported by ARCH, HDdUHB and SBUHB currently reviewing the requirement/fit of a NSTEMI Treat and Repatriate service within the future regional model/future pathway. Potential for re-establishment of NSTEMI Treat & Repat service at PPH currently under consideration.

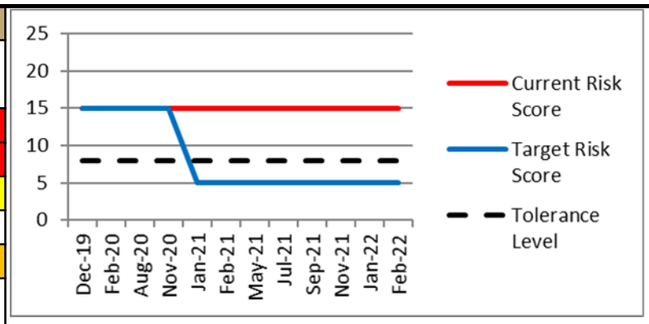
Increase regional capacity at Morriston Cardiac Centre to meet the 72 hour NICE guidelines.	Smith, Paul	31/12/2022	Supported by ARCH, SBUHB currently finalising SBAR outlining plans for increased capacity and delivery of 7 day Cardiac Cath Lab service. SBUHB detailed business case in development and scheduled for presentation at ARCH Regional Recovery Group on 17th March '22.
Explore options to commission NSTEMI pathway angiography service from an alternative provider/s across Wales	Smith, Paul	31/03/2023	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, whilst recognising the future potential need to explore alternative commissioning arrangements if this is not achieved. Cardiology Service Delivery Manager to feedback to QSEC on scoping undertaken to date regarding for potential to commission NSTEMI angiography/angioplasty from alternative providers across Wales and English borders.

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	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Feb-22
Strategic Objective:	3. Striving to deliver and develop excellent services	**Lead Committee:**	Health and Safety Assurance Committee	**Date of Next Review:**	Mar-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. 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:
Despite significant progress being made since the NWSSP IA Fire Precautions Report in May 2017 with regards to the key recommendations. In addition to this 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. This is evident from the recent fire safety improvement notice (FSIN) served on the UHB in Sep19 for Withybush General Hospital and Glangwili General Hospital on 17Apr20.

Rationale for TARGET Risk Score:
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.

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.	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. 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.	Introduce a system to manage fire risk assessment recommendations more effectively. System to have the ability to assign risks to risk owners, to track/manage risk and to demonstrate progress on the actions.	Evans, Paul	~~31/03/2020~~ 31/07/2021 30/06/2020 28/01/2021 30/06/2021 30/10/2021 27/12/2021	The fire team are utilising the current system as best as possible. An Excel system is being introduced (completion Jun20) however a more robust automated system is needed by the HB to track the significant number of actions. Progressing this has been delayed due to COVID-19, however quotes have now been obtained and are under discussion with the Director of Facilities. Approval has now been provided to purchase a system. Completion date for system 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.
	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.	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	~~28/01/2021~~ 30/06/2021 30/11/2021 30/12/2021 20/01/2022 20/02/2022	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.	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	31/03/2023	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.

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								
	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:	Jan-22	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jan-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Mar-22

Risk ID:	**1342**	**Principal Risk Description:**	There is a risk that the Health Board will be unable to plan and respond effectively to the pandemic and make effective decisions on critical business continuity issues, the application of Local Choices Framework and delivery of essential services. This is caused by the daily COVID case reports that the HB relies on to enable it to monitor, track and plan its response to COVID only include PCR test results and does not reflect the recent shift in testing policy to a greater reliance on LFD test results. This could lead to an impact/affect on not being able to deliver safe and effective services for COVID and Non-COVID patients, 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)		**No trend information available.**
Domain:	Quality/Complaints/Audit	
Inherent Risk Score (L x I):	5×5=25	
Current Risk Score (L x I):	4×3=12	
Target Risk Score (L x I):	3×3=9	
Tolerable Risk:	8	
Trend:	*New risk*	

Rationale for CURRENT Risk Score:
The change of testing policy during the latest wave of the pandemic has made it challenging for the Health Board to fully understand where it is on the pandemic curve, and make accurate decisions in stepping up and down services at the right time. Whilst the Health Board is utilising other proxy data, this may not provide a full picture of activity, and may contradict the public data on COVID cases in the local community. The level of risk has reduced from 20 when it was first identified to 12 as the peak of the 4th wave has passed.

Rationale for TARGET Risk Score:
It is anticipated that understanding of and confidence in proxy data sources will strengthen over time.

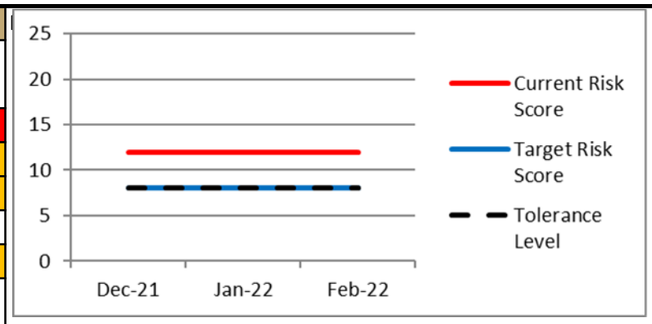
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Processes and systems for collection of HB data in place: - Daily reporting & monitoring of PCR positive cases per 100,000 - Daily reporting & monitoring of hospitalised cases split by those that are undergoing active treatment for COVID, recovering from COVID and those who have tested positive for COVID as a secondary diagnosis - Daily reporting & monitoring of staff sickness absence during anticipated 2 week peak period - Daily data on incidences and outbreaks in local schools/year groups/classes related to COVID-19 UHB Analytics department collate, analyse and present data to inform decision-making Multiplex testing	Not having a consolidated, accurate data source reflecting the positive COVID cases in the community to enable the monitoring and identification of risk and provide a timely and effective response to changes in infection rates within the local community PCR tests are only being undertaken on limited groups within the community, eg in-patients, pre-operative patients/ those undergoing chemotherapy, health and social care staff Under reporting of LFD results by the population	Working with WAST to ensure they flag at an early stage any increase in ambulance responses coded as pandemic flu or breathing difficulties	Carruthers, Andrew	31/03/2022	Discussions have taken place.
		The Health Board to support national communications of importance of reporting LFD results	Carruthers, Andrew	Completed	A number of communications have been issued by Health Board in respect of testing and reporting of LFD tests.
		Exploring inclusion of daily reporting & monitoring of LFD positive cases per 100,000 into daily report/dashboard	Carruthers, Andrew	~~31/01/2022~~ 25/02/2022	Data is still being qualified. Weekly aggregated LFD data that is de-duplicated from PCR data is available. Meeting on 15/02/2022 with PHW and DHCW to propose amendments to LFD reporting. Currently daily data is not accurately available from DHCW, which excludes double counting with PCR data.
		Request modelling cell to provide a weekly report triangulating the available data (to include waste water, PCR, LFD, positive hospital cases)	Carruthers, Andrew	~~11/02/2022~~ 25/02/2022	New action

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 department collates WPAS data in the data warehouse (eg hospital admissions, emergency attendances, etc)	1st				Duplication of test reporting	Understanding the LFD testing data to avoid double-counting with PCR testing	Carruthers, Andrew	~~31/01/2022~~ 25/02/2022	Meeting on 15/02/2022 with PHW and DHCW to propose amendments to LFD reporting. This is being done on a national level.
	Weekly COVID Monitoring meeting reviews data received from both external and internal sources	1st								
	Oversight of current data and agreement of HB response at Silver/Tactical Meeting	2nd								
	HSSG COVID 19 planning and response group (update on national modelling)	2nd								
	Public Health Acute Response and Ongoing Support (previously Public Health Gold Cell)	2nd								
	DHCW provides the Health Board with validated data on a daily basis (eg PCR & LFD test)	3rd								

Date Risk Identified:	Dec-21	**Executive Director Owner:**	Thomas, Huw	**Date of Review:**	Feb-22
Strategic Objective:	6. Sustainable use of resources	**Lead Committee:**	Sustainable Resources Committee	**Date of Next Review:**	Apr-22

Risk ID:	**1307**	**Principal Risk Description:**	There is a risk that the Health Board will not meet its statutory duty to breakeven against its Capital Resource Limit for 2021/22. This is caused by significant uncertainty in achieving the Capital Resource Limit exacerbated by the following: a) Supply Chain Issues; b) Global shortage of key components including glass and steel; c) Greater delivery lead time for digital and medical equipment; d) Impact of COVID 19 e.g. unable to complete programmes of work in live hospital environment, labour shortages due to self isolation; and e) Local supply issues of key construction materials such as concrete. This could lead to an impact/affect on the Health Board's Discretionary Capital Programme in 2022/23 and there would be a reputational risk to the Health Board.
Does this risk link to any Directorate (operational) risks?			

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



Rationale for CURRENT Risk Score:
Significant uncertainty lies in the delivery of the Capital Programme in 2021/22 due to a number of factors which lie outside of the control of the Health Board. Whilst previous years demonstrate that the Health Board has been able to meet its statutory duty to breakeven against the capital resource limit, there is an increased likelihood in 2021/22 that it will not be able to do so. The Health Board has received capital funding for a Demountable theatre at Prince Phillip Hospital totalling £19.937m in December with planned completion by the 31st March. Given the scale of spend required before the end of March 2022, any slippage in programme would be likely to be a significant financial value. Longer lead times for medical and digital equipment mean that opportunities to re-prioritise 2022/23 replacement programmes as capital scheme slippages are identified, are reduced.

Rationale for TARGET Risk Score:
The Health Board needs to demonstrate that it is able to manage its capital position effectively, cognisant of the risks which are inherent in the delivery of safe and timely care. Given the challenge in delivering the capital position this year, the Health Board will achieve a risk which is in line with the tolerable risk for the year.

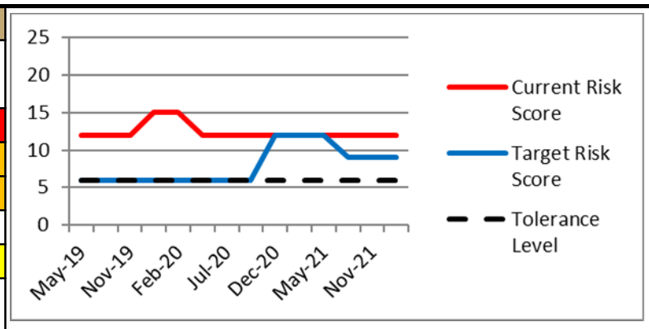
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
1. Timely financial reporting to Sustainable Resources Committee, Board and Welsh Government as key areas of concern emerge. 2. Bi-Monthly reporting to the Sustainable Resources Committee regarding the capital risk. 3. Prioritised replacement Medical and Digital equipment lists developed with lead times for delivery included. 4. Vesting / Bonding of equipment where delivery is unable to be achieved by the 31st March. 5.Weekly expenditure reports sent to key stakeholders highlighting any potential areas of slippage with explanations for key areas of concern required. 6. Regular meetings held to monitor spend profiles with escalation measures put in place immediately, where required.	Reporting of capital financial risks to relevant members of the Health Board Executive Team.	Monthly reporting to the Use of Resources Group to provide some additional controls / assurance with regards to the in year capital financial position.	Thomas, Huw	Completed	Report to be produced for a December Use of Resources Group meeting. Update - Report produced
		Written confirmation is being sought from suppliers confirming delivery before 31st March 2022.	Thomas, Huw	31/03/2022	In progress.

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 the Capital Resources Limit	Performance against plan monitored through Capital Monitoring Group with key internal stakeholders	1st			N/A	None				
	Detailed prioritisation to be agreed through Capital Planning Group	1st								
	Performance reports through to Capital, Estates and IM&T Sub-Committee	1st								
	Sustainable Resources Committee oversight of current performance	2nd								
	Capital report to Strategic, Development and Operational Delivery Committee	2nd								
	WG Scrutiny through bi-monthly monitoring	3rd								

Date Risk Identified:	Apr-17	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jan-22
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Mar-22

Risk ID:	**129**	**Principal Risk Description:**	There is a risk of the inability to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda patients This is caused by a lack of available of labour supply as GPs near retirement age and pay rate differentials across Health Boards in Wales impact the UHB's ability to recruit in the mid-long term. In the short term, seasonal illnesses, continued COVID19 pressures, and upcoming Christmas holiday period could further compromise the ability to fill shifts. This, combined with possible impacts on in-hours provision, will result in a deteriorating workforce position. In addition, some clinicians may preferentially work 111 First shifts, as they are potentially much lighter (already seen in SBU). Seasonal illnesses, continued COVID19 pressures, and usual winter pressures continue. 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 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 may also result in 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):	5×3=15
Current Risk Score (L x I):	4×3=12
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:	Rationale for TARGET Risk Score:
The COVID pandemic combined with the temporary overnight service changes has brought some respite to the service fragility, and this is reflected in the current risk score. Generally the rotas continue to be unstable, particularly at the weekends. Any further absence on out of hours provision is likely to rapidly result in further deterioration of the current position. As of Sep21 there has been no notable change/definite trend in the service fragility. Rotas continue to be fragile, particularly at weekends. The potential adverse affects of a third wave are currently being considered, combined with other seasonal pressures, including the potential affect of RSV.	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 this is further compounded by the need for salary staff to take annual leave and sessional staff to have time off to rest (particularly following the pressures of the Covid-19 pandemic). The August 2021 Bank Holiday rotas were still markedly reduced, despite the offer of Christmas rates (our highest hourly rates), which reflects exhaustion and burn out of clinicians. 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 requirements have been flagged as part of the IMTP. The Clinical Lead has 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. The potential adverse affects of the pandemic, plus RSV and Flu, are currently being considered, which should include further updates to the Exec Team. Target score has been reduced from 12 to 9 to reflect the 5 salaried GPs, on the assumption that they will complete recruitment. There is less of an improvement from this recruitment as it is being used to develop plans to re-open bases and provide better care, therefore the effect of the recruitment could be diluted through the expansion of the service.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**

# GP's rotas across the 3 counties are now managed centrally via the administration team based in Haverfordwest # Dedicated GP Advice sessions in place at times of high demand (mostly weekends). # Remote working telephone advice clinicians secured where required. # Additional remote working capacity has been secured to assist clinicians who may be shielding/ isolating to continue to support operational demand. # Workforce support from 111 programme team in addressing OOH fragilities available if required. # Health Professional feedback form in use between clinicians, service management and 111 (WAST) leads. # WAST Advance Paramedic Practitioner (APP) resource enhanced to provide more flexibility. # Rationalisation of overnight bases in place since March 2020, now subject to service review. # Workforce and service redesign requirements flagged as part of IMTP. # 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. # Home working provision in place for GPs. # Agreed pathway for PPH Minor Injury Unit in place. # GP Hub in place where locum sessions can be accessed centrally to support service provision. # 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). 5 new salaried GP may allow us to influence this positively. At present the staffing remains challenging, as we have lost the previous stability in the stable rota in Carmarthen. There are shortfalls in Pembrokeshire and Ceredigion that are affecting service provision throughout the 7 day operating period. Long term sickness has improved for one clinician but offset by medical retirement of another. The Clinical Lead has 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. 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, complicated by the inability to see red flow patients in an Out of Hours setting (option available for red flow patients is nearing completion). The focus on delivery of care via the telephone advice method is the significant factor in stabilising the risk at this time (70-80% of consultations is now dealt with on the phone)- but any reduction in capacity remains likely to require an increase in the risk level as the service delivery will be adversely affected.	Ensure Transforming Clinical Services Programme incorporates a long term, viable plan for OOH.	Rees, Gareth	~~30/09/2020~~ 31/12/2021 31/12/2022	As of January 2020 the development of a detailed redesign plan is underway but the timescale has yet to be identified. Feb 2020- this work is continuing to progress and work on medium term resolution has now commenced. March 2020- Working group stood down due to Covid-19 commitments June2020- Requests to restart working group are subject to re-prioritisation. Dec2020- inclusion in new IMTP process, awaiting decision on how to progress with service change. Delayed by Covid-19. Feb2021- Change in SDM, now subject to new focus. Still awaiting decision/direction on how to progress with service change. May 2021- Still awaiting decision/direction. Sept 2021- Still awaiting decision/direction on integration into TCS, as well as considering the impact of the ongoing Covid pandemic. Same situation in Jan 2022.
		Review the rationalisation of overnight temporary service change.	Richards, David	~~31/05/2021~~ 30/09/2021 31/12/2021 30/06/2022	All operational staff are aware that this review is now underway as of Feb21. The review is being designed and will look at patient demand and experience, and service risks. As of May21 this is being actively reviewed with the Director of Operations. The consultations will now take place into Jun21 with outcomes to be reported to the relevant UHB Committees in Sep21. Jul21- A patient and staff survey to be released and SDM to write paper to Director of Operations on service change. Currently working with Workforce colleagues to develop a true multidisciplinary team. Jan 22 - to continue with the temporary arrangements due to ongoing rota situation.

Implement 'RotaMaster' which will help with rostering going forward. Our issues with 'offer and accept', plus IR35, will be mitigated with the completion of this project.	Richards, David	~~31/08/2021~~ 30/09/2021 31/12/2021 30/04/2022	Admin team are currently building and inputting all services details. RotaMaster will then be tested before going live. As of Jul21 RotaMaster is still being built. Training sessions will become available once RotaMaster is in place and hopeful this will be completed by Dec21. Jan 22 - little progress due to Christmas and New Year period. Training sessions being set up, some of which have been undertaken, with the aim to complete and using RotaMaster by the March 2022.
Implement Locum Hub Wales.	Richards, David	Completed	Completed- Locum Hub Wales is live as of Jul21, however usage is currently limited due to geographical restrictions and other non Health Board issues, including issues with the system and small pool of Clinicians available who are already working in our Health Board. Remote working would be available but is of low utility when we need face to face cover.
Recruit Health Board wide GP posts.	Richards, David	~~30/06/2021~~ 31/12/2021 30/06/2022	Interviews taking place w/b 19/07/2021 for 5 GPs. Some of these GPs are finishing training, but will be recruited for referred enrolment. Further recruitment advert will be considered following these interviews. Jan 22 - recruited 8 (6WTE), but one has deferred, and others awaiting to start, and also staff on long term sick. Anticipated completion date for the action of June 2022.

Short term (1-2 years), the aim is to recruit Advanced Practitioners of all grades, with the potential opportunity to provide applicants with appropriate training and career development eg prescribing training within the available budget.	Richards, David	31/12/2023	Future growth of the MDT model will be on an incremental, opportunistic basis to prevent destabilising the wider system, as clinicians become available, or express an interest to join the service. Jan 22 - discussions on going as to the structure of the model.
In the long term (2-5 years), in cooperation with TCS, Workforce and national groups, to develop a programme to grow our clinical workforce, and to evolve and utilise a self-sufficient service which is fit for purpose, within available budget.	Richards, David	31/12/2026	Future growth of the MDT model will be on an incremental basis. Jan 22 - discussions on going as to the structure of the model.
Investigate the further use of digital technology and platforms to deliver the OOH service alongside current practices eg Attend Anywhere	Richards, David	31/12/2022	Jan 22 - options on other possible facilities or programmes identified after a successful roll out in other services. Follow up work to be undertaken on these.

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			QSEAC OOH Update Sep19 & Feb20 QSEAC - Peer review - Feb20 QSEAC- Review of risk 129 - Oct20 QSEAC- Review of risk 129 Apr21 QSEAC- OOH paper June20 ET- Risk to OOH business continuity - Sep19 ET- OOH resilience - Nov19 & Jan20 BPPAC Quarterly monitoring Nov19 BPPAC - update on the OOH Services peer review paper Dec19 BPPAC - OOH service design Feb20 QSEC - OOH Paper 5th October 2021	Lack of meaningful performance indicators.	Assess NHS 111 performance metrics to understand how they may influence Hywel Dda OOHs performance, and if a viable alternative - which may support improvement in shift fill.	Davies, Nick	Completed	New 111 Wales performance metrics are being prepared and will soon be circulated for review.
	Twice a week sitreps and Weekend briefings for OOH	1st								
	Monitoring of performance against 111 standards	1st								
	Issues raised at fortnightly meeting with Primary Care Deputy Medical Director and Associate Medical Director	1st								
	Monthly report to Joint Operations Group (WAST, 111 team & 111 Health Boards)	2nd								
	QSEAC monitoring	2nd								
	Issues raised, and performance Matrix reviewed, at National OOH forum (bi-monthly, attended by WG)	3rd								
	WG Peer Review Oct 19	3rd								

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Mar-22
Lead Committee:	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	May-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)		**No trend information available.**
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:	*New risk*	

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 on a downward trajectory for quarter 3 during 2021/22. This is 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. Performance since Sep21 has been steadily deteriorating and is now at 53% (Dec21).

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 is being developed by Informatics with the support of Business Intelligence (BI) SCP funding from the Wales Cancer Network, for delivery by Mar22. # Monitoring data of patients whose treatments have changed or suspended (some through patient choice) as a result of COVID-19. A 4-week follow up process has been implemented for these. # A Rapid Diagnosis Clinic (RDC) has been launched within the health board. Currently 1 clinic per week being held in PPH. # 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 in early 2022. # 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. # Implementing a Cancer Pathway Review Panel to identify any risk for those patients who have not received their treatment within 146 days. # 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.	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 to be appointed by end of Mar22. 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 plan for Radiology and explore short term opportunities to increase capacity.
		Review access to green surgical pathways across all sites to include access to green critical care.	Humphrey, Lisa	30/04/2022	BGH Green elective pathway has been re-established and the WGH Green elective pathway is going live as of the 09Mar22. Plan being developed for end of Apr22 for GGH.
		Introduce a central point of contact for navigator as a pilot to coordinate radiology USC appointments and reporting from Mar22	Humphrey, Lisa	31/03/2022	Interviews for this 12 month pilot post are taking place at the end of Feb22 with the aim to have this navigator in post in Mar22.
		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)	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
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	None identified.				
	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								

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

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

Risk ID:	**1335**	**Principal Risk Description:**	There is a risk of clinical services being unable to access 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)		**No trend information available.**
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:	*New risk*	

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.

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.	An absence of a sustainable long term solution for records management and storage In its paper form, the health record is not under teh 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	31/03/2022	Tenders have been issued and the award date is 23/02/22.
		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	A proposal will be submitted to Executive Team by 30/04/22.

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
	Information Asset Owner Registers Group	1st			Records Storage SBAR - Executive Team (Jul21)	Assurance arrangements to Board Committee	Agree formal reporting arrangements with Head of Corporate Governance	Rees, Gareth	31/03/2022	3 new Planning Objectives developed and will be aligned to Committee Workplans.
	Digital Health Records Project Group to oversee delivery of enabling work	2nd								
	IA Records Management Report (limited - follow up (reasonable) in Health Records only	3rd								

Date Risk Identified:	Dec-21	**Executive Director Owner:**	Rayani, Mandy	**Date of Review:**	Feb-22
Strategic Objective:	1. Putting people at the heart of everything we do	**Lead Committee:**	Health and Safety Assurance Committee	**Date of Next Review:**	Apr-22

Risk ID:	**1328**	**Principal Risk Description:**	There is a risk hat 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)		**No trend information available.**
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:	*New risk*	

Rationale for CURRENT Risk Score:
Porters at one acute site were called to support staff involved in Violence and Aggression incidents on 178 occasions between February and October 2021. 19 of which required Police intervention. On average, across the Health Board, 85 violence and aggression incidents are reported each month. There is no dedicated security guard force and here is also variation in the standard of coverage and quality including evidential standard required of CCTV (closed circuit television) systems across the Health Board.

Rationale for TARGET Risk Score:
A new 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	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	31/03/2022	A capital bid has been submitted to Head of Capital Planning for consideration in 2021/22. Contractor undertaking survey work at all four hospital sites to feed into the review.
		Undertake a review of security arrangements within Hywel Dda (linked to new PO agreed by Board in Jan22)	Harrison, Tim	31/03/2023	Benchmarking current security arrangements with other organisations to inform future security model for Hywel Dda which will aim to address gaps in control. Discussions have already taken place with C&V UHB. An All Wales Security group currently being set up.
		Additional electronic lock doors to be fitted at BGH.	Harrison, Tim	31/03/2022	Contractors currently on site.

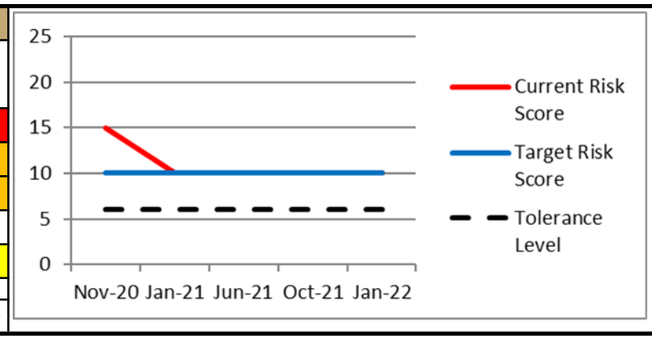
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Security incidents breaches are reported via Datix and investigated	1st			Premises and Security Update Deep Dive - HSC (Nov21)	Review of high risk areas to improve mitigations	Undertake security risk assessment in high risk areas	Harrison, Tim	30/06/2022	Work to commence.
	Reports on security arrangements and related incidents are provided to Health and Safety Committee	2nd					Establish Task & Finish Security Management Group, including involvement from Facilities colleagues.	Harrison, Tim	31/03/2022	Discussions being undertaken with Head of Operational Services to establish meeting dates.
	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:	Nov-20
Strategic Objective:	N/A - Operational Risk

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

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

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



Rationale for CURRENT Risk Score:
Social Distance risk assessments have been undertaken that highlight ways to allow services to be re-introduced while maintaining the social distance measures, however successful management of the risk depends on staff, visitors or patients adhering to the social distance guidance or using the 'Key Controls' measures in place. The current risk remains at 10 whilst the social distance measures continue to be required. There does appear to be an increase in the numbers of staff absent either because of close contact family members being off or contracting covid-19 themselves hence the need for continued distancing within Healthcare premises.

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Social distancing guidance in place for staff and is available on the intranet # Safety screen installations in hospital and ward/clinic reception areas # Instructional social distance posters, phones messages and floor signs # Hand sanitisers stations # Personal protective equipment (PPE) # Reducing room capacities to allow for social distancing # Use of IT systems e.g. Microsoft Teams to reduce the need for face to face meetings # Reduction in travelling between sites # Home working being encouraged where possible # Accommodation facilities for medical staff have been risk assessed and alterations made in line with social distance measures. # SD information on patient appointment letters, leaflets # One way pedestrian walkways # Controlled access into surgical wards and theatres # Hospital bed screens installed in identified wards in order to maximise inpatient capacity and minimise bed losses # Additional accommodation in Trinity St David's Campus to improve social distancing # Patient visiting arrangements include agreed timeslots and management arrangements	Due to the relaxation of COVID-19 rules outside of health settings, staff, visitors or patients are less likely to adhere to the social distance measures in healthcare Staff returning to work on sites may lead to a reduction to the availability of staff room and changing facilities as these spaces return to their original use. Longer term working from home/agile working will need further consideration for ensuring compliance with DSE Regulations. Compliance with new WG government guidance in respect of relaxation of social distancing measures in some areas.	Review current home working guidance for agile/homeworkers	Harrison, Tim	~~30/09/2021~~ 01/03/2022	Working from home assessment in development as an all Wales standard this has resulted in a delay with its completion.
		Increase screens in patient waiting areas to support compliance with new WG SD guidance to provide additional protection for patients whilst maintaining capacity	Chiffi, Simon	Completed	Screens installed within Patient Waiting areas to enable additional internal patient waiting capacity during winter months.
		Issue new guidance to operational & corporate management and request them to review social distancing arrangements and risk assessments in their areas in line with latest WG guidance, eg, non-clinical areas can reduce SD to 1m	Harrison, Tim	Completed	SBAR containing latest WG guidance to be considered by Executive Team, prior to communicating across HB.

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	Oversight is provided by the Social Distancing Cell, Chaired by Director of NQPE	1st				None identified.				
	Reviewing grade 4&5 incidents (RIDDOR reportable) involving staff contracting hospital acquired COVID	1st								
	Social Distancing Cell reports into Silver and Gold Groups	2nd								
	HSE visit Oct21 with no issues identified across the 2 acute and 2 community sites	3rd								