Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	25 May 2023
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Corporate Risk Register
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Steve Moore, Chief Executive
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Wilson, Director of Corporate Governance Charlotte Beare, Assistant Director of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

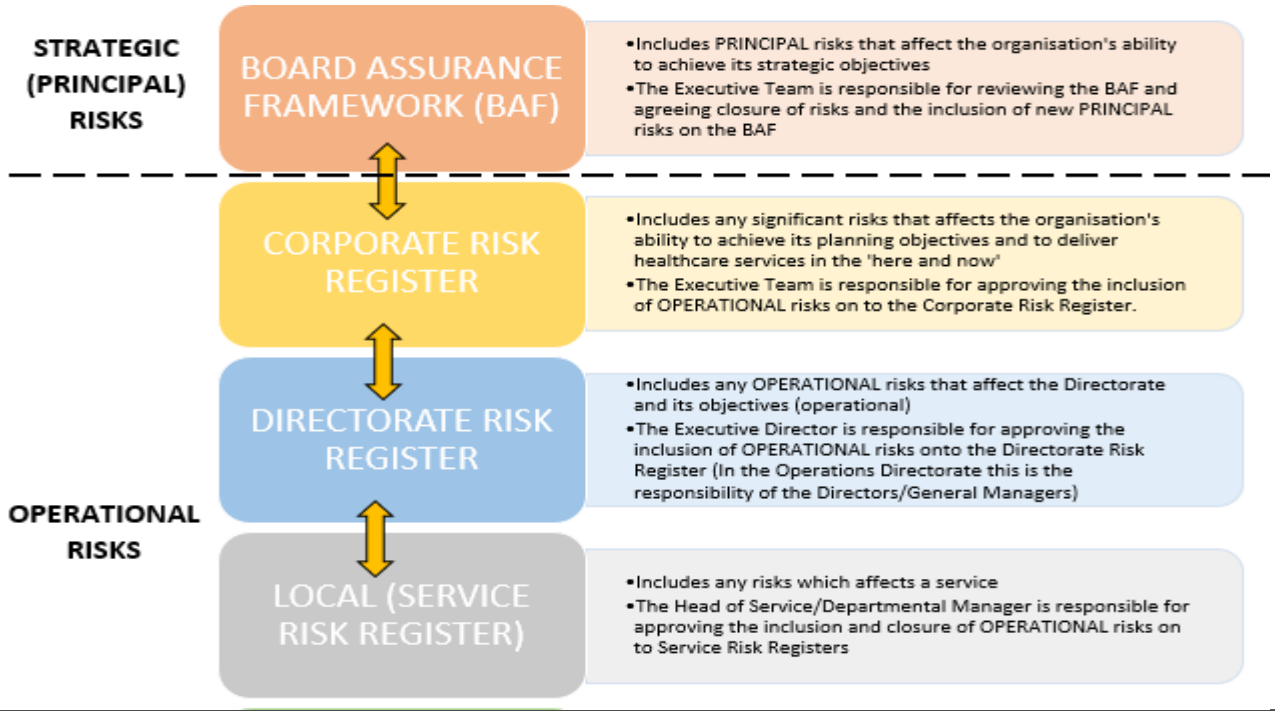
The Corporate Risk Register (CRR) is presented to the Board to advise of the corporate risks of Hywel Dda University Health Board (the Health Board) and provide assurance that these risks are being assessed, reviewed and managed appropriately/effectively.

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 January 2023, the risks have been discussed in detail at its Board Committees, and reported to the Board via the Committee Update Reports. Where assurance has not been received that corporate risks are being managed effectively, the Committees can request a more in-depth report at a subsequent meeting.

The CRR includes significant risks associated with delivering the 'here and now', whilst the Board Assurance Framework (BAF) will identify the Health Board's principal risks to achieving its strategic objectives, and these will be long term in nature. The BAF dashboard is reported to every other Board meeting.

The following changes have taken place since the CRR was previously presented to the Board in January 2023:

Total Number of Risks as at May 2023	18	
New/Escalated	5	*See note 1*
De-escalated/Closed	5	*See note 2*
Increase in risk score ↑	0	
Reduction in risk score ↓	4	*See note 3*
No change in risk score →	9	

Attached to this report to provide the Board with assurance on the management of its corporate 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.

Due to the sensitive nature of risks 1352 – Risk of business disruption and delays in patient care due to a cyber-attack, and risk 1328 – Security Management, the detail is being reported

to In-Committee Board, to provide discussion and assurance. Detail on the 16 remaining corporate risks is included in Appendix 2.

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		1531 (ESCALATED)	813 (→)	1027 (↓) 1657 (NEW)	
MAJOR 4			1559 (↓), 1548 (↓), 1433 (→), 684 (→), 1350 (→)	129 (→), 1340 (→), 1352 (→),1649 (NEW), 1642 (NEW)	1032 (→), 797 (ESCALATED)
MODERATE 3			1335 (↓)	1328 (→)	
MINOR 2					
NEGLIGIBLE 1					

Note 1 – New Risks

Since the previous report in January 2023, 3 new and 2 escalated risks have been added to the CRR:

Risk	Lead Director	New / Escalated	Current Risk Score (Lxl)	Rationale for Current Risk Score
1657 - Risk to delivery of Ministerial Priorities in relation to delivery of planned care recovery ambitions through 2023/24	Director of Operations	New	**4x5=20**	The risk was approved by Executive Risk Group via Chair's Action on 12 May 2023. The combined impact of current uncertainty regarding resources available to support recovery actions, the availability of workforce and /or externally provided capacity and the

				continuing impact of post-pandemic urgent and emergency care pathway pressures (as reflected in risk 1027) which continue to impact upon available capacity for some specialties, all pose a risk to achievement of ministerial priority expectations in relation to achievement of planned care recovery ambitions. The Annual Plan approved by the Board in March 2023 and supporting performance trajectories highlight significant gaps between the resourced level of capacity reflected in the plan, and the anticipated level of patient demand to be treated during 2023/24. Whilst further proposals have been submitted to WG to access retained recovery funding not yet allocated to health boards, revised delivery trajectories cannot be confirmed without a supporting resource plan. Subject to availability of additional resources to support additional recovery actions, it is anticipated that a significant volume of additional activity will need to be supported by externally provided solutions, either via neighbouring health boards or via the independent sector insource / outsource market. External capacity cannot be confirmed prior to formal market testing. Limits to staffing resource both in theatre, and post operatively, was a challenge before the COVID pandemic. Whilst positive progress has been achieved in increasing outpatient activity & capacity to levels comparable with pre-pandemic volumes, significant staffing deficits within the

				Anaesthetic medical and theatre staffing teams continues to limit the volume of elective operating sessions undertaken and therefore continues to limit progress in expanding overall activity levels to match/exceed pre-pandemic levels. The continuing legacy of the COVID-19 pandemic on urgent and emergency care pathway demand and the consequential impact on available bed capacity continues to limit sufficient capacity to support activity expansion plans in key specialties. Whilst no health board is currently achieving ministerial milestones in respect of planned care recovery, HDUHB has achieved the greatest progress compared to other health boards across Wales during 2022/23 and has achieved a significant improvement in the volumes of Stage 1 patients waiting > 52 weeks and total pathway patients waiting > 104 weeks.
797 - Shortage of staff in sonography affecting the whole Health Board.	Director of Operations	Escalated (risk originally identified 07/11/19)	**5x4=20**	The risk was approved by Executive Risk Group via Chair's Action on 9 May 2023. The service remains fragile and supported by long term agency staff. Vacancies remain unfilled, with the inability to recruit despite repeated recruitment attempts. Long term vacancies exist in Bronglais General Hospital (BGH), Prince Philip Hospital (PPH) and WGH - in particular in terms of modality lead sonographers at WGH and PPH as at April 2023. There are a number of expected retirements and planned maternity absences in the near future and there will also be the inability to secure agency staff from July 2023 in WGH.

				As a result of the loss of ultrasound modality leadership in the team at WGH, there is a reduced ability to undertake governance and audit requirements. A midwife has recently qualified after receiving sonography training at WGH in April 2023, and a further trainee qualified at PPH. More sonographers are due to be trained from January 2024. However, difficulties remain in obtaining locum staff, exacerbated by registration requirements. Antenatal scanning services at WGH were not fulfilled due to lack of staffing on 6 and 11 April 2023, affecting 12 patients.
1649 - Insufficient skilled workforce to deliver services outlined in the Annual Plan 23/24 and deliver Health Board strategic vision by 2030	Director of Workforce & OD	New	**4x4=16**	The risk was approved by Executive Risk Group via Chair's Action on 26 April 2023. This risk has been scored as 16 (the likelihood is "likely" and has the potential to have a "major" impact) as the number of staff impacted from staff sickness is still high at April 2023 compared to pre-Covid levels (circa 2-3% higher) however, there has been a general improvement over the last 12 months. Staffing levels in both acute and community settings continue to operate below established levels due to both vacancies and sickness/absence, and the use of bank and agency. There is still a significant risk of workforce misalignment with activity and required competence levels. Further work has been undertaken to understand the level of risk across each staff group, speciality and site to fully comprehend the level of risk the organisation carries as a whole. It is hoped as further action is taken through stabilisation, Improving Together sessions

				and workforce planning to reduce the risk score during 2023/24.
1642 – Risk of the Health Board not being able to meet the statutory requirement of breaking even 2023/24	Director of Finance	New	**4x4=16**	The risk was approved by Executive Risk Group via Chair's Action on 18 April 2023. The draft Annual Plan for 2023/24 of £112.9m is unacceptable to the Board and Welsh Government (WG) and has led to a further deterioration in an already unsupportable underlying deficit position which will impact future years. Through our 2023/24 planning process, operational plans to address the financial savings gap and operational variation have not provided sufficient assurance to mitigate the current financial trajectory. Without further support, at this stage, the Health Board will require further cash-backed support from WG as the extent of our cash allocation will be insufficient to continue to service our liabilities as they fall due after early February 2024. If this support is unavailable, which is a risk given the national financial position, then this could affect patient services and our key stakeholders.
1531 - Inability to safely support the Consultant on-call rota at Withybush General Hospital (WGH) and Glangwili General Hospital (GGH)	Director of Operations	Escalated (risk originally identified 10/11/22)	**5x2=10**	The risk was approved by Executive Risk Group on 5 April 2023. The current risk score has been reduced since the risk was initially escalated to reflect the Board decision in March 2023 to introduce 3 in 1 consultant on-rota at WGH. There are currently 2 consultants on the rota, with no transfers to date. The new rota is under constant monitoring and review to ascertain and address any issues.

Note 2 – De-escalated / Closed Risks

Since the previous report to Board in January 2023, 4 risks have been closed, and 1 risk has been de-escalated from the CRR:

Risk	Lead Director	Closed / De-escalated	Date of closure	Reason
1406 - Risk of insufficient skilled workforce to deliver services outlined in Annual Plan 22/23 & deliver Health Board strategic vision by 2030	Director of Workforce & OD	Closed	26/04/2023	Risk now superseded by 1649 (above) - Insufficient skilled workforce to deliver services outlined in the Annual Plan 23/24 and deliver Health Board strategic vision by 2030.
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 & Director of Clinical Strategy	Closed	08/03/2023	The Executive Risk Group agreed to close risk on 8 March 2023 as external review has been finalised and published.
1432 - Risk to the delivery of the Health Board's draft interim Financial Plan for 2022/23	Director of Finance	Closed	09/05/2023	The risk has now been closed, with new risk 1642 - risk of the Health Board not being able to meet the statutory requirement of breaking even 2023/24 being approved for the current financial year, as agreed by the Chair of the Executive Risk Group.
1349 - Ability to deliver ultrasound services at Withybush (WGH)	Director of Operations	De-escalated	09/05/2023	The risk has been superseded on the CRR by existing risk 797 - shortage of staff in sonography affecting the whole Health Board, reflecting the scope of the risk across the organisation. The risk specific to WGH has been de-escalated to Directorate level as agreed by the Chair of the Executive Risk Group.
1407 - Risk to delivery of Annual Recovery Plan & achievement of WG Ministerial Priorities for the reduction in elective waiting times	Director of Operations	Closed	15/05/2023	The risk has now been closed, with new risk 1657 - risk to delivery of Ministerial Priorities in relation to delivery of planned care recovery ambitions through 2023/24, as agreed by the Chair of the Executive Risk Group.

Note 3 – Increase/decreases in Current Risk Score

Since the previous report to Board in January 2023, there have been changes to the scores of the following 4 risks:

Risk	Risk Owner	Previous Risk Score	Risk Score May 2023	Date risk identified	Rationale for Current Risk Score
1027 - Delivery of integrated community and acute unscheduled care services	Director of Operations	**5x5=25**	**4x5=20** ↓	19/11/20	Levels of urgent and emergency pathway capacity pressures continue at significantly escalated levels. This is driven by post pandemic demand and the broader impacts of COVID-19. Workforce deficits, handover delays, 4- and 12-hour performance, bed occupancy rates and significant pressures on wider community and social care capacity are all demonstrating significantly worrying trends. The indirect legacy of the pandemic has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. The situation remains at high levels of risk escalation across our acute sites on a daily basis. During recent months, increased levels of COVID-19, Influenza, respiratory disease and norovirus has placed additional pressure on available capacity. Notwithstanding these challenges, positive progress has been achieved since January 2023 in reducing peak levels of pressure with notable improvements achieved in key urgent and emergency care (UEC) pathway metrics relating to ambulance handover and emergency departments (ED) waiting times. Progress remains consistent with small incremental improvements, and as at May 2023 the risk score has reduced to 20 based on a reduction from 5 to 4 on likelihood.

1559 - Risk of power outages impact across all clinical and corporate functions of the Health Board	Director of Therapies & Health Science	**5x3=15**	**4x3=12** ↓	01/11/22	The risk of power outages has been highlighted at UK level in the National Security and Risk Register and also at regional level in the Dyfed Powys Local Resilience Forum Community Risk Assessment. WG is working with UK Government on the resilience of the energy system. In line with standard practice, the systems operators for gas and electricity have completed their winter outlooks. Their central scenarios, based on the functioning of normal market conditions, suggest there will be sufficient margins across both gas and electricity. However, there is recognition that we face unprecedented threats to the normal operation of energy markets, the key threat being the impact of supply restrictions of Russian gas to mainland Europe and the impact this has on rest of the world supplies and energy trading arrangements from mainland Europe into the UK. This on top of traditional winter risks (low renewable energy generation, major infrastructure failure and high demand as a result of colder weather) mean there is a reasonable worst-case scenario where emergency measures are enacted. The Health Board has a number of measures in place to respond to such events, however assurance is being sought on wider impacts which may affect the Health Board's delivery of safe patient care. The current risk score has been reduced in March 2023 due to the intelligence gathered and mitigation measures in place.

1548 - Risk to the Health Board maintaining service provision due to industrial action	Director of Therapies & Health Science	**5x4=20**	**3x4=12** ↓	09/11/22	The Royal College of Nursing (RCN), The Royal College of Midwives (RCM) and the Chartered Society of Physiotherapy (CSP) have all confirmed ballot results in favour of industrial action which have or could still result in strike action in the Health Board. In addition, there has been, and may be further strike action taken by Unite, RCN and GMB members in Welsh Ambulance Service NHS Trust (WAST). Mitigation and contingency measures, together with command and control structures put in place have resulted in a co-ordinated response to minimise impact as far as possible. To date, no instances of direct patient harm have been recorded. However, a significant number of patient appointments and surgical slots have had to be re-scheduled impacting on waiting times. There has also been a deterioration in unscheduled care performance. There are currently no future strike dates scheduled whilst negotiations continue between WG and the unions. However, should negotiations fail, there is a potential for significant concurrent strike action from a number of unions co-ordinated to ensure maximum impact. The risk score has been reduced to reflect the current position as at March 2023.

1335 - Risk of being unable to access paper patient records at the correct time and place in order to make the right clinical decisions	Director of Operations	**4×3=12**	**3×3=9** ↓	05/10/21	Currently across the Health Board there is a considerable variance in both practice and process, operationally when utilising and dealing with the various types of records in use throughout directorates, services and departments. The current records management methodology, results in a non-standardised approach to delivering effective records management arrangements. With a lack of agreed criteria in terms of managing the record during its life cycle from creation, during retention and to disposable. There is a requirement for an investment in a modern day solution and an alteration to culture and attitude that will embrace change and technology associated with a digital health record (DHR), to manage the risk. The Health Board has selected its electronic document management system (EDMS) supplier.

‘Acceptance’ of Risk

The Executive Risk Group at its meeting in March 2023 agreed a new risk relating to the Health Board’s ability to meet its statutory requirement to break even in 2023/24 (Risk 1642 above). As part of the discussion, it was agreed that approval should be sought by the Board to accept that it is unlikely that the Health Board will be unable to reduce this risk to the current Health Board tolerance level of 6 for a risk in ‘Finance inc. Claims’ domain’, and the target risk score should be tolerated for this risk, recognising that while the Annual Plan mitigates this risk to an extent, the Health Board will still be unable to meet WG requirement of breaking even. As per Health Board escalation guidance, the Director of Finance as the Executive Risk Owner has approved the proposed increase to the Board tolerance risk score. The proposal has also been ratified by the Chair of the Executive Risk Group.

The Board is asked to agree and ‘accept’ that the below risk can only be reduced at this time to the target risk score (4x3=12) and will remain above the current Health Board agreed tolerance level (6).

Risk	Risk Owner	Current Risk Score	Target Risk Score	Agreed Tolerance level (impact domain)	Discussion
1642 - Risk of the Health Board not being able to meet the statutory requirement of breaking even 2023/24	Director of Finance	**4x4=16**	**4x3=12**	6 (Finance inc. Claims)	The Board have agreed the Annual Plan, which goes some way towards mitigating this risk. However, it is unlikely the score of this risk will be reduced to the agreed tolerance level for this Impact Domain (6) during the current financial year and meet the statutory requirement of breaking even. In light of these challenges, the Committee is asked to consider and agree an increased tolerance score of 12 (4x3).

Argymhelliad / Recommendation

The Board is asked to:

- **CONSIDER** whether it has sufficient assurance that corporate 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;
- **APPROVE** a revised tolerance risk score of 12 for risk 1642 - Risk of the Health Board not being able to meet the statutory requirement of breaking even 2023/24.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable

Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. 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.

Appendix 1

CORPORATE RISK REGISTER SUMMARY MAY 2023

Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score May-23	Trend	Target Risk Score	Risk on page no...
1027	Delivery of integrated community and acute unscheduled care services	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×5=25	**4×5=20**	↓	**3×4=12**	6
1032	Risk of not meeting Welsh Government targets for Mental Health and Learning Disabilities (MH&LD) clients	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	**5×4=20**	→	**3×4=12**	11
797	Shortage of staff in sonography affecting the whole Health Board.	Carruthers, Andrew	Workforce/OD	8	N/A	**5×4=20**	New risk	**3×4=12**	18
1657	Risk to delivery of Ministerial Priorities in relation to delivery of planned care recovery ambitions through 2023/24	Carruthers, Andrew	Safety - Patient, Staff or Public	6	N/A	**5×4=20**	New risk	**3×4=12**	21
1352	Risk of business disruption and delays in patient care due to a cyber attack	Thomas, Huw	Statutory duty/inspections	8	4×4=16	**4×4=16**	→	**3×4=12**	N/A
1642	Risk of the Health Board not being able to meet the statutory requirement of breaking even 2023/24	Thomas, Huw	Finance inc. claims	6	N/A	**4×4=16**	New risk	**3×4=12**	24
1649	Insufficient skilled workforce to deliver services outlined in the Annual Plan 23/24 and deliver UHB strategic vision by 2030	Gostling, Lisa	Workforce/OD	8	N/A	**4×4=16**	New risk	**3×4=12**	28
129	Ability to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda patients	Carruthers, Andrew	Service/Business interruption/disruption	6	4×4=16	**4×4=16**	→	**3×3=9 Accepted**	33
1340	Risk of avoidable harm for HDUHB patients requiring NSTEMI pathway care	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×4=16	**4×4=16**	→	**1×4=4**	37
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**	40
1433	Inability to maintain routine and emergency services in the event of a severe pandemic event	Shakeshaft, Alison	Service/Business interruption/disruption	6	3×4=12	**3×4=12**	→	**2×4=8**	45
1350	Risk of not meeting the 75% waiting times target for 2022/26 due to diagnostics capacity and delays at tertiary centre	Carruthers, Andrew	Quality/Complaints/Audit	8	3×4=12	**3×4=12**	→	**2×4=8**	48
684	Risk to the timely investment and replacement of Radiology equipment	Carruthers, Andrew	Service/Business interruption/disruption	6	3×4=12	**3×4=12**	→	**2×4=8**	51
1559	Risk of power outages impact across all clinical and corporate functions of the Health Board	Shakeshaft, Alison	Safety - Patient, Staff or Public	6	3×5=15	**3×4=12**	↓	**2×4=8**	55
1328	Security Management	Rayani, Mandy	Safety - Patient, Staff or Public	6	4×3=12	**4×3=12**	→	**3×2=6**	N/A
1548	Risk to the Health Board maintaining service provision due to industrial action	Shakeshaft, Alison	Safety - Patient, Staff or Public	6	5×4=20	**3×4=12**	↓	**2×3=6**	58
1531	Inability to safely support the Consultant on-call rota at WGH and GGH	Carruthers, Andrew	Safety - Patient, Staff or Public	6	N/A	**2×5=10**	New risk	**5×2=10**	61
1335	Risk of being unable to access paper patient records at the correct time and place in order to make the right clinical decisions	Carruthers, Andrew	Quality/Complaints/Audit	8	4×3=12	**3×3=9**	↓	**2×3=6**	64

Appendix 1

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

Appendix 1

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.

Appendix 1

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	*NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you*
Detailed review of relevant information	
Medium level review	
Cursory or narrow scope of review	

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

Appendix 2

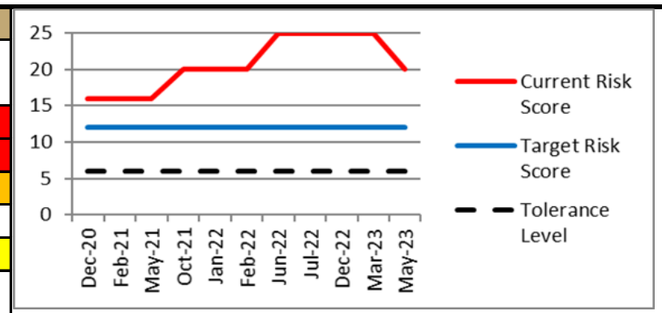
Date Risk Identified:	Nov-20		
Strategic Objective:	5. Safe and sustainable and accessible and kind care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	May-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jun-23

Risk ID:	**1027**	**Principal Risk Description:**	There is a risk to the consistent delivery of timely and high quality urgent and emergency care. This is caused by significant fragility across the urgent and emergency care (UEC) system (acute, primary care, community and social care services), related to workforce compromise and increasing levels of demand and acuity. This is not related to COVID-19 per se but is driven by post-pandemic demand and the broader impacts of COVID -19. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increased incidents of a serious nature relating to ambulance handover delays and overcrowding at Emergency Departments and delayed ambulance response to community emergency calls, increasing pressure of adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.

Does this risk link to any Directorate (operational) risks?	1406, 1548, 1210, 750, 205, 86, 820, 232, 1298, 1281, 906, 1380, 1116, 878, 839, 1167, 1223, 111, 114, 199, 523, 136, 200, 1115, 1078, 572, 1295, 1231, 966, 967, 565, 852, 1295, 1435, 1377, 1083, 180, 1424, 1417, 1309, 291, 118, 925, 119, 1245

Risk Rating:(Likelihood x Impact)		
Domain:	Safety - Patient, Staff or Public	
Inherent Risk Score (L x I):		5×5=25
Current Risk Score (L x I):		4×5=20
Target Risk Score (L x I):		3×4=12
Tolerable Risk:		6
Trend:		



Rationale for CURRENT Risk Score:
Levels of urgent and emergency pathway capacity pressures continue at significantly escalated levels. This is driven by post pandemic demand and the broader impacts of COVID-19. Workforce deficits, handover delays, 4- and 12-hour performance, bed occupancy rates and significant pressures on wider community and social care capacity are all demonstrating significantly worrying trends. The indirect legacy of the pandemic has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. The situation remains at high levels of risk escalation across our acute sites on a daily basis. During recent months, increased levels of COVID-19, Influenza, respiratory disease and norovirus has placed additional pressure on available capacity. Notwithstanding these challenges, positive progress has been achieved since January 2023 in reducing peak levels of pressure with notable improvements achieved in key urgent and emergency care (UEC) pathway metrics relating to ambulance handover and emergency departments (ED) waiting times. Progress remains consistent with small incremental improvements, and as at May 2023 the risk score has reduced to 20 based on likelihood.

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. In light of the positive progress achieved in since January 2023 in reducing peak levels of pressure with notable improvements achieved in key UEC pathway metrics relating to ambulance handover and ED waiting times, this risk and target risk score will be reviewed and revised for 2023/24.

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	# Fragility of Care Home Sector exacerbated by COVID related issues such as financial viability, staffing deficits, recruitment and retention of workforce. # Significant paucity of domiciliary care/social care availability due to recruitment and retention of staff # Nurse staffing availability to ensure safe levels of care as a consequence vacancies. # Post-COVID-19 fatigue is exacerbating workforce capacity and availability of bank and agency staff who would be available. # COVID-19 incidence continues to further exacerbated workforce capacity and availability of bank and agency staff who would be available. # Inability to offload ambulances to release them back for use within community. # Increased pressures at ED as a result of WAST ambulance response policy resulting in very poorly patients self-presenting. # Better understanding of ED presentations to ensure development of alternative pathways in primary care / community to prevent ED attendance # Effective and timely communication to the public at times of pressure but also of safe alternatives to hospital admission / ED presentation that will contribute to changing public mind set / expectation and culture in terms of use of NHS resource and 'Home First' # Education and training for best practice in frailty management mandated to effect culture of 'unsafe to admit' for our very / severely frail # Supporting staff to be able to better	Create live UEC performance dashboard.	Matthews, Rhian	Completed	UEC live performance dashboard in place.
		Recruitment to UEC Programme Management Office	Matthews, Rhian	Completed	Recruitment process complete.
		Implementation of 111 First and local streaming hub as well as enhancing Same Day Emergency Care (SDEC) provision to reduce conveyance and conversion	Matthews, Rhian	Completed	Fully recruited to existing scheme
		Explore and gain approval for funding for 2wte COTE consultants	Matthews, Rhian	Completed	Completed
		To implement the Standard for Discharge to Assess in accordance with the WG Discharge Guidance	Matthews, Rhian	Completed	Plan to be developed.
		To consider alternative models of medical oversight i.e service level agreement with local GPs and HB salaried community GPs	Matthews, Rhian	Completed	Pending confirmation indemnity for the local GPs to deliver.
		Refer CRR 1649 detailing actions to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	31/03/2024	Ref CRR 1649 for detailed progress.
		To undertake a quality improvement project to map flow across GGH unscheduled system supported by Improvement Wales.	Perry, Sarah	~~31/12/2022~~ 31/12/2023	Work is ongoing, and being rolled out to PPH and BGH
		To codesign schemes with Local Authorities that put urgent capacity into the system to reduce bed occupancy rate for frail, complex patients	Lorton, Elaine	Completed	Work concluded in March 2023, action therefore completed.
		Review extant Escalation Policy to incorporate the whole UEC system	Jones, Keith	Completed	HB Escalation Policy reaffirmed. Sites regularly operating at Red (Level 4) status with limited non-urgent elective surgery undertaken at the four sites due to urgent and emergency care pressures.
		Incorporate and deliver actions that will address control gaps into the Health Board's UEC Plan.	Matthews, Rhian	31/03/2025	Launch of the UEC Improvement Programme on 16/06/22 to galvanise a collective approach to improvement, and ongoing as at May 2023.

Review wider nursing establishment requirements across 25A wards (outside of NSLA) to support increasing capacity and environments for patients.	Passey, Sian	Completed	Complete - All wards have been reviewed and will continually be reviewed, throughout the nurse staffing cycles and through the workforce stabilisation meetings Chaired by workforce, these meeting include each site and consider all wards and services nurse staffing. Additional capacity has been created in Amman Valley. An Alternative Care Unit Y Lolfa became operational in November on the GGH site, with the focus on complex discharges and prevention of further de-conditioning of patients. There are close working relationships with Home First Teams and other based community teams with the purpose of supporting discharge of complex patients into the community at the earliest opportunity. Review of nursing models within EDs will continue through the nurse stabilisation meetings now established.
To review the West Wales Care Partnership Regional Discharge 2 Assess policy and develop action plan to ensure effective implementation of Policy Goal 5 (optimal hospital care following admission)	Passey, Sian	Completed	Confirmed as complete by Rhian Matthews on 02/12/2022
Review ambulance handover procedure in conjunction with WAST and HB Review Escalation Policy	Passey, Sian	Completed	The Ambulance Hand over policy which has been updated in collaboration with WAST has now been ratified. An updated self - assessment in relation to recommendations received from HIW has been submitted to WAST in October. Partnership working with WAST and other colleagues continues to address hand over delays and this is being taken forward through TUEC work streams
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.

homes and community hospitals
SRO in place to lead agreed Urgent and Emergency Care (UEC) programme
Supernummery HCSWs aligned to the acute response teams to support failing community care capacity
Support for complex discharge caseload management tool (SharePoint) appointed
Reminders issued to management on importance of robust management of staff sickness and the use of COVID-19 Risk Assessment to help manage staff absences.
SDEC models continuously reviewed and refined to maximise impact on admission avoidance.
Staff are encouraged to participate in the UHB's ongoing COVID-19 vaccination programme.
Alternative models of medical oversight i.e service level agreement with local GPs and HB salaried community GPs.
Service provision in the community for people pending ambulance conveyance, and where conveyance is not possible to manage ambulance handover delays.
Increased bedding capacity in community hospitals.
UEC live performance dashboard in place.
Local streaming hub.
Direct referral into SDEC in WGH, GGH and PPH.
Operational joint meeting with WAST to identify and taking forward key action to help address conveyance.
Clinical Streaming Hub includes APP Navigator working with Physicians to triage and stream patients pending conveyance to more appropriate pathway in the community (In Hours).

Supporting staff to be able to better manage family dispute relating to expectation eg home of choice, transfer pathways to short term placement in care home pending home care availability
Development of a 'tool' that supports staff to assess risk across the whole system to support decision making when discharge appears to be 'risky' to the individual patient. This includes decision making for 'further rehabilitation required in the acute environment' (why not at home?), further blood analysis to confirm medically fit to discharge, home care not available but family happy to take in the interim.
For all patients with LOS > 21 days the need for escalation and 'senior think tank'
If there is a paucity of home care to the extent that we are unable to provide > 28 hours per week (calls four times per day) - why are we advocating this level of commissioning?
Clarity regarding roles and responsibilities for discharge planning and coordination
The availability of live data at Cluster, County and Site level with sufficient analytical support
the ability to risk stratify for people at moderate to high risk of admission in the community to implement proactive anticipatory care plans to support avoidance of exacerbation / decompensation and hence increased risk of hospital admission
Optimising our bedded facilities in the community i.e we should aim for 'step up' from community and from 'front door' hospitals (within 72 hours) rather than as a 'step down' from acute hospitals after long length of stay. LOS should be no more than 10 days
Bespoke recruitment targeted at critical posts that will deliver improvements in UEC eg ANPs, APPs, PAs etc. and accept risk to permanently fund such posts i.e

should not be temporarily funded. # Frailty screening by staff in ED and reporting into WPAS to support risk stratification of patient cohorts who should spend no more than 10 days in hospital. Majority should be turned around in 12 hours and < 72 hours. # Frailty screening and reporting into WPAS of inpatients who either have formal care in place on admission or whose level of frailty on admission suggests a need for care and support on discharge. This will support risk stratification to support discharge planning and coordination. # Consideration of workforce development for existing staff but also bespoke opportunities for non clinical roles that releases clinical time for 'clinicians to only do what they can do' # Reduce service duplication across sites # Development of 24/7 urgent primary care service that integrates urgent primary care service in the day and GPOOH and provides timely information, advice and assistance to patients and clinicians to provide safe alternatives to hospital admissions.	Review nursing models to support increasing capacity and environments for patients	Passey, Sian	Completed	Continuous discussions with Heads of Nursing and regular operational consideration given to scoping patient profile and pathways. In conjunction with primary care colleagues additional capacity in Amman Valley Hospital.
	Explore service provision in the community for people pending ambulance conveyance, and where conveyance is not possible to manage ambulance handover delays	Matthews, Rhian	Completed	Completed.
	Recruit additional workforce in line with safe staffing requirements for 28 beds in Amman Valley Hospital	Matthews, Rhian	Completed	Completed.
	Development of enhanced Bridging Service and to actively recruit HCSWs to support domiciliary care services	Lorton, Elaine	Completed	Completed.
	To implement the Standard for Discharge to Assess in accordance with the WG Discharge Guidance	Matthews, Rhian	31/07/2023	New Welsh Government guidance issued
	To review findings of local Peer Review and data analysis to inform SDEC model 2023/24	Matthews, Rhian	30/09/2023	Model to be developed
	To review findings of GP Out Of Hours Peer Review, and implement actions as part of planning objective 3A	Matthews, Rhian	30/09/2023	Work is underway
	To develop a plan with Local Authority partners that sets out a model for integrated community health and care provision for older adults and adults living with frailty	Matthews, Rhian	30/11/2023	Work is underway across the three counties.

Appendix 2

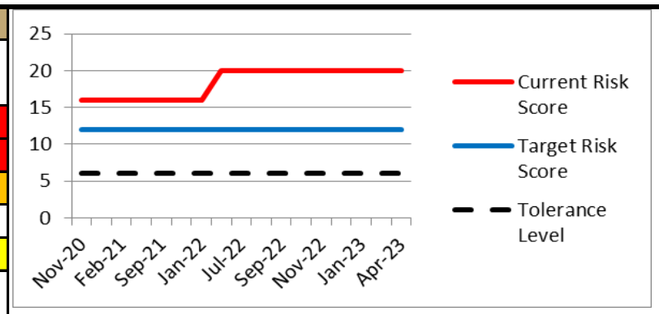
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
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								

Appendix 2

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Apr-23
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	May-23

Risk ID:	**1032**	**Principal Risk Description:**	There is a risk of the Health Board not achieving Welsh Government targets in relation to the start of diagnosis of ASD within 26 weeks, and commencement of interventions for Psychological Therapies within 26 weeks. This is caused by an increase in referrals and increasing DNA rates (c25%), as well as recruitment challenges for psychologists. 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. Additionally, there is potential for adverse publicity, and increased scrutiny/escalation from Welsh Government.
Does this risk link to any Directorate (operational) risks?		138, 1249, 1286, 1287, 1392, 1455, 1422, 1524, 1290, 1260	

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:
The service was experiencing significant waiting times as a result of increasing demand levels which are now back to pre-pandemic levels, compounding the backlog due to Covid restrictions. Due to increasing Did Not Attend (DNA) rates (c25%), ongoing recruitment challenges and increasing demand there is an impact on the services' ability to see the same volume of service users as they were previously able to. Some posts continue to be funded on fixed term basis which can make staff retention challenging along with having to train new incoming staff. For Autism Spectrum Disorder (ASD), a meeting took place with with the Delivery Unit to establish trajectories, along with the commissioned service which since have been agreed in March 2023. For psychological services a trajectory is now in place for 1% per month.

Rationale for TARGET Risk Score:
The Directorate is prioritising implementation of WPAS in key areas within MHLD and this will enable improved reporting and waiting list management and enable forward trajectories of improvement in waiting times to be determined. The target risk score will be dependent on securing recurring funding for the IAS as well as having access to appropriate clinical venues and other agencies being able to undertaken their associated assessments. While trajectory plans are in place as of March 2023, there is recognition that the Health Board will not achieve WG targets.

Appendix 2

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Use of IT/virtual platforms such as AttendAnywhere when appropriate. Clinical prioritisation regarding assessment and treatment of service users by engaging in a dynamic process of reviewing waiting lists in line with any other referrals that may be received in respect of that service user. Additional funding provided for recruitment however national shortage of required skills - 3 new staff have been recruited into the ASD team. Services are in contact with individuals to provide information regarding mainstream/Tier 0 support, wellbeing at home and guidance should their situation deteriorate. Regular meetings with Women and Children's Service to strengthen interdepartmental working. Process in place to ensure individuals on waiting lists are being contacted periodically through the wait for assessment/treatment to monitor any alteration in presentation. Papers have been presented at the Quality Safety and Experience Assurance Committee with a further update paper provided for the December 2021 meeting outlining control measures to manage the waiting times that the Directorate have at present. A paper was presented at Board Seminar in June 2022 to provide assurance on current waiting times and control measures. Service Delivery Manager appointed and in place. Continual review of vacancies via MHLD QSE meetings resulting in the consideration of alternative staffing models when recruitment drives do not materialise. Workforce Redesign Group has been established. Trajectories have been identified for Memory Assessment Services and S-	Continued lack of IT impacts on staff who have to work from home not having full accessibility. Estates issues ongoing with no access to clinical areas in some localities to see CYP and unable to access GP or LA sites thus restricting clinical sessions. Telephone assessments ongoing, virtual assessment offered but uptake not good for ASD and SCAMHS client group. Reliant on locally held data until reporting available via WPAS team. Currently with Software Development Team since go-live in April 2022.	Directorate is working with the Health Board Performance Team to provide a more detailed report as to the current actions being taken by the Directorate.	Carroll, Mrs Liz	Completed	This work is aligned to the migration of services to WPAS on a priority basis, and complete as at March 2023.
		Explore opportunities for outsourcing for CAMHS ASD and Psychological Therapies.	Carroll, Mrs Liz	Completed	Action included on service level risk register.
		Keeping in touch processes to be in place (Adult Inpatient and Learning Disabilities Services).	Bassett-Gravelle, Ms Lisa	~~30/04/2023~~ 30/06/2023	Psychology In February 2023, 31 (29.8%) patients out of 104 were waiting less than 26 weeks to start psychological therapy in the Learning Disabilities Psychology Service. 73 (70.2%) were waiting more than 26 weeks. This is an improvement since January 2023 and the position is likely to further improve due to Psychologists returning from maternity leave and recruitment. All new referrals are screened by the Community Teams and priority given where possible. Waiting lists review has been undertaken and all on the waiting list have been contacted by telephone. Letters in easy read are being developed to keep in touch. Interviews for vacant 8b post took place in March 2023 and the post was offered to the successful applicant. OT Urgent referrals taking priority.

CAMHS and there are systems in place to monitor waiting lists at service level, through IPAR and Directorate performance meetings. Regular meetings with Estates to look at accessing/leasing/enhancing the current MH estates with a view to increase MH estate footprint. Within the service there is progress in terms of identifying clinical space due to the challenges experienced in accessing additional accommodation outside of the Directorate. Linking with wider Health Board, including corporate teams/Local Authority use of hubs. Works completed in Bro Cerwyn and staff have now returned. Units within the MH&LD footprint have been repurposed. IT are updating infrastructure to enable most efficient use of available space. Service Leads have been tasked with identifying alternative estate options for their areas. Work underway across all services who have waiting times, be they intervention or assessment. Use of HB Third Party Contractor has begun and initial letters sent to those waiting appointments with the Memory Assessment Service, Integrated Autism Service and Adult ADHD. Public facing webpages with QR codes are also being developed to give further guidance and support whilst individuals are waiting. Template letters being developed within further areas. Monitoring of this process will be the responsibility of individual service leads. Service Leads are exploring opportunities for outsourcing for CAMHS ASD and Psychological Therapies. Commissioned external provider for ASD services across all ages, similar contract out to tender for Psychological Therapies. 'Grow your own' scheme is coming into place with funding provided in academic year 23/24 for 3 places on the Clinical Psychologist programme.				•Continue to prioritise referrals and support workforce modelling as part of service improvement work underway. •Training redeployed staff in use of equipment and manual handling. •Additional up-skilling B4 techs •Reviewing universal offers of support/workshops for families and carers particularly around sensory processing referrals. •Reviewing use of caseload weighting tools and enhanced professional lead oversight of caseloads •Limited clinical support from AMH B7 in Pembs CTLD. Ty Bryn B6 supporting the two Carmarthenshire teams. •Additional 1.0WTE B6 OT post to cover Carmarthenshire, and 1.0WTE OT B6 post within WEIT being proposed as part of SIP. Physio LD Service Manager EOC will attend peer meetings in the absence of a professional lead and has arranged a catch up meeting for May 2023. EOC has advised the Physiotherapist that she will be validating and monitoring the waiting list reporting to the Information Dept on a monthly basis until they have a Prof Lead in place. All LD Therapies Service Manager EOC will be advising them to adopt Psychology's approach of formally writing to each individual on the WL over 6/12 as part of the regular Waiting list review cycles.
Repurposing current MH&LD Estate in line with clinical priorities identified.	Carroll, Mrs Liz	~~31/03/2023~~ 30/06/2023	Progress is ongoing, with a view that Tudor House may be available by May 2023.

Identify alternative venues/space to hold clinics(CAMHS & Psychological therapies).	Lodwick, Angela	~~31/03/2023~~ 30/06/2023	Challenges continue in access to Estates to undertake assessments across the three counties. Remains ongoing. SBAR being developed to repurpose the use of Tudor House.
Identify alternative venues/space to hold clinics (Integrated Psychological Services).	Marshall, Selina	~~31/07/2023~~ 31/07/2023	Rolling programme of groups being developed to enable additional clinical capacity within the service.
Identify alternative venues/space to hold clinics(Commissioning /CDAT).	Richards, Matthew	~~31/03/2023~~ 31/09/2023	New North Dock premises are being progressed by APB to deliver new base in Llanelli with accessible clinic space. Currently going through planning and concerns about potential delays due to public objections
Directorate to transfer all service data collection processes to WPAS.	Amner, Karen	~~31/03/2023~~ 30/06/2023	Priority areas due to be completed by end of December. Delays to the Dementia Wellbeing Service migration due to IT staff taking leave. Delayed implementation of IAS service due to clinical pathway review by the service.
Request to be made for additional IT kit to support agile working.	Carroll, Mrs Liz	Completed	Request submitted 23.10.21.
Directorate has funded 12 month fixed term post to accelerate the transition of the entire Directorate on to WPAS with a view to this improving waiting list management and demand and capacity planning. A further two posts have been funded within the Informatics service.	Amner, Karen	Completed	Mapping work continuing MAS, Admiral Nursing, DWBT and Perinatal. Data migration of Integrated Psychological Therapies spreadsheets completed 10.4.22 and service now inputting data at source. for IAS service with the new Service Delivery Manager has now gone live on the 1/11/22 Training sessions continue to be available.
Identify alternative venues/space to hold clinics.	Carroll, Mrs Liz	Completed	These actions have become control measures.
Services will be in contact with individuals to provide information regarding community support, well being at home and guidance should their situation deteriorate.	Carroll, Mrs Liz	Completed	Action assigned to individual service leads.

Funding for Interim Clinical Psychologist lead post to assist with the waiting lists and service development has been identified fixed term for 12 months and will work in conjunction with the new ASD Service Delivery Manager (in post 6 March) to address waiting lists.	Carroll, Mrs Liz	Completed	Interim Clinical Psychologist due to take up post by end of July 2022.
To complete an impact assessment on the recommendations of the Autism Code of Practice.	vaughan, Catherine	Completed	The Regional Partnership Board have commissioned Alder Advice to undertake an audit of our compliance (Health Board/Local Authority/Stakeholders) against the recommendations outlined in the code of practice. We have submitted our developments to date. A regional action plan will be developed based on the outcome of this audit. Implementation plan has been received which members of the Regional Strategy Group are considering. Mapping exercise being undertaken with regard to training needs. Understanding Autism training being rolled out across the Health Board with more specific training for clinicians within the MH&LD Directorate being commissioned.
Review workforce skill mix in light of any potential new funding received from WG for Neurodevelopmental services.	Carroll, Mrs Liz	31/03/2024	As at March 2023, awaiting updates from WG with regards to the release of ND funding
Monitor the use of SIFT monies for service development.	Carroll, Mrs Liz	31/03/2024	Discussions are taking place with WG, and regular updates provided in respect of the spend. Discussions include the use of slippage for waiting list activity in relation to ASD and other SIFT related service development.

Appendix 2

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Welsh Government performance indicators along with internal monitoring arrangements will be used to ensure the actions are having the desires effect or whether there is more that needs to be done.	Management monitoring of referrals	1st			Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC (Oct21) MHLD progress update on Planning Objective 5G - Board (Mar22)	System to improve analysis of patient experience	Outcome measures to be in place to measure effectiveness/quality of services provided (CAMHS & Psychological therapies).	Lodwick, Angela	~~31/03/2023~~ 30/09/2023	S-CAMHS is implementing nationally agreed Welsh Government Outcome Measures - staff have received training as part of the Welsh Government Initiative. Gold Based Outcomes, SDQ and YP Core. Remains ongoing.
	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd					Outcome measures to be in place to measure effectiveness/quality of services provided (Older Adult Mental Health Services).	Mason, Neil.	~~31/03/2023~~ 31/10/2023	Information reported through Head of Service report to QS&EG. Patient experience feedback process in development in collaboration with corporate team. Admiral Nurse Service is fully compliant. All CMHTs have agreed a standard-set of outcome measures CROMS/PROMS/PREMS for both People Living with Dementia & service users with functional mental ill health problems and their carers, commencing application. MAS have nearly completed. OAMH hosted a Regional Lead post to facilitate directorate wide improvements for PROMS.
	MH&LD QSE Group overseeing patient outcomes	2nd					Outcome measures to be in place to measure effectiveness/quality of services provided(Adult Inpatient and Learning Disabilities Services).	Bassett-Gravelle, Ms Lisa	~~31/03/2023~~ 30/06/2023	Due to staffing issues it has been difficult for the Business Manager to take further with the SALT team due to pressures within services. Business Manager is liaising with Sarah Mackintosh from Carmarthenshire People First with questions to go onto an easy read format. Meeting with Carmarthenshire People first on 17th April 2023 to go through the questions for the easy read format. Once easy read format has been completed Business Manager will take to Q&S Team to add a QR Code to give the service user the choice of both options.

Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC	2nd			Outcome measures to be in place to measure effectiveness/quality of services provided(Commissioning /CDAT).	Richards, Matthew	~~31/03/2023~~ 31/09/2023	CDAT outcomes measures are gathered using TOP assessment for all service users and reported via quarterly KPI's to APB and WG. Commissioning outcomes measures are being reviewed and recent work with NCCU will support this. Possibly pilot an outcome framework with NCCU as a temaplate for national approach.
W-PAS Internal Audit (reasonable assurance)	3rd			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.
An update was requested by the Chair and provided for the August Quality, Safety, Assurance Committee.							

Appendix 2

Date Risk Identified:	Nov-19		
Strategic Objective:			

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Apr-23
Lead Committee:	Operational Quality, Safety and Experience Sub Committee	**Date of Next Review:**	May-23

Risk ID:	**797**	**Principal Risk Description:**	There is a risk of being unable to provide a full range of ultrasound services including antenatal. This is caused by the retirement and resignation of current sonography staff, low availability of sonographers UK wide, including locum staff and the inability to recruit to due national shortages of qualified staff, and the inability release existing workforce to train and develop to meet current service demands. This could lead to an impact/affect on delays in diagnosis which could result in detrimental outcomes for patients, inability to meet diagnostic targets and cancer pathway targets, and an inability to hold clinics to meet demand in ante natal screening services within required timescales. In addition, there is an impact on staff health and wellbeing in terms of the volume of patients examined within a shift/overtime, which could lead to increased incidents of repetitive strain injuries (RSI), along with increased incidents of staff stress and burnout. This could ultimately lead to increased errors when performing the dynamic diagnostic test.
Does this risk link to any Directorate (operational) risks?		1557, 1349	

		No trend information available.
Risk Rating:(Likelihood x Impact)		
Domain:	Workforce/OD	
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:	8	
Trend:	*New risk (escalated)*	

Rationale for CURRENT Risk Score:
Despite best efforts, the service remains fragile and supported by long term agency staff. Vacancies remain unfilled, with the inability to recruit despite repeated recruitment attempts. Long term vacancies exist in Bronglais, Prince Philip and Withybush - in particular in terms of modality lead sonographers at Withybush and Prince Philip as at April 2023. There are a number of expected retirements and planned maternity absences in the near future. There will also be the inability to secure agency staff from July 2023 in Withybush. As a result of the loss of ultrasound modaitiy leadership in the team at Withybush, this is resulting in reduced ability to undertake governance and audit requirements. A midwife has recently qualified after receiving sonography training at Withybush in April 2023, and a further trainee qualified at Prince Philip. More sonographers are due to be trained from January 2024. However, difficulties remain in obtaining locum staff, exacerbated by registration requirements. Antenatal scanning services at Withybush were not fulfilled due to lack of staffing on 6th and 11th April 2023, affecting 12 patients.

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Process in place for the movement of staff across the Health Board to maintain capacity. Additional sessions held in WGH where possible. Urgent escalation at WGH is currently covered by site lead, however this is not sustainable. Ultrasound Control Group now in place, meeting on a weekly basis to assess current sonography position across the Health Board, and to develop a short-term and medium-term strategy, both temporary and permanent to encompass and look at current models and staff skill set. Meetings are attended by colleagues from Women and Children, Head of Strategic Workforce Planning, AD of Therapies, Director of Public Health, GM for Radiology, Head of Radiology and site leads.	No long-term modality lead in WGH. The PPH modality lead has left however will be a secondment filled for a 6 month period. Inability to release existing staff to train and develop to undertake sonography and growth scans. Inability to recruit and retain staff. Lack of suitable accommodation to attract new staff.	Develop a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.	Lingwood, Gill	~~31/12/2022~~ 31/10/2023	Discussions have taken place with Head of Maternity Services. Protocols and training being developed. Implementation date to be agreed.
		Train members of staff to become sonographers, the number of which dependant on capacity to take training.	Roberts-Davies, Gail	~~31/03/2020~~ ~~31/12/2022~~ ~~01/02/2023~~ ~~30/09/2024~~ 31/01/2026	As at April 2023, it is hoped that 4 members of staff can be trained - however this is dependant on the desire of current to undertake the training, and the ability to recruit to training positions. Training positions take two years to complete, with a view to these commencing in January 2024.
		Work with the workforce planning team to build a sustainable workforce plan for ultrasound services.	Roberts-Davies, Gail	31/10/2023	Progress to be provided at the next review.
		Seek support to undertake a demand and capacity (D&C) review and detailed establishment review of the radiology service.	Jones, Keith	~~30/06/2022~~ ~~30/11/2022~~ ~~31/03/2023~~ 30/08/2023	Initial contact made with workforce planning team re: establishment review work, and this work is also being supported by the Value Based Health Care team as of November 2022. This has been discussed in the Radiology Use of Resources Meeting and further discussions are taking place in regard to establishing a Radiology Planning and Delivery Group to bring together all pieces of work with the necessary expertise. It is noted that this group has yet to be established as of April 2023, however a focussed Ultrasound Control Group has been set up, recognising the imminent loss of service. Radiology dashboard is now in place and functional.
		Explore opportunities of recruitment/training of physiotherapists, midwives and other Allied Health Professionals to undertake ultrasound examinations	Roberts-Davies, Gail	31/10/2023	Opportunities are discussed via the Ultrasound Control group which commenced 21st April 2023, and progress to be provided at next risk review in terms of developments.

Explore opportunity to creating and recruiting a lead sonographer trainer post for the Health Board	Lingwood, Gill	31/10/2023	Initial scoping has been undertaking in terms of this new role, and position currently being job-matched, after which the post will be advertised.
Explore incentivisation options in terms of being recruit and retain substantive sonographers	Roberts-Davies, Gail	30/09/2023	Opportunities are discussed via the Ultrasound Control group which commenced 21st April 2023, and progress to be provided at next risk review in terms of developments.
To review accommodation options to support the recruitment of locum sonographers.	Roberts-Davies, Gail	30/09/2023	Opportunities are discussed via the Ultrasound Control group which commenced 21st April 2023, and progress to be provided at next risk review in terms of developments.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES			
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Non-Obs ultrasound - currently >over 40 weeks Radiology Dashboard IPAR Reports WG Cancer PTL, reported monthly	Management review of sonography and SCP diagnostic waiting times	1st			Sonography Report to Acute Bronze and Operation Planning and Delivery Programme meeting					
	Monthly review of USC performance undertaken monthly (24% of USC carried out in 7 days, 41% carried out in 14 days at March 2023), included in the IPAR & reported to WG	1st								
	Performance monitored at Directorate Improving Together Sessions	2nd								
	Performance monitored via IPAR, overseen SDODC & Board	2nd								

Appendix 2

Date Risk Identified:	May-23		
Strategic Objective:	5. Safe and sustainable and accessible and kind care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	May-23
Lead Committee:	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Jun-23

Risk ID:	**1657**	**Principal Risk Description:**	There is a risk of non-delivery of ministerial priority expectations in relation to delivery of planned care recovery ambitions through 2023/24. This is caused by by current uncertainty regarding resources available to support recovery actions, the availability of workforce and /or externally provided capacity and the continuing impact of post-pandemic urgent and emergency care pathway pressures (as reflected in risk 1027) which continue to impact upon available capacity for some specialties. 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?		1548, 180, 523, 525, 632, 958, 1083, 1027, 1628, 1629	

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

Rationale for CURRENT Risk Score:
The combined impact of current uncertainty regarding resources available to support recovery actions, the availability of workforce and /or externally provided capacity and the continuing impact of post-pandemic urgent and emergency care pathway pressures (as reflected in risk 1027) which continue to impact upon available capacity for some specialties, all pose a risk to achievement of ministerial priority expectations in relation to achievement of planned care recovery ambitions. The Annual Plan approved by the Board in March 2023 and supporting performance trajectories highlight significant gaps between the resourced level of capacity reflected in the plan, and the anticipated level of patient demand to be treated during 2023/24. Whilst further proposals have been submitted to WG to access retained recovery funding not yet allocated to health boards, revised delivery trajectories cannot be confirmed without a supporting resource plan. Subject to availability of additional resources to support additional recovery actions, it is anticipated that a significant volume of additional activity will need to be supported by externally provided solutions, either via neighbouring health boards or via the independent sector insource / outsource market. External capacity cannot be confirmed prior to formal market testing. Limits to staffing resource both in theatre, and post operatively, was a challenge before the COVID pandemic. Whilst positive progress has been achieved in increasing outpatient activity & capacity to levels comparable with pre-pandemic volumes, significant staffing deficits within the Anaesthetic medical and theatre staffing teams continues to limit the volume of elective operating sessions undertaken and therefore continues to limit progress in expanding overall activity levels to match/exceed pre-pandemic levels. The continuing legacy of the COVID-19 pandemic on urgent and emergency care pathway demand and the consequential impact on available bed capacity continues to limit sufficient capacity to support activity expansion plans in key specialties. Whilst no health board is currently achieving ministerial milestones in respect of planned care recovery, HDUHB has achieved the greatest progress compared to other health boards across Wales during 2022/23 and has achieved a significant improvement in the volumes of Stage 1 patients waiting > 52 weeks and total pathway patients waiting > 104 weeks.

Rationale for TARGET Risk Score:
The combined impact of current uncertainty regarding resources available to support recovery actions, the availability of workforce and /or externally provided capacity and the continuing impact of post-pandemic urgent and emergency care pathway pressures (as reflected in risk 1027) which continue to impact upon available capacity for some specialties, all pose a risk to achievement of ministerial priority expectations in relation to achievement of planned care recovery ambitions. The Annual Plan approved by the Board in March 2023 and supporting performance trajectories highlight significant gaps between the resourced level of capacity reflected in the plan, and the anticipated level of patient demand to be treated during 2023/24. Whilst further proposals have been submitted to WG to access retained recovery funding not yet allocated to health boards, revised delivery trajectories cannot be confirmed without a supporting resource plan. Subject to availability of additional resources to support additional recovery actions, it is anticipated that a significant volume of additional activity will need to be supported by externally provided solutions, either via neighbouring health boards or via the independent sector insource / outsource market. External capacity cannot be confirmed prior to formal market testing. Limits to staffing resource both in theatre, and post operatively, was a challenge before the COVID pandemic. Whilst positive progress has been achieved in increasing outpatient activity & capacity to levels comparable with pre-pandemic volumes, significant staffing deficits within the Anaesthetic medical and theatre staffing teams continues to limit the volume of elective operating sessions undertaken and therefore continues to limit progress in expanding overall activity levels to match/exceed pre-pandemic levels. The continuing legacy of the COVID-19 pandemic on urgent and emergency care pathway demand and the consequential impact on available bed capacity continues to limit sufficient capacity to support activity expansion plans in key specialties. Whilst no health board is currently achieving ministerial milestones in respect of planned care recovery, HDUHB has achieved the greatest progress compared to other health boards across Wales during 2022/23 and has achieved a significant improvement in the volumes of Stage 1 patients waiting > 52 weeks and total pathway patients waiting > 104 weeks.

Appendix 2

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage planned care risks on daily basis including multiple daily multi-site calls in times of escalation. # Prioritised review of patients based on an agreed risk stratification model. # Provision of dedicated elective beds on 3 sites. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Escalation plans for acute and community hospitals (within limits of staffing availability). # Outpatient transformation programme in place with a continuing focus on alternatives to face to face delivery of outpatient care to enable increases in care volumes delivered. # Robust sickness absence management arrangements in place. # Comprehensive programme of outsourcing of planned care volumes in place utilising capacity available via independent sector providers. # Weekly review of outsourcing volumes and further opportunities progressed jointly by Planned Care and Commissioning teams. # Elective care delivery plan developed for inclusion within Annual Delivery Plan. # Additional Planned Care Recovery proposals submitted to WG May 2023.	# Limited impact to date of the wider urgent and emergency care plan in reducing capacity pressures on acute sites and the ability to protect sufficient elective pathway capacity for elective patients. # Theatre staffing availability to support expansion of theatre capacity at required pace and level. # Timeliness of the All Wales Commissioning Framework to support rapid decision making and commissioning of independent sector activity levels when supported by non-recurrent funding released part-way through the year. # Sufficiency of Health records service capacity to support planned expansion of outpatient activity. # Sufficiency of Anaesthetic medical staffing capacity to support planned expansion of required operating lists.	Elective care delivery plan developed for inclusion within Annual Delivery Plan.	Jones, Keith	Completed	Plan complete and submitted within refreshed Annual Recovery Plan.
		Additional Recovery proposals submitted to WG May 2023 against WG £50m retained Recovery Fund	Jones, Keith	Completed	Additional proposals submitted. Outcome awaited.
		Opportunities to enhance dedicated elective pathway capacity across sites is dependent upon successful delivery of the transforming urgent and emergency care plan.	Jones, Keith	30/09/2023	Partially Complete - Dedicated elective capacity in place at PPH, BGH. Dedicated elective capacity at WGH not available until Q2 due to estate infrastructure challenges at WGH. Limited dedicated elective pathway capacity at Glangwili Hospital to support sufficient internal capacity for Urology & ENT surgery.
		Workforce development and recruitment plan jointly developed between Planned Care & Workforce Team	Hire, Stephanie	30/06/2023	Continued progress achieved in recruitment of theatre staffing and consultant anaesthetic appointments, but levels remained below required WTE.
		Subject to availability of additional resources to support additional recovery actions, access to sufficient external insource / outsource capacity will be dependent upon formal market testing	Hire, Stephanie	30/06/2023	To be progressed subject to confirmation of resource availability.

Appendix 2

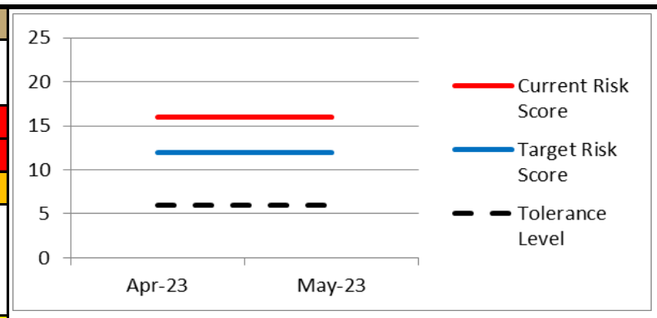
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
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			Annual Plan 2023/24 - Board (Mar23)	None				
	Daily performance data overseen by service management	1st								
	Delivery Plans overseen by Acute Services Triumvirate	1st								
	Bi-monthly reports to SDODC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	IPAR Performance Report to SDODC & Board	2nd								
	WG IQPD & Enhanced Monitoring Meetings	3rd								

Appendix 2

Date Risk Identified:	Apr-23	**Executive Director Owner:**	Thomas, Huw	**Date of Review:**	May-23
Strategic Objective:		**Lead Committee:**	Sustainable Resources Committee	**Date of Next Review:**	Jun-23

Risk ID:	**1642**	**Principal Risk Description:**	There is a risk that the Health Board is unable to meet Ministerial prorities of breaking even, and therefore to the sustainability of the Health Board's financial position from both a revenue and cash resource perspective. Welsh Government (WG) have confirmed that a revenue deficit position in excess of £25m is not acceptable or supportable. This is caused by the Financial Plan for 2023/24 presenting a significant deficit position, which reflects the significant step-change in expenditure during COVID-19. This has persisted, as operational pressures have remained; and a further step-change in expenditure is expected into next year, arising, largely, from inflationary pressures. Additional causes include: 1. Insufficient assurance over the identification or operational delivery of the required level of savings in the year because of continued operational and clinical challenges across our services, in particular within urgent and emergency care; 2. Further in-year operational cost deterioration either due to operational decisions or market price volatility within areas such as Prescribing and Energy. The Board have been involved in the discussions and decisions in the development of the 2023/24 Plan both through our Committees of the Board, Board Seminar sessions, and Public Board meetings. As a consequence of these on-going discussions and decisions, the Board, at its meeting on the 30th March 2023, approved the annual plan for 2023/24, recognising the forecast financial outturn remains unacceptable and in breach of the Health Board's statutory requirement to achieve financial balance; further work will be required during 2023/24 to improve the position. At the Board meeting on the 30th March 2023 it was also noted that without further support, at this stage, the Health Board will require further cash-backed support from Welsh Government as the extent of our cash allocation will be insufficient to continue to service our liabilities as they fall due after early February 2024. The Health Board was placed in WG's Targeted Intervention level of escalation on 29 September 2022, partly relating to our financial position; the 2023/24 Plan presents a deterioration in both the in-year and underlying financial position since 2022/23. This could lead to an impact/affect on the Health Board's current expenditure trajectory, and the ability to maintain patient services.
Does this risk link to any Directorate (operational) risks?			980, 968, 964, 966, 975, 983, 971, 965, 1644, 1646

Risk Rating:(Likelihood x Impact)	
Domain:	Finance inc. claims
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:	6
Trend:	*New risk*



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
The draft Annual Plan for 2023/24 of £112.9m is unacceptable to WG and has led to a further deterioration in an already unsupportable underlying deficit position which will impact future years. Through our 2023/24 planning process, operational plans to address the financial savings gap and operational variation have not provided sufficient assurance to mitigate the current financial trajectory. Without further support, at this stage, the Health Board will require further cash-backed support from Welsh Government as the extent of our cash allocation will be insufficient to continue to service our liabilities as they fall due after early February 2024. If this support is unavailable, which is a risk given the National financial position, then this could affect patient services and our key stakeholders.	The Health Board needs to demonstrate that it is able to manage its financial position effectively, cognisant of the risks which are inherent in the delivery of safe and timely care. The current draft Financial Plan does not provide sufficient assurance of this and urgent management actions are required to address this. Given the challenge in delivering an acceptable financial position this year, it is unlikely that the Health Board will achieve a risk which is in line with the existing tolerable risk of 8 for the year. Consequently, it has been requested of the Board to increase the tolerable risk score to 12 in line with the Target.

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 Operational Drivers to inform central and local scrutiny, feedback and decision-making. 4. Oversight arrangements in place at Board level and through the Executive Team structure. 5. Exploration of a number of funding streams, including: Local Health Board funding arrangements; Funding arrangements through the Regional Partnership Board and Local Authority partners. Funding from WG's own sources or from HM Treasury via WG.	The costs of addressing the Health Board's local needs may exceed available revenue and cash funding. The organisation may fail to deliver the required level of transformational change during the year through which the opening cost base is expected to be rationalised. This is in relation to the continuation of core and other services, the direct (programme) response to COVID-19, specific exceptional costs and the delivery of Recovery and Sustainability Plans.	Finance Delivery Unit have been invited in to work closely with the Finance and Performance team to translate the Planning Objectives that relate to our Target Operating Model into the financial and performance impacts we should expect to see.	Thomas, Huw	30/06/2023	Letter to Director General requesting support has been sent. The inception Targeted Intervention meeting with WG colleagues took place on 27th October 2022, at which point the approach, and support available, to be taken forward was agreed. A TI Framework is in place with agreed actions assigned to Executive Leads. Progress is being made at pace to complete all required actions. 9th March 2023 meeting has taken place and all agreed deliverables were shared and discussed with the FDU and further feedback will be acted upon at pace. Next meeting scheduled to take place in June 2023.

6. Opportunities Framework refreshed with the expectation that identified areas of waste will present deliverable cost reductions/formal savings schemes. Linked to Planning Objectives workplan, which will be shaped by the Health Board's strategy, “A Healthier Mid and West Wales", and align to the design assumptions set out in that.

7. Accountability statements in relation to the Opening Directorate Budgets underpinning the draft interim Financial Plan for 2023/24 will issued to the Executive Team in May 2023. 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 represents best value; and, that there is the expectation that these operational needs can be clearly demonstrated and that additional costs will reduce as and when decisions are made.

8. Performance against Plan monitored through Improving Together Meetings with Services, including Performance, Quality and Financial information.

9. Implementation of systems for efficiency (Malinko, WellSky, Nurse Documentation system) are driving financial systems for control (Symbiotics, Caf M in Facilities and Estates, Allocate), alongside the Digital Strategy improving grip and control.

10. Weekly financial reporting to Executive Team, tracking week-on-week progress against key metrics.

11. Tactical TI Group meets on a fortnightly basis, led by the Director of Finance as SRO. This reports into an escalation Steering Group, which meets on a monthly basis, chaired by the CEO where specific executive leads meet to discuss, agree and implement corrective actions to respond to the escalated Targeted Intervention status that Welsh Government placed the Health Board during October 2022. The weekly Executive Team meeting chaired by the CEO will be the internal group that monitors and drives progress, focusing on:

a) delivery of our Planning Objectives and the subsequent financial benefits;

b) efficiency and productivity opportunities (based on our Opportunities Framework);

c) corrective actions identified through our regular Executive-led Directorate Use of Resources meetings to reduce current expenditure trajectories.

Targeted Intervention working group and escalation Steering Group to discuss, agree and implement corrective actions to respond to Targeted Intervention status.	Moore, Steve	30/06/2023	Through the approval of the Annual Plan the Board has accepted the validity of the current operational drivers and accepted the choices and identified opportunities available to mitigate the current trajectory. The process is in place, however the cycles are yet to identify corrective actions leading to an in-year or future year financial improvement. As these corrective actions are identified, these will be added to the risk Action Plan.
The Delivery Unit and Improvement Cymru have been invited to undertake a desk top review with our Planning Team of all the Planning Objectives we are progressing this year in relation to implementing our Target Operating Model (including a review of the underpinning plans for each) to provide the Board and Welsh Government with assurance that the actions we are taking are sufficient in their scope and ambition to achieve what we have set out in our plan and that the underlining action plans are sufficiently robust.	Davies, Lee	~~11/11/2022~~ ~~15/12/2022~~ 30/06/2023	Letter to Director General requesting support was sent. The inception Targeted Intervention meeting with WG colleagues took place on 27th October 2022, allowing us to understand the approach, and support available, to be taken forward; from this meeting the actions required in order to exit a Targeted Intervention escalation status are clearly defined. Clarity is awaited following the meeting on the next steps. May-23 - Update on Action has been requested.
Develop a revised roadmap to financial sustainability based on the Board's agreed key priorities and revised Planning Objectives in line with our Strategy.	Davies, Lee	30/06/2023	May-23 - Update on Action requested.

Appendix 2

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance against operational plans and targets through Performance KPIs In-month financial monitoring	Performance against plan monitored through Improving Together Meetings.	1st			* Mth 10 Finance Report - Sustainable Resources Committee, February 2023 * Mth 11 Finance Report - Board, March 2023 * Mth 12 Finance report - Sustainable Resources Committee, April 2023 (subject to audit)	None				
	Sustainable Resources Committee oversight of current performance	2nd								
	Transformation & Financial Report to Board & SRC	2nd								
	WG scrutiny through monthly monitoring returns	3rd								
	WG scrutiny through revised monthly Monitoring Returns (specific supplementary templates) and through Finance Delivery Unit	3rd								
	Audit Wales Structured Assessment process	3rd								

Appendix 2

Date Risk Identified:	Apr-23		
Strategic Objective:			

Executive Director Owner:	Gostling, Lisa	**Date of Review:**	Apr-23
Lead Committee:	People, Organisational Development and Culture Committee	**Date of Next Review:**	May-23

Risk ID:	**1649**	**Principal Risk Description:**	There is a risk there will be insufficient skilled workforce available to meet our Ministerial Priorities across all areas (UEC, Planned Care, Cancer and Mental Health etc). This is caused by the imbalance between the demand and supply of workforce. External demand is caused by increases in patient morbidity and life expectancy, and also by a contracting labour market. This is further exacerbated by the rurality of the Health Board, an ageing estates infrastructure, financial pressures and staff morale and wellbeing. This could lead to an impact/affect on workforce plans and capacity to respond, there may be an inability to foresee risks, to realign funding and create new workforce models for delivery of service provision. Without a sufficiently skilled workforce, then we may not be able to take actions to future proof and implement the necessary solutions within 2023-2026 time frame for the development and delivery of the UHB's strategic ambitions to 2030. In addition, this may lead to the inability to meet statutory and professional requirements in terms of safe staffing levels that are needed to deliver quality patient care.

Does this risk link to any Directorate (operational) risks?	205, 86, 820, 232, 1298, 1281, 906, 90, 632, 525, 1223, 1083, 111, 114, 199, 523, 1238, 200, 180, 1245, 1224, 1309, 1152, 1211, 105, 119, 118, 1305, 1295, 1377, 842, 138, 153, 156, 939, 940, 1409, 1419, 628, 1316, 1317, 340, 1301

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

Rationale for CURRENT Risk Score:

This risk has been scored as 16 (the likelihood is "likely" and has the potential to have a "major" impact) as the number of staff impacted from staff sickness is still high at Apr23 compared to pre-Covid levels (c2-3% higher) however, there has been a general improvement over the last 12 months. Staffing levels (acute & community) continue to operate below established levels due to both vacancies and sickness/absence, and use of bank and agency. There is still a significant risk of workforce misalignment with activity and required competence levels. Further work has been undertaken to understand the level of risk across each staff group, speciality and site to fully comprehend the level of risk the organisation carries as a whole. It is hoped as further action is taken through stabilisation, Improving Together and workforce planning to reduce the risk score during 2023/24.

Rationale for TARGET Risk Score:

The Target Risk score indicates the likelihood of the risk occurring (absence continues to be high at c7% but lower than peak at 12% but has not returned to pre-pandemic levels of c5%). Other intelligence leads as to be alert to workforce issues as evidence suggests that patient acuity is increasing and therefore workforce requirements will increase by proxy until new models/methods to reduce or manage complexity can be identified. Also, it may be that there could be concerns for the specific services and/or the annual risk of a winter surge developing when at full capacity for recovery/ministerial priorities as we have a "finite" resource in our people that can only be stretched so far without causing detriment. Therefore, the probability sits between 75-90% when taking account of multiple factors - respiratory infections, increased patient acuity, the longer term impacts of COVID-19 on the population i.e. inability to access services needed, and workforce resilience. We hope we will be able to take mitigated actions noted below predominantly through our interventions under the Regeneration Framework in the short term and for the medium to long term begin to realign available workforce to new service design and models of care. This risk is wider than a 12 month period as actions taken or not taken today will have a long term legacy on our available future workforce and capacity/capability to manage the associated challenges of service & workforce redesign.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Organisational Governance Structure People, Organisational Development and Culture Committee (PODCC) Strategic People Planning and Education Group (SPPEG) & underpinning Governance Structure for People Planning & Education to create an organisation wide assessment for our 10 year strategy Improving Together approach to be align to People Planning approach supported by People Planning Team to create an organisational wide approach to in year service challenges Organisational Gap Analysis based on a 10 year profile developed and annual assessment strategic & operational review of workforce (including Education Commissioning Assessment) Inter-People and Corporate Team & Planning Objectives Establishment Control Agency usage Bank Utilisation & ongoing onboarding of supply Efficient Rostering practice Roll out of new rostering system Overview of organisation and service wide risks (assessment of each service area based on workforce availability) Continuous process of assessment of services to be stood down and	Workforce planning groups need time to mature and develop focus underpinning SPPEG Capacity and capability in people planning within team and across organisation required Establishment control cannot be relied on as one source of truth for information as a) partially due to temporary changes linked with pathways, b) 9 sources of information not all feed into the establishment control tool and c) data management issues in ESR, eg, single employer status for our medical workforce. Tools to enable modelling in short, medium and long term to enable alignment of population health, labour market, internal labour market, activity & performance analysis aligned to financial constraints (work arounds utilised but gaps/issues exist). Critical analysis of people alignment to priorities for delivery within financial considerations for short,	Development of All Professions led people plans to align to in year tactical & operational plans linked to the overarching Strategic 10 year Workforce Plan. (See carried forward action below)	Walmsley, Tracy	31/03/2023	Improving Together alignment to overarching professional groups to create alignment to in year tactical & operational issues; to be summarised and fed into Strategic People Planning & Education Group for quarterly monitoring. Summary of status of all professional groups in place via the development of the Workforce Technical Document. Stabilisation programme supporting specific services/sites - alignment required to 3-10 year strategy via development of People Road Map (Linked to People Planning Objectives 2c - Overarching workforce, od and partnership workforce plan) 1-3 year workforce plans in place testing "robustness" through assessment of risk and service change proposals.
		Analysis of all service levels workforce & od risks within 1-3 year timeline, and where appropriate to 10 year timeline.	Walmsley, Tracy	30/06/2023	Paper summarising all W&OD risks will be issued to SPPEG for review and assessment of agreed prioritisation of actions.
		Develop Career Progression Opportunities for all that want them aligned to the overarching workforce plan & strategy (ensuring underpinning methods and processes support this activity i.e. education commissioning)	Glanville, Amanda	30/07/2023	Plan on a page developed.

deployment options based on service needs (ODPD) Targeted prioritisation of recruitment/onboarding of new employees to the highest areas of risk in terms of maintaining service delivery (People & OD Strategic Group) Temporary People Utilisation reports shared regularly to monitor levels of supply	medium & long term. A robust framework of competency based people planning and related training to underpin the Team around the Patient initiatives and new model development of care.	Completion of Education Commissioning Plan to HEIW and critical assessment to known service level plans as at March 2023 submission to Welsh Government.	Walmsley, Tracy	05/09/2023	Education & Commissioning response for 2023 shared in Mar23 with HEIW. Queries & gaps raised by People Planning Colleagues and HEIW. Follow up actions in place. Ongoing plan & specifics based on a critical analysis of IMTP by professional leads and service plans over a 5 year time frame. 2023/24 Education Commissioning Template for 2026/27 outturn will be completed and updated as requested by HEIW by 26 Apr23. Ongoing dialogue between service/education leads/HEIW in place. (Linked to People Planning Objectives 1b, 2c.) Critical issues paper to be developed from submission and discussion for meeting with HEIW on 9th May 2023 to include Psychology, Radiology (Sonography - Ultrasound) etc.
		Further develop training resources and capacity to support managers with workforce planning challenges to alleviate risks	Walmsley, Tracy	~~31/07/2023~~ 30/09/2023	Initial training programme drafted; dates in diary Jul to Sep23. Linking with Risk Team to ensure aligned process including awareness raising and support.
		Approach to future community workforce development model requires alignment to UEC, Primary Care and Community Programmes of work & teams.	Walmsley, Tracy	31/07/2023	Baselines in place; design methodology required and bought into by group. Progress: stalled due to "definition" of community and underpinning frameworks. May be other opportunities to reflect on work linking to social model approaches. Requires an assessment of approach and capacity to move forward. Work with leads to define "what and how".

Analysis, design and development of the infrastructure and governance to develop the a new model of care i.e. OBC and Social Model of Health i.e. resource requirements, alignment to current structure and service design programmes (workforce planning for workforce, planning/project management, communications & engagement, clinical oversight).	Williams, Paul	30/09/2023	Resource identification has been reviewed and a phased plan of implementation agreed by Executive Team. Requires alignment of new resources within current operating model/infrastructure to make best use of resource and manage risks. Progress: no further update on specific as Clinical Review with WG in progress and will be complete by Aug23. A re-assessment will be needed aligned to work that will start within the "pathways" and PMO/TPO. Consideration of governance mechanisms to support alleviation of strategic workforce risks (7-10 years)
Digital support with workforce planning to support speed in decision making at local, regional & national levels. (Regeneration Framework adopted as a national model). Interdependent need to link population health, external labour market analysis, demand & capacity and activity modelling, internal labour market analysis to pathway design, patient outcomes and staffing models based on appropriate assumptions, scenario planning and financial models. (objective 2c c link " quantitative and qualitative workforce intelligence").	Walmsley, Tracy	30/09/2023	HEIW developing National Observatory in 2023/24. Data Design & Solution Project Manager in post. Exploring approach to workforce data linked to People Planning Objective 2c and Improving Together and BAF work.
Stabilisation Plans across critical professional groups.	Gostling, Lisa	31/03/2024	Nursing Plan in place monitored via the Workforce Regeneration Framework and Nursing Workforce Groups. Links to 2b - workforce effectiveness stabilisation programme. To review following risks assessment and priorisation work.
Agree actions to mitigate strategic risks of workforce supply based on assessment paper	Gostling, Lisa	31/03/2024	Risk assessment in progress
Test "WFP" Project Support Role within a Directorate to strengthen operational and strategic workforce planning: Women & Children	Walmsley, Tracy	30/11/2023	Meeting with LH held to test aligned to Improving Together action identified. Initial introduction planned mid May 2023 for a 6 month trial period.

Methodology to support new and enhanced roles scoped and implemented.	Walmsley, Tracy	30/07/2023	Linked to Pepople Planning objectives 23/24 - plan on a page in development. Alignment of learning to date from role design, team around the patient, quality improvement and value based healthcare to be assessment.
Interrogate financial establishment/SIP to ensure "a source of truth" and align to identified and prioritised risks (operational and strategic).	Spratt, Andrew	31/03/2024	Meeting to review risk to be set up.

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**		
	Monitoring of workforce SIP and gaps in establishment control	1st			
	Strategic People Planning & Education Group	1st			
	Workforce levels monitored at Service Level, Professional Groups and Operational Delivery Group & Improving Together meetings	2nd			
	PODCC - IMTP Plan, and process mapped through Planning Sub Group	2nd			
	Workforce Planning Internal Audit (Substantial Assurance) 2021/22. Ongoing Audit by WAO in progress Jan to March 2023	3rd			
	Wales Audit Office review of Workforce Planning (Fieldwork underway - report expected Summer 2023)	3rd			

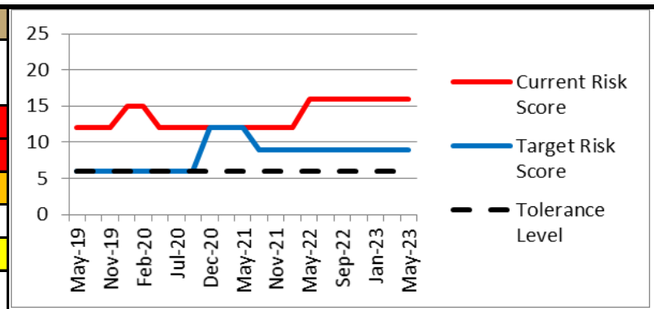
Gaps in ASSURANCES				
Identified Gaps in Assurance:	**How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
Assessment & continuous development mechanisms	Draft Maturity Matrix to be tested in SPPEG May23	Walmsley, Tracy	31/05/2023	Draft developed to be tested in SPPEG May23.

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	May-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jun-23

Risk ID:	**129**	**Principal Risk Description:**	There is a risk of the inability to deliver the statutory requirement of an Urgent Primary Care Out of Hours Service for Hywel Dda patients This is caused by outdated and unsustainable GP dominant workforce model as GPs near retirement age and pay rate differentials (50% reduction over last 5 years) across Health Boards in Wales that impact the UHB's ability to recruit in the mid-long term. This could lead to an impact/affect on a detrimental impact on patient experience, as patients would need to go to an ED/MIU to receive treatment for a primary care complaint to be managed. The inability to provide an out of hours service would also add to day to day GP demand, delayed care for patients and over-reliance on other services such as district nursing and ART teams. The unscheduled care pathway including WAST/primary care could continue to suffer ongoing disruptions due to unmet demand for the OOH service seeking alternative management. This risk may also result in the unforeseen deterioration of an unmanaged condition in a patient, thus becoming more complex to resolve if not dealt with in a timely manner.
Does this risk link to any Directorate (operational) risks?		826, 1352	

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	3×3=9
26/11/2020 - Board 'Accept' Target Risk	
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
Fragility of out of hours (OOH) service delivery continues. Rotas continue to be fragile, particularly at weekends and holiday periods. The inability to recruit GPs, caused primarily by an aging workforce, combined with increased demand for face-to-face, longer complex consultations, and increasing pressures in day-to-day primary care which is impacting the ability of GPs to be available for OOH shifts. In addition, some clinicians may preferentially work in other urgent emergency care initiatives such as 111 First or Same Day Emergency Care (SDEC), as they are potentially much lighter (a pattern reported by Swansea Bay University Health Board (SBU HB) OOH service). This is exacerbated by the minimal numbers of newly qualified GPs applying or enquiring about OOH working patterns. Any further absence on OOH provision is likely to rapidly result in further deterioration of the current position. Availability of daytime work, potentially leading to less availability of locums available for OOH. The Health Board currently has approximately 43 GPs (compared to 100 5 years ago) who regularly work the rotas, and an additional 10-20 who only work bank holidays rotas due to enhanced rates. Advanced Nurse Practitioners (ANP) staff have reduced from 4 to 1 which covers 4 hours over a weekend period (0.1 WTE). Recruitment is ongoing for further GPs (both sessional and salaried), which may improve the current service provision if successful. Minimal impact from recent industrial action, mainly due the availability of Advanced Paramedic Practitioners (APP) for the OOH service. While the Easter 2023 rotas proved difficult to fill, and Level 4 status reported, an improved position was noted for the early May Bank Holiday weekend, with Level 1 status being reported. Position to be reviewed in June 2023 to confirm if the improved performance is maintained, and to review risk score in light of this.	Service rota positions remain variable with continued shortfalls in clinical cover variably affecting service provision. Generally the rotas continue to be unstable, particularly at the weekends and holiday periods, and this is further compounded by the need for salaried staff to take annual leave and sessional staff to have time off to rest. Medium term actions are still required, especially in terms of service modernisation. Work to develop a long term plan for OOH Services has now recommenced following Covid-19 in order to reduce this risk on a permanent basis so to ensure the out of hours service provision is not interrupted. Workforce and service redesign are being considered which will take into account the findings of the recent peer review. There are concerns regarding the future stability of the service, and a need for a greater workforce development plan from central government is really required. TCS must include a more realistic workforce plan to future proof the whole Health Board.

Key CONTROLS Currently in Place:	**Gaps in CONTROLS**

(The existing controls and processes in place to manage the risk)	**Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# GP's rotas across the 3 counties are now managed centrally via the administration team based in Haverfordwest and using Rosta master to identify gaps in shifts and cover # Dedicated GP Advice sessions in place at times of high demand (mostly weekends and bank holidays). # Remote working telephone advice clinicians secured where required. # Health Professional feedback form in use between clinicians, service management and 111 (WAST) leads. # WAST Advance Paramedic Practitioner (APP) resource in place. # Rationalisation of overnight bases in place since March 2020, now subject to service review. # Workforce and service redesign requirements flagged as part of IMTP. # Deputy Medical Director meetings on a weekly/bi-weekly basis, helps to ensure governance of the service. # Regular review of risk register with Assurance & Risk Officer. # Agreed pathway for PPH Minor Injury Unit in place. # GP Hub in place where locum sessions can be accessed centrally to support service provision - however there are issues/delays with onboarding in Hywel Dda therefore this has not benefitted Hywel Dda. # Ongoing recruitment activity and workforce planning/design in order to bolster the MDT model and maintaining service stability, and links developed with Primary Care to support this activity. # Use of telephone consultations for service delivery alongside remote working, which has increased by 60% due to the pandemic. # Business Continuity Plans in place to ensure continuity of service, and daily BCI meeting between the National 111 team, WAST and health boards. # Service capacity is measured via a national RAG status # Improvements in the qualitative data and reporting, with support from Primary Care # Regular interaction with regards to industrial action and subsequent planning # January 2023, review of pay structures for sessional GPs, with hourly rates now increased for those shifts considered to be more undesirable. All hourly rates were increased by 5%, with additional variance for the more shifts with higher demands - noted that this is a trial scheme, which is to be reviewed. # Improving Together Sessions in place, where progress and performance of the OOH service reviewed. # Peer Review (June 2022) noted on the Health Board's Audit and Inspection Tracker, and progress against recommendations monitored bi-monthly via Audit and Risk Assurance Committee (ARAC) # Improved use of Dashboard reporting to determine demand and capacity	The ability to influence workforce participation remains limited due to the lack of contractual agreements (reliance on sessional staff). Difficulties in the recruitment and retention of staff. Competing with other services for same staff, eg SDEC. Concerns regarding the future stability of the service and wider impact on other services such as A&E and admissions and daytime services, GP practice and district nursing, and a need for a greater workforce development plan from central government is really required. TCS must include a more realistic workforce plan. Need for formalised workforce plan and redesign is still required - reflected in IMTP submission. Covid continues to influence the risk-position with frequent short notice absences and limited opportunity to find cover in these circumstances. The focus on delivery of care via the telephone advice method is the significant factor in stabilising the risk at this time however there is a slow return to seeing more patients face to face with calls completed as telephone advice now reduced to 60-70%. Any reduction in capacity remains likely to require an increase in the risk level as the service delivery will be adversely affected. Low levels of incident reporting and feedback to improve understanding of quality of service. Onboarding of GPs in Hywel Dda from GP Hub hasn't translated into any	Develop a sustainable out of hours service aligned to TCS and the Urgent Emergency Care (UEC) Programme taking into consideration the the findings of the internal service review and the recent Peer Review (when received).	Richards, David	31/10/2023	Peer Review report to be presented at May 2023 OpQSE, with recommendations from the review being worked through. Meetings and discussions ongoing with UEC management. Progress is ongoing and reported through Improving Together sessions.
		Implementation of the recommendations of Out of Hours Peer Review undertaken in Jul22	Richards, David	Completed	Report has been received, to be presented at May 2023 OpQSE, and the recommendations are noted on the UHB Audit Tracker, progress of which is monitored bi-monthly by ARAC.
		Educate GPs on importance of incident reporting to improve the quality of service	Archer, Dr Richard	Completed	Journal club was held 5th April 2023 in order to educate GPs, a result of which has seen a slight increase in the number of incidents being reported. This will be continued to be monitored.
		Develop a streamlined process to onboard GPs from the All Wales GP Hub with workforce colleagues	Archer, Dr Richard	~~31/01/2023~~ 31/05/2023	Improving Together sessions being utilised to identify methods to streamline this process. Peer review findings and management responses were due to be discussed with Welsh Government on 6th March 2023, however this meeting was cancelled. Dates are being circulated to reschedule for mid-April 2023. Peer review and management responses to be presented to OpQSE on 11th May 2023. As at May 2023, GPs are able to onboard within a few weeks, which is an improved position for the Health Board - however it is noted that this is not as streamlined as other Health Boards in Wales.

capacity	GP Hub hasn't translated into any significant improvement in shift uptake Peer review identified cultural issues within the service. The impact of the ADASTRA cyber security hack has resulted in the inability / limited opportunity to use the system in a non-NHS environment. It has also impacted on the availability of data to monitor performance, capacity, and complaints / incident management. While PPH MIU Pathway in place, the site are experiencing difficulties with regards to GP cover, affecting the efficiency of this pathway. National RAG status isn't yet mature, doesn't differentiate between the the spectrum of clinical competencies and abilities. ADASTRA system is back up and running, however a backlog of circa 8000 patient records which are available to the Health Board however not necessarily with WAST/111. Work is ongoing to upload this information, envisaged to be completed by June 2023 - however need to factor in the impact of industrial action on this timescale, and any further demand increase. It is also noted that the current system contract expires in December 2023, and should there be any delays with the rollout of Salus (replacement system), the service will need to revert to Business Continuity Plans	Work with the workforce relationship team to improve the relationship between management, clinical staff and GPs	Richards, David	~~31/10/2023~~ 31/03/2024	Service Delivery Manager to meet with Workforce to progress further with this action, along with the Deputy Director of Operations and potentially Assistant Director of Primary Care. Findings from the recent Peer Review as at May 2023, along with the Internal Service Review to form basis of future discussions.
		Review leadership roles and recruit to expand both at system and operational level	Richards, David	30/09/2023	Leadership capacity is subject of discussion at Improving Together sessions, however longer term development opportunities may be required.
		Develop escalation plan with clear routes and methods of escalations.	Richards, David	30/09/2023	Existing escalation plans to be reviewed, and to consider intra-shift escalation plans going forward.
		Pilot a model in Carmarthenshire based on the Airedale rural model, which will offer support to the residential care sector	Matthews, Rhian	30/09/2023	This action was raised in the Jun 2022 Peer Review model, and progress tp be provided at future risk review in terms of its implementation.

Appendix 2

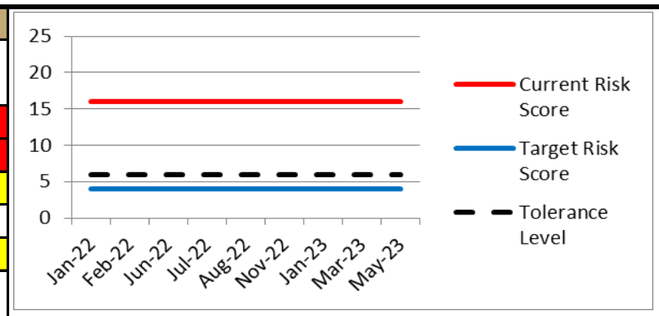
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Bi-monthly IPAR. (Monthly updates to IPAR including areas of concern and statistics). National Standards and Quality Indicators- submitted monthly to WG. Issues raised, and performance Matrix reviewed, at National OOH forum (bi-monthly, attended by WG).	Daily demand reports to individuals within the UHB	1st			OOH Paper - QSEC (Oct21)					
	Twice a week sitreps and Weekend briefings for OOH	1st								
	Monitoring of performance against 111 standards	1st								
	Issues raised at fortnightly meeting with Primary Care Deputy Medical Director and Associate Medical Director	1st								
	Monthly report to Joint Operations Group (WAST, 111 team & 111 Health Boards)	2nd								
	QSEC monitoring	2nd								
	Issues raised, and performance Matrix reviewed, at National OOH forum (bi-monthly, attended by WG)	3rd								
	WG Peer Review Oct 19	3rd								
	Peer Review Jul-22 (final report to be presented to OQSESC in May 2023)	3rd								

Appendix 2

Date Risk Identified:	Jan-22	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	May-23
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Jun-23

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 follow-on PCI if indicated) within 72 hours (3 days) of 'admission/presentation' for people with unstable angina or non-ST-elevation myocardial infarction (NSTEMI) who have an intermediate or higher risk of adverse cardiovascular events' (recommendation 1.1.6). In support of this recommendation/target, the aim is to 'refer' patients to Morriston Cardiac Centre for angiography within 24 hours of 'admission/ presentation' in order to achieve a total pathway target of 72 hours. As a baseline, in 2021 the median time between 'admission/presentation' and 'referral' was 39.5 hours and for the entire pathway ('admission/ presentation' to 'angiography') it was 213.5 hours (8.9 days). For context, the 2021 position was a deterioration from that maintained in 2019 where the Prince Philip Hospital (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. Although January-October 2022 data demonstrates some improvement, the NSTEMI/ACS pathway continues to fall short of the NICE recommended 72 hours pathway, with median time between 'presentation' and 'referral' at 37 hours and entire pathway duration ('admission/presentation' to 'angiography') at 169 hours (7 days)

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

Appendix 2

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: Pilot of Chest Pain Nurse NSTEMI patient review and processing of referrals at GGH and PPH currently in progress with interim impact report due April 2023	Smith, Paul	Completed	Evaluation of Chest Pain Nurse NSTEMI Project completed - findings/recommendations reported and incorporated in regional ACS Business Case currently in development.
		Introduce workforce solutions to support the reduction of presentation to referral to a median time of 24 hours: 4 WTE Band 7 NSTEMI/Chest Pain Nurse (1 per HDUHB Acute Site)	Smith, Paul	~~31/08/2022~~ ~~01/05/2023~~ 31/07/2023	Evaluation of Chest Pain Nurse NSTEMI Project completed - findings/recommendations reported and incorporated in regional ACS Business Case currently in development.
		Re-instate of NSTEMI Treat and Repatriation service and/or identify steps to improve patient transportation and logistics.	Smith, Paul	Completed	PPH NSTEMI/ACS Treat & Repatriate Pathway / Service re-commenced w/c 24th April 2023.
		Increase regional capacity at Morriston Cardiac Centre to meet the 72 hour NICE guidelines.	Smith, Paul	~~31/12/2022~~ ~~31/03/2023~~ 31/07/2023	Case for increased capacity / delivery of 6/7 day Cardiac Cath Lab service at Morriston incorporated in regional ACS Business Case currently in development.
		Explore options to commission NSTEMI pathway angiography service from an alternative provider/s across Wales	Smith, Paul	Completed	HDUHB Commissioning and Contracting Team have approached Cardiology NSTEMI/ACS centres/facilities across Wales and on the Wales/England borders and there is no available capacity to support HDUHB NSETMI/ACS pathway. ARCH Regional Cardiology Project Group and HDdUHB ACS Working Group continue to pursue a plan that will see an improved Cardiac Cath Lab service from Morriston Cardiac Centre.

Appendix 2

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	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								

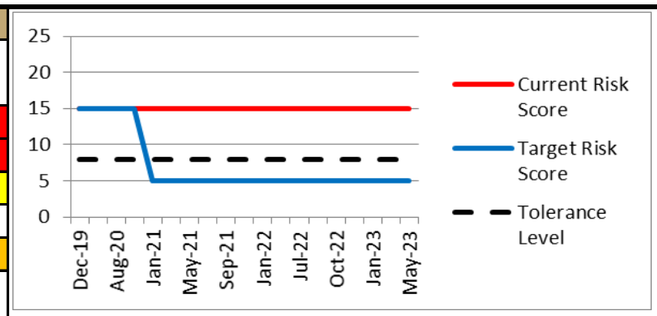
Appendix 2

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	May-23
Lead Committee:	Health and Safety Committee	**Date of Next Review:**	Jun-23

Risk ID:	**813**	**Principal Risk Description:**	There is a risk of failing to fully comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO). This is caused by 1: The age, condition and scale of physical backlog, circa £20m (+) relating to fire safety (i.e. non compliant fire doors, compartmentation defects and general fire safety management issues) across our estate significantly affects our ability to comply with the requirements of the RRO in every respect. 2:Difficulties managing the actions within the current fire safety risk assessment system - to enable complete transparency and ongoing management of actions assigned to responsible persons. The new Boris system will address this issue. 3: Management responsibilities for fire safety not fully understood by all responsible managers. 4: Fire safety training attendance figures are not reaching HB agreed targets. This could lead to an impact/affect on the safety of patients, staff and general public, HSE investigations and further fire brigade enforcement (already served on Withybush and Glangwili General Hospitals), fines and/or custodial sentences, adverse publicity/reduction in stakeholder confidence.
Does this risk link to any Directorate (operational) risks?		708, 951, 503	

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:
Phased fire safety improvement works are ongoing across our sites, with significant investments being made to address the recommendations in the MWWFRS letters and Enforcement Notices. All programme dates have been agreed with the HB, WG and MWWFRS senior inspecting officers. We intend to review the progress of our completed actions to determine the risk score as we progress with these works. MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed that are comfortable with the current position. As of February 2023, the risk is felt to still be extreme until further progress is made on the above Fire safety improvement works. This will be reviewed regularly. 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.

Rationale for TARGET Risk Score:
Further improvements in culture and ownership for fire safety. It is the scale of physical backlog for fire safety compliance (additional surveys) that will remain until appropriate measures are put in place to address the deficit. Despite annual investment from statutory capital for fire safety components (circa £200k), the scale of current investment is clearly not adequate to address the true scale of backlog the UHB has. It is anticipated that when training attendance levels specifically for L2 training have reached > 80% targets and are sustained at this level continuously, coupled with the completion of key fire safety investment programmes and phases across our acute sites (completing in circa April 2025), the HB will then be in an informed position to look at the reduction of risk score for risk 813. This decision will be reviewed regularly.

Appendix 2

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**
Pre Planned Maintenance (PPM) checks are carried out across the UHB on fire safety components. 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. Individual Fire Risk Assessments (FRA's) in place for all sites across the UHB identifying fire related risks. Training Needs Analysis (TNA) for fire safety training in place, as defined in Fire Policy. UHB has implemented a governance structure for fire safety reporting. Estate plans with fire zones, fire doors, fire compartmentation, fire infrastructure items (alarm and detection system). 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. Annual prioritisation of investment against high risk backlog. Internal governance review (2019/20) initiated by the CEO and all action implemented from review. 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. The UHB has improved fire safety management culture and management ownership for fire safety	Despite significant investments already in place following enforcement notices and letters of fire safety matters, additional investment is required to address fire safety defects at other sites within the UHB, which are being inspected by MWWFRS. We have firm plans in place to address a range of fire safety projects over the coming years and these are all fully identified as actions within this risk with anticipated timelines. Inability to allocate fire risk actions to appropriate owners on current fire risk assessment system hosted by NHS Wales Specialist Estates Services (NWSSP-SES). Inability to manage and control recommendations within the HB's own Fire Risk Assessments. Staff fire training attendance figures are below targeted figures set by the HB at 85% for all levels - inability to undertake face to face training has impacted (Covid). Despite making improvements to the culture of fire safety management and ownership, the HB does need to ensure this is organisational wide and embedded within it's workforce and cascaded by management.	Implementation of a new software system to manage the content of the HB's fire risk assessments. Boris software has now been purchased and is currently being implemented. Date agreed as part of internal fire safety governance review.	Evans, Paul	Completed	Boris software now purchased Dec 2020, initial implementation planned for March 2021. Implementation of risk assessments will now be planned for July 2021. System now supports the use of mobile technology therefore risk assessments can be completed live on the system. System now being tested on site, fully operational by Jan (now Feb) 2022
		Additional fire surveys are required across various sites to obtain costs for all fire compartmentation defects, doors, fire alarm systems and other associated items.	Evans, Paul	Completed	fire safety team and compliance team are working with site operations to determine what the gaps are and to agree what surveys will be required.
		Introduce new innovative ways of improving fire training attendance across the HB to increase the percentage figures agreed and set by the HB. As part of the next risk review the fire team intend to split this action into individual sections so we can track and close off action as and when completed.	Evans, Paul	Completed	The fire safety team have been trialing the use of MS teams for L2 Fire training, which has proved to be very successful. We are planning to roll this out to other areas of fire training levels, such as L5/L4 & L3. This will have a positive impact on staff being able to attend the session. We will need to improve communications on this and to ensure staff are made fully aware of the sessions taking place and the dates.
		To introduce ways to help improve the culture and ownership of fire safety across the HB. Although management training is taking place at the "Managers Induction Programme" and this is well received. The HB still needs to do more to avoid areas of poor practice that is sometimes identified.	Evans, Paul	Completed	To look at improving the current training content and programme that's currently on offer for management. Regular global communications of do's and don'ts. Having a fire safety share point system, with links to interesting info on effective fire safety management.

management ownership for fire safety. The fire team will also look to implement a regular training global e-mail as a reminder for staff on when and how to book a session. Works already completed following issue of Enforcement Notices and LoFSM at various sites. For EN sites (WBH and GGH) - Advanced Works to vertical escape routes now completed. Also further improvements under LoFSM at Tregaron, Bronglais, Glangwili and Withybush Hospitals. Level 1 & 2 Fire Safety training is delivered via Teams. Level 3 Fire Safety training is provided face to face. Level 4 training (Fire Safety Warden training) is also a face to face session, with an external trainer. Level 5 training is provided on Teams as part of the H&S Managers induction training. Boris fire safety system implemented across the UHB, giving the ability to review all risks from fire risk assessments via a dashboard.	Now the new Boris fire safety system is being implemented across the HB (training planned for June 22 for staff), fire risk assessment actions from this need to be monitored by those responsible. These actions need to be communicated at all fire safety sub groups and fed to the HB wide FSG for complete transparency.	Evans, Paul	Completed	System now live in the HB and staff training programme in place. From this point all fire risk assessment actions will be closely monitored using this system.
	Introduce a system to manage fire risk assessment recommendations more effectively. System to have the ability to assign risks to risk owners, to track/manage risk and to demonstrate progress on the actions.	Evans, Paul	Completed	The fire team are utilising the current system as best as possible. An Excel system is being introduced (completion Jun20) however a more robust automated system is needed by the HB to track the significant number of actions. Progressing this has been delayed due to COVID-19, however quotes have now been obtained and are under discussion with the Director of Facilities. Approval has now been provided to purchase a system. Completion date for system trial on site by July 2021. System now being tested on site on a few Fire Risk Assessments, we plan to go fully live in Nov/Dec 2021.
	Establish a teams training platform to deliver the level 3 and level 4 fire safety training programmes. Although this will also be supported by face to face sessions.	Evans, Paul	Completed	Following a review of level 3 & 4 fire safety training programmes it has been established that these cannot be delivered via Teams. These are now delivered as follows: Level 3 training has been reviewed and requires a face to face practical delivery. Level 4 training (Fire Safety Warden training) is also a face to face session, with an external trainer.

WBH - Completion of Phase 1 works - For all remaining horizontal escape routes.	Elliott, Rob	~~31/01/2023~~ ~~31/03/2023~~ 31/08/2023	MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. WGH Phase 1 works is planned to be completed by August 2023.
WBH - Completion of Phase 2 works - For all departments, ward areas and risk rooms.	Elliott, Rob	30/04/2025	Phase 2 works remain on programme to be completed by April 2025.
GGH - Completion of Phase 1 works - For all remaining horizontal escape routes.	Elliott, Rob	~~28/04/2023~~ 22/01/2024	The current forecast completion date is January 2024, however this will need to be closely monitored and reviewed as the project progresses
GGH - Completion of Phase 2 works - For all departments, ward areas and risk rooms.	Elliott, Rob	30/04/2024	Phase 2 remains on programme to be completed by April 2024 (subject to the full due diligence work needed as part of the Business Case development).
Develop a Fire Training information pack for distributing to agency staff across all 4 sites.	Elliott, Rob	Completed	Completed - We have supported the HoN on this recommendation and issued our current training material to all agency companies. We will continue to support the HoN with any new welcome packs they introduce.

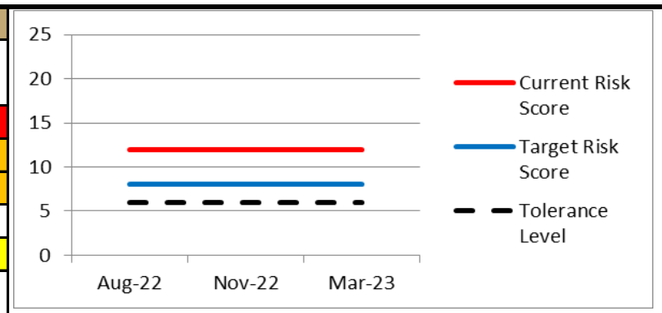
Appendix 2

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Maintain a zero or as low as possible number of outstanding fire risk assessments.	Bimonthly review of outstanding actions from fire risk assessments	1st			IA Fire Precautions Report - ARAC Jun18 SBAR submitted to each HSAC meeting, which includes themes of all fire safety risks.	General site management checks/walkarounds on all sites				
	Site Fire wardens reporting fire safety issues	1st								
	Annual Online Fire Audit Self-Assessment submitted to NWSSP	1st								
	Review of compliance through fire safety groups	2nd								
	4 Fire Safety Sub Groups (one at each site) which report into the UHB wide Fire Safety Group (reporting into the HSC)	2nd								
	Fire Safety SBAR reports regularly issued to HSC	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								
	IA Fire Governance follow up in July 2022 - Substantial assurance.	3rd								
	IA WGH Fire Precautions Works: Phase 1 in Aug 22 - Reasonable rating.	3rd								
	High level action plan meeting with MWWFRS (Dec 8th 22) - with very positive comments received from then on our commitment to improve fire safety performance.	2nd								

Date Risk Identified:	May-22	**Executive Director Owner:**	Shakeshaft, Alison	**Date of Review:**	Mar-23
Strategic Objective:	4. The best health and wellbeing for our individuals and families and our communities	**Lead Committee:**	Health and Safety Committee	**Date of Next Review:**	May-23

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

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
The national security and risk assessment was reviewed and re-published in November 2022. The previous pandemic influenza risk has been changed into 2 new risks, one generic pandemic event and 2 emerging infectious diseases. Current likelihood scored at a 3 to reflect the risk of the Health Board being unable to respond to the scale and severity of the pandemic - not the likelihood of the pandemic actually occurring.

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

Appendix 2

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Major Incident Plan # Well established command and control structures for managing pandemic response both nationally and locally # Continuation of current COVID-19 national vaccination programme until at least March 2023 # Future service model for contact tracing and testing in place until March 2023 # Extensive knowledge across Health Board in managing a pandemic event # COVID-19 response measures which can be adapted to respond to any future pandemic event # Local Resilience Forum (LRF) multi-agency plans for managing pandemic influenza (approved by Strategic LRF 14/11/18 now under review) # LRF Excess Deaths Plan (which supports the LRF multi-agency pandemic influenza management arrangements) developed as a recommendation from Exercise Cygnus. Plan was ratified by the LRF Strategic Group on 11/07/2018. Will be reviewed imminently via LRF Health Group. # Health Board Pandemic Influenza Response Framework and associated plan(currently outdated awaiting review) # Quality assurance process via national & local exercise programmes. # Access to national counter measures stockpile # Surge Plans in place to enable HB to respond to future spikes/waves of infection requiring recommencement of contact tracing, testing & vaccination # Continuous learning from COVID-19	# Current Health Board pandemic framework will need to be updated to incorporate new Cabinet Office review implications/ recommendations and broaden remit to generic pandemic response rather than be influenza specific. # Current response measures, especially around contact tracing, testing and vaccination are time limited and currently in the process of being stood down. Will need to be re-established to respond to future pandemic situation.	Reinstate Health Board Pan Flu Group with a wider remit to consider future pandemic response arrangements within the HB and to enact Cabinet Office Influenza Review implications when publicised.	Hussell, Sam	20/04/2023	Awaiting publication.
		Health Protection Manager tasked to lead re-establishment of HB Pandemic Planning Group and review of Pandemic Response Framework.	Hussell, Sam	30/09/2023	Progress to be provided at next risk review.

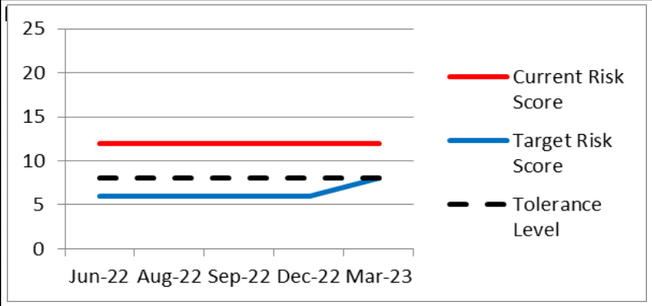
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the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

Appendix 2

Date Risk Identified:	Feb-22	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Mar-23
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	May-23

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 capacity challenges within the first 28 days of the pathway in first Outpatients Assessment and diagnostics, particularly in the large volume tumour sites, lower GI and urology. This is compounded by a backlog of patients waiting in excess of 62 days due to the impact of COVID--19. This could lead to an impact/affect on increased number of patients waiting in excess of 62 Days and 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?		1223, 114, 111, 1537	

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



Rationale for CURRENT Risk Score:
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 and urology diagnostics. A decrease in capacity for appointments and results reporting within radiology, due to sickness, current vacancies and planned annual leave within two of the four health board sites. Patients have been offered alternative appointments on other sites, however some patients have not agreed to attend and have requested an appointment close to home. Cancer performance has been variable since quarter 3 2021/22. Performance since April 2022 has been variable whilst the priority focus has been on reducing the backlog of patients awaiting diagnosis and/or treatment. Since July 2022, the number of patients waiting in excess of 62 days has reduced by 43% (data as at February 2023). Improvement trajectories are now in place, with the aim to achieve 70% by March 2024, with a backlog volume of 231 (inclusive of tertiary waits).

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. Target risk score amended in March 2023 to reflect that current trajectories for March 2024 aims to achieve 70%, recognising that there is still further work to be done to achieve the ministerial requirement of 75%.

Appendix 2

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# A SCP Diagnostic Group with all the relevant service managers is in place to look at the capacity & demand for diagnostic services, looking at what capacity is required for a 7 day turnaround diagnostic service. # Fully established cancer tracking team in place to allow patients to be proactively tracked through their pathways. # A new cancer dashboard has now been developed by Informatics with the support of Business Intelligence (BI) SCP funding from the Wales Cancer Network. This is now live with accesses for Cancer Services staff and Service Managers. This will allow MDTs to actively monitor tumour site specific patients on a SCP. # A Rapid Diagnosis Clinic (RDC) has been launched within the health board. Currently 1 clinic per week being held in PPH. Funding has now been secured and plans are being discussed to role this service out across all 3 counties. # As per the Wales Bowel Cancer Initiative, a successful FIT10 screening in the management of USC patients on a colorectal pathway was implemented in Jun20. This initiative is due to be rolled out to primary care by the endoscopy service by April 2023. # Digital Delivery of Care was implemented during the first wave of the pandemic, resulting in two thirds of patients receiving virtual appointments and only a third requiring face to face appointments. # Virtual appointments are being undertaken via digital solutions e.g. Attend Anywhere. # Weekly Cancer Watchtower meetings where services managers are in attendance. The function of this group is to monitor and address service demand, capacity and risk issues. # Monthly performance meetings with Welsh Government. Trajectory performance plans are currently being developed for each tumour site by the relevant services, with regards to improving performance. This also includes Backlog Trajectory plans on how these improvements will be achieved. # Cancer Pathway Review Panel has been implemented to identify any risk for those patients who have not received their treatment within 146 days. # 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.	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	Completed	Project Manager appointed and took up post in Apr22. This will be a 2 year fixed term appointment to run alongside the optimisation project. Request made 18th November to the WCN for sessions to develop and strengthen our Cancer Recovery plan and maximise optimum pathway opportunities
		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~~ 31/07/2023	Initial Meeting with Head of Radiology 09Mar22 to scope schedule of work for demand & capacity (C&D) plan for radiology and explore short term opportunities to increase capacity, which is ongoing as of March 2023. A draft C&D has been carried out by the Radiology service in collaboration with the Delivery Unit. An SBAR that contains the cost of associated gaps in service provision has been developed in draft and presented to Cancer Delivery Board. Next step is to present to the SOBM in May 2023.
		Review access to green surgical pathways across all sites to include access to green critical care.	Humphrey, Lisa	Completed	As of March 2023, service now operating as at pre-covid capacity. Action complete.
		Introduce a central point of contact for navigator as a pilot to coordinate radiology USC appointments and reporting from Mar22	Humphrey, Lisa	Completed	The Radiology Navigator took up post in April 22.
		Each MDT to review and adopt recommended optimal tumour site specific pathways. (Timescales may change depending on COVID)	Humphrey, Lisa	~~31/03/2023~~ 30/09/2023	The Macmillan Cancer Quality Improvement Manager is working with the teams with regards to implementing the new pathways.

Appendix 2

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
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 - Nov22	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								

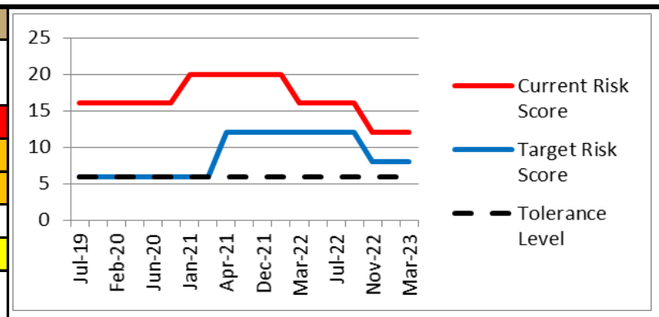
Appendix 2

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Mar-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	May-23

Risk ID:	**684**	**Principal Risk Description:**	There is a risk to the radiology service provision from breakdown of key radiology imaging equipment (the general rooms and mobile fluroscopy unit 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?	925, 114		

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



Rationale for CURRENT Risk Score:
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 Health Board's ability to meet its Referral to Treatment (RTT) target and impact to patients can include delays in diagnosis and treatment. CT and MR scanners have been replaced and has reduced the frequency of machine downtime compared to previous experience. The CT scanner in Bronglais General Hospital (BGH) is due to be upgraded by the end of financial year 2022/23. The PPH MRI scanner is due to be included in the next series of upgrades, pending financial support for 2023/24. The risk score has been reduced to 12 reflecting that some equipment has been installed and is operational. A costed plan along with a rolling programme for the installation of additional equipment is in place. The next batch of equipment for replacement has been prioritised and identified, however funding has been secured (for financial year 2023/24). A paper was submitted to the September 2022 Capital Sub-Committee meeting for information. As at March 2023, confirmation on funding was awaited.

Rationale for TARGET Risk Score:
While equipment has been installed as part of the current WG funding allocations, there is uncertainty as at November 2022 with regards to continued equipment replacements for financial year 2023/24 due to the discontinuation of a dedicated imaging equipment replacement allocation. New All Wales PACS procurement requires all equipment to be DR for compatibility. This has meant that replacement priorities have changed, and that some of the older DR compliant equipment are now overdue for replacement, and at risk of being de-prioritised. 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.

Appendix 2

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports.Some funding has been secured from AWCP for some replacements but does not cover all outdated equipment nor the future requirements. # Escalation process in place for service disruptions/breakdowns. # WG Funding agreed for 2 x CT scanners (GGH & WGH) - now installed # Additional CT secured in the form of a mobile van in December 2020. # Newly created National Imaging and Capital Priorities Group ensures there is a robust governance process to support a national, sustainable clinically focused capital equipment programme across Wales. This will ensure that all HB's in Wales agree to a prioritisation process which will allow for timely equipment procurement and delivery to support healthcare demands across Wales.	Limitation of spare parts for some older equipment leading to extended outages. This issue may be compounded by Brexit. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Reliance on AWCP for replacement of equipment.	Work with planning colleagues about sourcing capital funding through DCP and AWCP.	Roberts-Davies, Gail	Completed	Two business cases have been funded by WG. Further Business Cases for the further 3 CT scanners and or General Rooms (depending on priority) to be submitted in 2022/23.Submit updated paper to CEIMTSC to outline current priorities and funding requirements from DCP and AWCP. 21/12/2021 - discussion with the Head of Radiology has confirmed that all relevant funding has been sourced, with ongoing work to install equipment / updates to be made alongside the Estates time. Action complete with regards to funding.
	Installation of CT Scanner at Withybush General Hospital		Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise. As of 25/05/2022 the installation of this equipment is currently running to schedule.
	Installation of scanner at Prince Philip Hospital		Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise. Installed and operational in October 2022.
	Installation of CT Scanner at Bronglais General Hospital		Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise.
	Installation of DR room in Prince Philip Hospital		Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise. Installed and operational in October 2022.
	Installation of DR room in Glangwili General Hospital		Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise. Installed and operational in November 2022.

Installation of DR room in Withybush General Hospital	Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise.
Installation of fluoroscopy room in Bronglais General Hospital	Roberts-Davies, Gail	~~28/02/2023~~ ~~01/04/2023~~ 30/04/2023	Expected handover of fluoroscopy is the 17th April, along with the DR room, at which point action can be noted as complete.
Replacement of Mammography equipment at Prince Philip Hospital	Roberts-Davies, Gail	~~31/03/2023~~ 03/05/2023	Expected to be operational by the end of the financial year with additional funding secured. Delivery equipment expected on March 24th, with handover expected 4th April.
To confirm the capital funding to replace existing aged equipment for FY 2023/24	Roberts-Davies, Gail	~~31/03/2023~~ 30/06/2023	A prioritisation list of aged equipment to be replaced has been devised as at November 2022, however confirmation needed on funding in order to undertake the required work. Potential funding from WG as part of RISP projects. Still awaiting funding outcomes as at March 2023.

Appendix 2

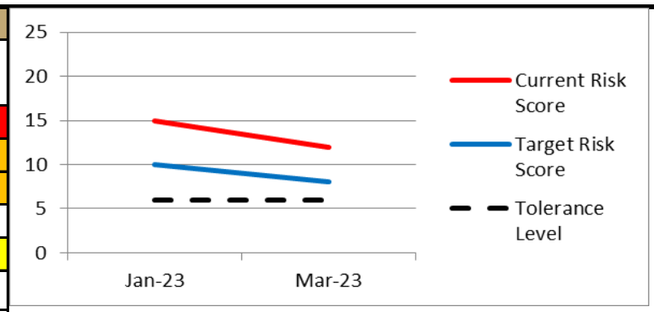
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Reduction of waiting times to under 6 weeks by Mar22. Reduction in overtime costs to nil by Mar22.	Monthly reports on equipment downtime and overtime costs	1st			Radiology Equipment SBAR - Executive Team - Mar19 Further updates CEIMT 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								

Appendix 2

Date Risk Identified:	Nov-22	**Executive Director Owner:**	Shakeshaft, Alison	**Date of Review:**	Mar-23
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	May-23

Risk ID:	**1559**	**Principal Risk Description:**	There is a risk of the Health Board being unable to maintain all areas of health board business including routine, urgent and emergency service provision, corporate and administrative functions across health board sites and in our communities/patient's homes in the event of planned and unplanned power outages. This is caused by by supply failure by energy suppliers or severe weather events. This could lead to an impact/affect on patient care, patient safety and delivery of services (including medical devices and equipment). Additionally this could also impact delivery of the Health Boards delivery plan.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	



Rationale for CURRENT Risk Score:

Risk from power outages has been highlighted at UK level in the National Security and Risk Register and also at regional level in the Dyfed Powys Local Resilience Forum Community Risk Assessment. Welsh Government is working with UK Government on the resilience of the energy system. In line with standard practice, the systems operators for gas and electricity have completed their winter outlooks. Their central scenarios, based on the functioning of normal market conditions, suggest there will be sufficient margins across both gas and electricity. However, there is recognition that we face unprecedented threats to the normal operation of energy markets. The key threat being the impact of supply restrictions of Russian gas to mainland Europe and the impact this has on rest of the world supplies and energy trading arrangements from mainland Europe into the UK. This on top of traditional winter risks (low renewable energy generation, major infrastructure failure and high demand as a result of colder weather) mean there is a reasonable worst-case scenario where emergency measures are enacted. The Health Board has a number of measures in place to respond to such events, however assurance is being sought on wider impacts which may affect the Health Board's delivery of safe patient care. The current risk score has been reduced due to the intelligence gathered and mitigation measures in place.

Rationale for TARGET Risk Score:

The target score has been reduced in March 2023 from 10 to 8, as the controls that will be put in place are aimed to reduce the likelihood of impact to patient safety and patient care.

Appendix 2

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**
Power Outage Planning Group established. Hospital Sites (all in-patient facilities): Generator provision on inpatient sites (200 hours running time) EFAB bid approved to install plug-in generator connection points on acute hospital sites. Works to be completed by Autumn 2023. Generator maintenance contract with Power Electric. Planned generator maintenance and testing programme in place. Diesel polishing programme underway for bunkered diesel supplies. Acute sites listed on energy provider Protected Supply List (excluding BGH) Rota load disconnection process - all acute sites covered plus AVH and LCH. Primary and Community Care: Out of Hours Service able to operate in all but one base (Llandysul) as located on acute hospital sites. Confirmation of little/no generator provision across primary care. Primary care to manage via their business continuity plans. Local Resilience Forum: Multi agency planning group considering power outage preparedness Regional table top exercise held on 16 Feb 23 (Exercise Lemur) National Tier 1 exercise planned for 28-30 Mar23 (Exercise Mighty Oak)	Hospital Sites: Back up generators on inpatient sites - only one per site in place rather than the recommended two per site. Generator connection points to enable portable generators to be connected in times of primary generator failure. Other: Contingency measures for ICT capability and loss of power across health board sites and remote workers for those staff who work from home Community tensions Potential impact on HB premises, eg public accessing sites for power, warmth and communications Development of Communications Strategy Assurances from partner agencies	Strengthening generator provision across all Health Board facilities.	Elliott, Rob	~~31/03/2023~~ 31/10/2023	EFAB bid successful for generator connection points on acute hospital sites with work to be completed by Autumn 2023. Capital bid for additional generators. Bid to be developed for purchase of back-up generator that could be located on any hospital site as needed.
		Clarification on facilities on the Protected Supply List to be sought.	Elliott, Rob	~~31/01/2023~~ 30/04/2023	Challenge on decision to not include BGH on the Protected Supply list submitted to energy provider.
		Confirmation of preparedness and mitigation measures including any knock-on impact to Health Board to be sought from primary care contractors.	Bond, Rhian	Completed	Completed. Little/no generator provision across primary care.
		Assurance on levels of contingency measures contained within individual care plans in the community covering use of medical devices and equipment (prioritising those relying on life maintaining devices).	Paterson, Jill	~~31/01/2023~~ ~~28/02/2023~~ 30/04/2023	Heads of Community Nursing and Head of Long Term Care progressing via T&F Group. Equipment held identified and levels of resilience now being established.
		Assurance on contingency plans for Out of Hours bases and systems to be sought.	Richards, David	Completed	Completed. Only one Out of Hours base located in primary care (Llandysul) - all other bases are on acute hospital sites, so covered by generator provision.
		Communications plan to be developed as and when further clarity on potential outages is known.	Hughes-Moakes, Alwena	~~28/02/2023~~ 30/04/2023	Will be developed as and when needed.
		Assurance on levels of contingency measures contained within Social Care (Care Homes and Dom Care packages) to determine any knock-on impact to Health Board.	Paterson, Jill	~~31/01/2023~~ ~~28/02/2023~~ 30/04/2023	Head of Long Term Care progressing.
		Assurance on levels of ICT system resilience and contingencies	Tracey, Anthony	~~31/01/2023~~ 30/04/2023	In progress.

Appendix 2

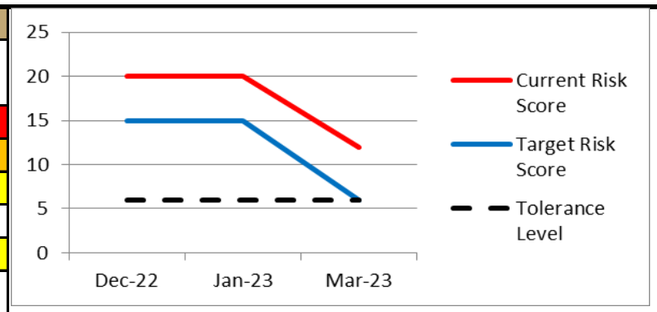
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
	Power Outage Planning Group established.	1st								
	Regular updates to Executive Team and OPDP.	2nd								
	Dyfed Powys Local Resilience Forum responding to risk.	3rd								
	Dyfed Powys LRF regional Exercise Lemur focusing on power outages held Feb 2023.	3rd								
	National Tier 1 Exercise Mighty Oak focusing on power outages planned for March 2023 - being led by the Cabinet Office and Emergency Planning College.	3rd								

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

Executive Director Owner:	Shakeshaft, Alison	**Date of Review:**	Mar-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	May-23

Risk ID:	**1548**	**Principal Risk Description:**	There is a risk of the Health Board being unable to maintain routine, urgent and emergency service provision across the organisation in the event of industrial action by HB staff and staff in other NHS/partner organisations, eg WAST. This is caused by a number of unions balloting members on willingness to participate in strike action, and subsequently members actually taking strike action. This could lead to an impact/affect on patient care, patient safety, delivery of services and organisational reputation. Additionally this could also impact delivery of the Health Board's delivery plan, waiting lists (and associated initiatives) and financial position.
Does this risk link to any Directorate (operational) risks?		1027, 1407, 1550	

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):	3×4=12
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	6
Trend:	



Rationale for CURRENT Risk Score:

The Royal College of Nursing (RCN), The Royal College of Midwives (RCM) and the Chartered Society of Physiotherapy (CSP) have all confirmed ballot results in favour of industrial action which have or could still result in strike action in the UHB. In addition, there has been, and may be further strike action taken by Unite, RCN & GMB members in Welsh Ambulance Service NHS Trust (WAST). Mitigation and contingency measures, together with command and control structures put in place have resulted in a co-ordinated response to minimise impact as far as possible. To date no instances of direct patient harm have been recorded. However, a significant number of patient appointments and surgical slots have had to be re-scheduled impacting on waiting times. There has also been a deterioration in unscheduled care performance. There are currently no future strike dates scheduled whilst negotiations continue between Welsh Government and the unions. However, should negotiations fail, there is a potential for significant concurrent strike action from a number of unions co-ordinated to ensure maximum impact. The risk score has been reduced to reflect the current position.

Rationale for TARGET Risk Score:

The impact has been reduced in March 2023 as the controls that will be put in place are aimed to reduce the impact to patient safety and patient care. The likelihood score has also been reduced as a result of current negotiations.

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**
Industrial Action Planning Group formed for planning, developing contingency measures and response arrangements. Command & Control structures in place at local, regional and national level. Scoping of staff groups included in planned action completed. Proactive compilation of critical service areas from a HB perspective (based on Essential Services Guide) completed. Regular scheduled meetings with Trade Unions in place. Regular liaison with RCN Strike Committee established. Process for requesting derogations including on the day requests. Derogation negotiations (exemptions) in place and will be reviewed for each day of action. Arrangements for students in place. Process developed for scoping scale of staff intentions to take industrial action in place. Process developed for scoping of staff groups in planned action in place. Data capture process in place to determine impact on service delivery, patient care and financial position. Process for measurement of "harm" agreed. Communication strategic approach agreed with staff FAQs, public communications, internal staff communications and partner agencies. Guide for line managers and staff on understanding the derogation process and response developed.	Clarity regarding the intentions of the unions.	Produce a guide for line managers and staff on understanding the derogation process and response	Hughes-Moakes, Alwena	Completed	Complete. Guide for line managers and staff on understanding the derogation process and response developed, and included in risk controls.
		Scoping of scale of staff intentions by developing template and key points for service leads to use.	Morgan, Steve	Completed	Complete.
		Scoping of staff groups included in planned action.	Morgan, Steve	Completed	Completed - clarification received from Trade Unions
		Proactive compilation of critical service areas from a HB perspective	Jones, Keith	Completed	Completed
		Commencement of exemption negotiations with trade unions.	Morgan, Steve	Completed	Completed - meetings held with RCN on 17/11/22 & 2/12/22. Further regular scheduled meetings to be utilised to progress negotiations.
		Clarification of position of students on placement and/or bank, during industrial action.	Oliver, Will	Completed	Nurse student position established - students will be on study days and not in placements. All other students to continue as normal unless otherwise advised by University or national steer.
		Data capture process to determine impact on service delivery, patient care and financial position.	Morgan, Steve	Completed	Completed, and included in risk controls
		Development of response strategy to cover workforce gaps and protect delivery of critical services.	Shakeshaft, Alison	Completed	Action closed as superseded by new action regarding the development of specific response plans when required.
		Process for responding to "on the day" derogation requests to be confirmed with IA Planning Group and RCN Strike Committee.	Morgan, Steve	Completed	Completed, and included in risk controls
		Process for measurement of "harm" to be agreed by IA Planning Group.	Shakeshaft, Alison	Completed	Completed, and included in risk controls

Development of communications strategy in response to emerging position.	Hughes-Moakes, Alwena	Completed	Complete. Communication strategic approach agreed with staff FAQs, public communications, internal staff communications and partner agencies, and included in risk controls.
Specific response plans will be developed following notification from specific Trade Unions on dates they intend to take strike action on.	Shakeshaft, Alison	31/05/2023	Will progress as and when strike dates announced.
Proposed reflection/debrief session planned to consider the learning from the last round of derogation submissions and TU response.	Shakeshaft, Alison	Completed	Complete.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Industrial Action Planning Group Meeting daily	1st					Scoping of measurement process for Health Board response to action.	Shakeshaft, Alison	Completed	Complete. Process developed for scoping scale of staff intentions to take industrial action in place, and included in risk controls.
	Regular updates to Executive Team and OPDP	1st								

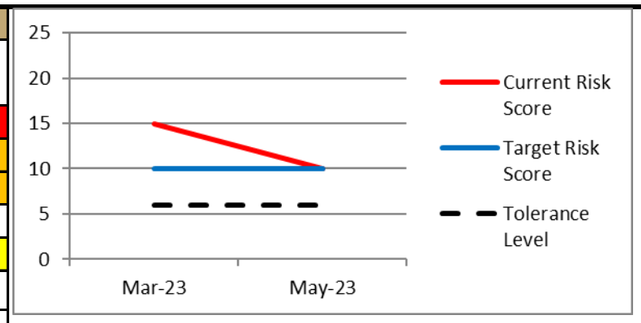
Appendix 2

Date Risk Identified:	Nov-22		
Strategic Objective:			

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	May-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jul-23

Risk ID:	**1531**	**Principal Risk Description:**	There is a risk to provide a safe and sustainable general surgery consultant on-call rota at WGH. This is caused by vacancies and long-term sickness across the General Surgery Consultant rota (1:5) at WGH and reduced capacity to support rotas internally (BGH/GGH Consultants). This could lead to an impact/affect on the ability to continue general surgery at WGH, patient experience, clinical delays, deterioration, and outcomes for patients, the wellbeing of remaining consultants who are already working to full capacity and increased expenditure on agency locum consultants.
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):	5×2=10
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
The current risk score has been reduced to reflect the Board decision in March 2023 to introduce 3 in 1 consultant on-rota at WGH. There are currently 2 consultants on the rota, with no transfers to date. The new rota is under constant monitoring and review to ascertain and address any issues.

Rationale for TARGET Risk Score:
The Board approved a proposal to introduce a 1:3 day-time consultant on-call rota from May 2023 which will make the rota safe. From 5pm-9am weekdays and 5pm, Friday to 9am, Monday, consultant on-call will be provided by either BGH or GGH which will reduce the risk to the Target Risk Score, however this will not address the longer term sustainability of the rota. This will prioritised as part of the development of the Clinical Service Plan in 2023/24.

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**
Adverts out for consultant vacancies when vacancies arise. Current staff backfill with locum consultants to maintain the rota. Requests with agency for consultant cover. Continuously liaison with the rota coordinator at WGH for potential gaps on the rota. Proactive sickness management Escalation to clinical leads Engagement with WGH Medical Staff Committee and public on changes to services Board approval on 31Mar23 to introduce a contingency model of 1:3 rota to WGH with out of hours support from BGH/GGH from 01May23	Vacancies remain due to inability to appoint permanent Consultants to WGH. Due to the fragility of the on call rota there is limited elective capacity for locum consultants, which makes this post less attractive than other Health Boards. Reduced capacity to support this rota internally (BGH/GGH Consultants). Prolonged change to rota may impact on training of surgical doctors in WGH. Concerns from WGH physicians on the wider implications on the emergency service model at WGH	Recruitment of 2 x substantive and 1 x locum positions	Lewis, Caroline	31/10/2023	9 candidates have been shortlisted for the locum post, however there were no suitable candidates for the substantive post. In the process of shortlisting and arranging interviews with a view appoint by Jun23.
		To introduce a contingency model of day time consultant on-call rota in WGH with support from GGH and BGH consultant cover out of hours.	Lewis, Caroline	Completed	Report discussed at Acute Leadership Group, Executive Team and Operational Planning and Delivery Programme (OPDP) meetings. A 1:3 rota was agreed and will commence from 01May23.
		Review the longer term sustainability of general surgery on-call rotas across Hywel dda (recommendation from Getting it Right First Time (GIRFT) review in Jan23 - awaiting final report)	Lewis, Caroline	31/12/2023	This is to be prioritised for early review as part of the development of a Clinical Services Plan. It will also be informed by the success of current recruitment activity.
		Robust plans to be developed for transfer and repatriation of patients	Lewis, Caroline	Completed	SOP has been developed and discussed with clinicians.

Appendix 2

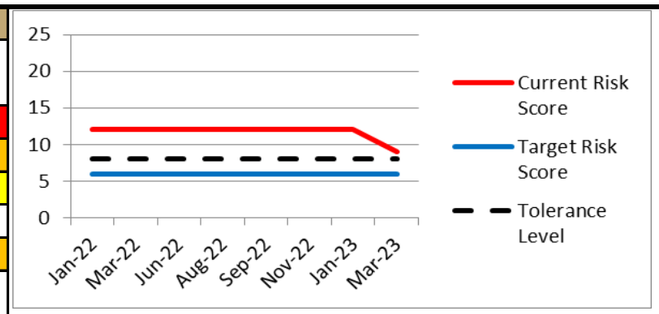
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	WGH Medical Staff Committee established to develop models of sustainability	1st			Management team have presented an SBAR to Acute Leadership Group (Feb23) SBAR to Executive Team and OPDP to agree 1:3 rota (Mar23) General Surgery Report to Board (Mar23)	Assurance to Board on communication and repatriation arrangements	Produce update report to Board in May23 to include details on communications with clinicians and the public, details of repatriation arrangements and accommodation and support for families, the patient experience and the governance arrangements for onward scrutiny	Lewis, Caroline	25/05/2023	To be provided at next risk review
	Reported to monthly General Surgery Business Meetings on each site (BGH/GGH/WGH)	2nd								
	Reported to bi-monthly Scheduled Care Quality, Safety and Experience Group through exception reporting	2nd								
	Assurance to be reported to the Board following introduction of temporary rota	2nd								
	GIRFT report on General Surgery which raised the sustainability of general surgery across 3 sites in Hywel Dda - final report awaited	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:**	Mar-23
Lead Committee:	Sustainable Resources Committee	**Date of Next Review:**	May-23

Risk ID:	**1335**	**Principal Risk Description:**	There is a risk of clinical services being unable to access paper patient records, at the correct time and place in order to make the right clinical decisions and provide effective patient care. This is caused by not having a fit for purpose records management infrastructure along with organisational management arrangements which are insufficient in capacity and scope. This could lead to an impact/affect on the interruption to clinical services, ability to provide effective patient care including compliance with and attainment of nationally agreed Cancer, RTT and Stroke targets, review and fine by the ICO (<£17.5m - £35m fine per episode), increased litigation and negligence claims, complaints and possible redress, non-compliance with GDPR in regards access to patient information, underutilisation of clinical staff, outpatient facilities and day case areas and theatres, inappropriate disclosure of confidential information, missing patient information and confidential documentation, and non-compliance with nationally agreed retention timescales.
Does this risk link to any Directorate (operational) risks?		1434, 1427, 1369, 939,1247, 1419,1445,1627, 708, 1282, 1627	

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×3=9
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	8
Trend:	



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

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Health Board Information Asset Register Identified Information Asset Owners (IAOs) Health Records Policies, Procedures and SOPs Some digitalisation projects commenced, eg, physiotherapy, A&E cards Health Board e-nursing documentation implementation Planning Objective 5M aligned to SDODC for reporting 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 Acquisition of a electronic document management system (EDMS). Lease of a second storage facility Scanning of 227,500 non active patient records	An absence of a sustainable long term solution for records management and storage In its paper form, the health record is not under the accountability of any one Executive and hence the degree of influence is potentially compromised. Reduced understanding or records types (across various services) and those appropriate for scanning, long term storage or destruction, leading to a non-consistent criteria for records management during the records life cycle from creation, to retention and ultimate destruction. With the requirement to implement and standardise health records protocols across all services.	Develop and implement scanned health record solution over the next 12 years depending on the split between determination of scanning and deep storage (DHR).	Carruthers, Andrew	31/03/2033	Ã‚£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	Completed	SBAR submitted to Executive Team in October 2022 outlining the plan for future records management arrangements. Further discussions are now required to fully implement the transition and move records to one centralised locality.
		Director of Operations to meet with Executive Leads with professional responsibility for clinical records to determine agreement on future record management arrangements, required resources and project support. This will be largely driven by individual information asset owners providing comprehensive schedules of information assets under their responsibility.	Carruthers, Andrew	31/03/2023	Meeting to be arranged.

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	Information Asset Owner Registers Group	1st			Records Storage SBAR - Executive Team (Jul21)					
	Digital Health Records Project Group to oversee delivery of enabling work	2nd								
	SDODC overseeing delivery of Planning Objective 5M	2nd								
	IA Records Management Report (limited - follow up (reasonable) in Health Records only	3rd								