Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	25 January 2024
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/Board Secretary Charlotte Wilmshurst, 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.

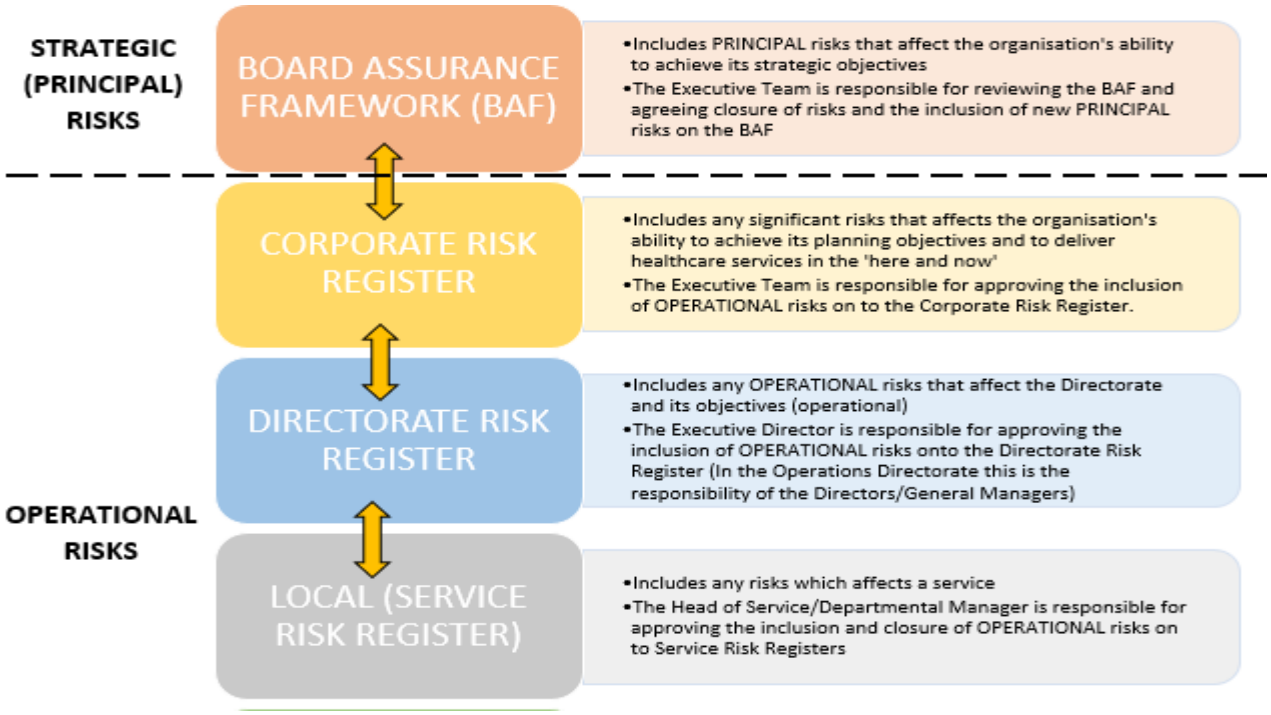
Cefndir / Background

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 September 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 September 2023:

Total Number of Risks as at December 2023	19	
New/Escalated	1	*See note 1*
De-escalated/Closed	4	*See note 2*
Increase in risk score ↑	5	*See note 3*
Reduction in risk score ↓	1	*See note 4*
No change in risk score →	12	

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 the following risks, the detail is being reported to In-Committee Board, to provide discussion and assurance:

- 1352 (Risk of business disruption and delays in patient care due to a cyber-attack); and
- 1328 (Risk of harm to staff, patients and critical assets due to insufficient physical security measures).

Details on the 17 remaining corporate risks are included in Appendix 2.

The Executive Risk Group (ERG) have agreed to review the risk statements for all corporate risks during Q4 of financial year 2023/24 to ensure that they accurately reflect the risks currently facing the Health Board.

The 19 corporate risks are detailed on the below heat map:

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 5
CATASTROPHIC 5			813 (→) 1531 (↑) 1745 (NEW)	1027 (→) 1664 (→) 1699 (↓)	1642 (→)
MAJOR 4			1350 (→) 1433 (→)	1352 (→) 1649 (→) 684 (↑) 1708 (↑)	797 (→) 1032 (→) 1328 (↑) 1657 (→)
MODERATE 3			1335 (→)		1548 (↑)
MINOR 2					
NEGLIGIBLE 1					

Note 1 – New Risks

Since the previous report in September 2023, 1 new risk has been added to the CRR:

Risk	Lead Director	New / Escalated	Current Risk Score (Likelihood x Impact)	Rationale for Current Risk Score
1745 – Risk of not being able to safely deliver services due to ageing estate and	Director of Operations	New	**3x5=15**	The current risk score is based upon the level of detailed information the Estates department has for its buildings, plant and infrastructure,

infrastructure across the Health Board *(approved by Executive Risk Group in October 2023)*				including external reports, risk information and Estates and Facilities Performance Management System (EFPMS) data submitted to Welsh Government (WG), clearly articulating the scale of backlog and deficiencies across the Health Board. The Health Board has been working closely with WG for many years to develop a programme business case (PBC) to modernise its estate. In 2018/2019, the Health Board developed a PBC for circa £528m for modernisation of its 4 acute sites. WG requested the Health Board to review this PBC to consider the 'A Healthier Mid and West Wales' (AHMWW) programme timeframe. In 2020, a revised PBC was completed with a cost of circa £246m to keep Withybush General Hospital (WGH) and Glangwili General Hospital (GGH) operational whilst the AHMWW programme was being delivered. The investments at Bronglais General Hospital (BGH) and Prince Philip Hospital (PPH) remained the same. In 2021, a further review for WG was undertaken to carry out priority works excluding elements included in the AHMWW programme, such as ward refurbishments and fire precautions upgrades at WGH & GGH. This option was agreed and costed at circa £87m for the 4 acute sites. In 2022, WG requested a further piece of work to provide priority schemes specifically for areas of patient safety, the budget was again re-evaluated at circa £130m.

				This exercise was concluded in March 2023 and submitted to NHS Wales Shared Services Partnership Specialist Estates Services (NWSSP-SES) for draft scrutiny. *Note: a detailed review of the risk is scheduled to be undertaken at Health and Safety Assurance Committee at its meeting in January 2024.*

Note 2 – De-escalated / Closed Risks

Since the previous report to Board in September 2023, 4 risks have been de-escalated from the CRR:

Risk	Lead Director	Closed / De-escalated	Reason
1382 - Risk to patients and staff due to a lack of assurance of safe estate as a consequence of Reinforced Autoclaved Aerated Concrete (RAAC) (WGH)	Director of Operations	De-escalated	The risk score has been reduced to tolerance level to reflect the works undertaken and was agreed by Executive Risk Group to de-escalate the risk in October 2023. All compromised wards were decanted in September 2023, and areas have been secured with authorised access only allowed via keypad entry systems. Other ground floor areas have been fully propped and signed off by the structural engineers as being safe to occupy. Project plans are in place in terms of when remedial actions will be undertaken, and capital has been secured to fund these works. It is envisaged that all wards will be re-occupied by March 2024. Remedial works on other areas are due to commence in April 2024, with a view to completion by September 2024 In January 2024, the Health Board is looking to stand down the internal major incident as declared in August 2023, and to manage the ongoing situation within local governance arrangements.

1559 - Risk of power outages across all clinical and corporate functions of the Health Board due to external influences	Public Health	De-escalated	The risk was agreed for de-escalation at Executive Risk Group in October 2023 due to current control measures in place to manage risk.
1707 - Risk of breaching Capital Resource Limit (CRL) in 2023/24 due to additional significant demands for funding	Director of Strategy and Planning	De-escalated	The risk was agreed for de-escalation at Executive Risk Group in October 2023 as the Health Board received funding approval from WG on 29 August 2023 to support the remedial works at WGH relating to RAAC, as well as the phased fire works on the site.
1719 - Risk of loss of Radiology services across the Health Board from March 2025 due to delayed implementation of Radiology Information Systems Procurement (RISP)	Director of Operations	De-escalated	The risk was agreed for de-escalation at Executive Risk Group in December 2023 due to progress made with contract negotiations.

Note 3 – Increase in Current Risk Score

Since the previous report to Board in September 2023, the score of 5 risks have increased:

Risk	Risk Owner	Previous Risk Score: Sept 2023 (Likelihood x Impact)	Risk Score: Dec 2023 (Likelihood x Impact)	Date risk reviewed	Rationale for Current Risk Score
684 - Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Director of Operations	4x3=12	4x4=16 (↑)	18/12/2023	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. Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) scanners have been replaced and has reduced the frequency of machine downtime compared to previous experience. The risk score is noted as 16, reflecting that some equipment has been installed and is operational, however further investment is required given recent breakdowns of key imaging equipment. 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 not been secured (for financial year 2023/2024). As at December 2023, confirmation on funding is awaited but early indications are that this may not be fully available, with the likelihood that it will only fund the replacement of one X-ray room. Gamma camera at Withybush General Hospital (WGH) is the only scanner of its nature in the Health Board and has experienced a breakdown in August 2023 due to intermittent failures which resulted in several Healthcare Inspectorate Wales (HIW) reportable Ionising Radiation (Medical Exposure) Regulations (IRMER) incidents. This item of equipment is on the current priority list of items to replace as at November 2023.

					While a new CT scanner has been obtained and installed at GGH, the original CT scanner has had a number of breakdowns due to its age. The technology on this scanner is also now out of date and impacts directly on the resilience of the service at our major trauma site in the Health Board. Like-for-like replacement of existing equipment is not necessarily a cost-effective method of maintaining services and in certain circumstances does not meet updated regulatory compliance or meet the requirements of maintenance warranty agreements. This means there will need to be upgraded infrastructure such as air handling units, water chiller systems and the size/accommodation for modalities at an initial increased cost but representing long term savings and service resilience overall.
1708 - Risk of increasing fragility in primary care contractor services due to recruitment challenges	Director of Primary, Community and Long Term Care	3x4=12	4x4=16 (↑)	18/12/2023	The capacity of the Health Board in terms of staffing to absorb further contract reform will impact on the ability to effectively deliver services, and a detrimental impact on staff welfare. With new contract implementation relating to Optometry due in January 2024, there is an expectation of a shift from hospital care to the community, however the model is untested in terms of contractor capacity and skill set. In addition, the potential risk of RAAC planking in premises used by Primary Care contractors to deliver the full range of contracted services could have a further impact on service stability and sustainability.

1548 - Risk to the Health Board maintaining service provision due to industrial action	Director of Public Health	4x3=12	5x3=15 (↑)	21/12/2023	This risk has increased as the British Medical Association (BMA) have declined an offer of 5% uplift (1.5% uplift for Junior Doctors including staff, associate specialist and specialty doctors (SAS Doctors) for 2023/2024 to basic pay. Ballot notices were received by employers (both Hywel Dda Health Board and NHS Wales Shared Services Partnership (NWSSP)) detailing that the ballot to members would run until December 2023. This applies to Junior Doctors only. Confirmation has been received that the BMA reached the 50% threshold required to mandate action for the period January to June 2024. Mitigation and contingency measures, together with command-and-control structures put in place during periods of previous action by Trade Unions resulted in a co-ordinated response to minimise impact as far as possible, and this has been re-established. The BMA have advised that they intend to take an initial 72 hours consecutive period of industrial action from 15 January to 18 January 2024. This will be a full walk out of all junior doctors including those providing emergency cover. No formal notification has been received relating to the SAS Doctors or Consultants to date. Additionally, we are expecting to receive formal notice from the British Dental Association notifying of their intention to ballot members in the new year. This will be a full walk out of all junior doctors including those providing emergency cover. No formal notification has been received relating to the SAS Doctors or Consultants to date. Additionally, we are expecting to receive formal notice from the British Dental Association notifying of their intention to ballot members in the new year.

1531 - Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Director of Operations	2x5=10	3x5=15 (↑)	21/12/2023	The risk score has increased since the risk previously reported to Board in September 2023, with the risk score increasing in October 2023 to 20 to reflect the uncertainty in maintaining the on-call rota with GGH and BGH consultants withdrawing from the model. The introduction of a Medacs locum allowing the surgical emergency service at WGH to continue on a 1:4, 24/7 rota with 2 substantive consultants, 1 NHS locum and 1 Medacs. No issues have been noted to date. The rota remains fragile due to the reliance on Medacs locum cover and the cost and risks that this involves. An NHS locum consultant was appointed in November 2023, but withdrew. There will now be a continued reliance on Medacs locum cover. The speciality doctor rota is also being supported by a Medacs locum but a 12 months fixed term post has been appointed to which is an exit strategy for the Medacs locum on that rota.
1328 - Risk of harm to staff, patients and critical assets due to insufficient physical security measures	Interim Director of Nursing, Quality and Patient Experience	4x4=16	5x4=20 (↑)	22/11/2023	Detail provided within In-Committee paper.

Note 4 – Reduction in Current Risk Score

Since the previous report to Board in September 2023, the score of 1 risk has reduced:

Risk	Risk Owner	Previous Risk Score: Sept 2023 (Likelihood x Impact)	Risk Score: Dec 2023 (Likelihood x Impact)	Date risk reviewed	Rationale for Current Risk Score
1699 - Risk of loss of service capacity at WGH due to surveys and remedial work relating to RAAC	Director of Operations	5x5=25	4x5=20 (↓)	18/12/2023	Due to the works completed to date, the likelihood score of this risk has been reduced to a 4. All RAAC affected inpatient wards were vacated as of August 2023. Detailed surveys complete in Wards 7,8/Critical Care Unit (CCU),10, 11 & 12 with remedial work requirements identified. Works scheduled to complete in Wards 7 and 11 by December 2023. Works completed in Wards 9 & 12 and reoccupied as medical capacity from October & November 2023. Throughput of inpatient elective surgery, as would ordinarily be delivered from Ward 9, remains low with same day admission pathway to Day Surgery Unit (DSU), and gynaecological elective patients on Ward 4. Medical patients vacated the DSU footprint in October 2023 when it returned to service with resumption of day case surgery on site. Medical patients withdrawn from the Pembrokeshire Haematology & Oncology Day Unit (PHODU) in November following reopening of Ward 12. This enabled reinstatement of full service to PHODU. Suitability of Ward 3 to be utilised as outpatient therapy capacity is being scoped. Visual survey in Outpatients A has identified significant RAAC related issues (P1 planks). Detailed survey completed with remedial works to follow, scheduled to return to service at end of June 2024. Alternative locations for outpatient provision being coordinated and scoped by scheduled care directorate, and completed as at December 2023.

					Schedule for detailed survey programme for ground floor areas developed with programme to complete by end of March 2024. Remedial works to follow detailed survey in physiotherapy area, resulting in need to decant from February - end of June 2024. Remedial works on Wards 8/Critical Care Unit (CCU),10 are scheduled to commence in January 2024, and complete in March 2024.

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.
- **NOTE** that the Executive Risk Group (ERG) has agreed to review the risk statements for all corporate risks during Q4 of financial year 2023/24, to ensure that they accurately reflect the risks currently facing the Health Board

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Included within the body of the report.
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 DECEMBER 2023

Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Dec-23	Trend	Target Risk Score	Risk on page no...
1642	Risk of Health Board not meeting statutory requirement to break even 23/24 due to significant deficit position	Thomas, Huw	Finance inc. claims	6	5×5=25	5×5=25	→	3×4=12	6
1027	Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	4×5=20	→	3×4=12	12
1032	Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	5×4=20	→	3×4=12	17
797	Risk to the ability to deliver ultrasound services due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	8	5×4=20	5×4=20	→	3×4=12	24
1657	Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 23/24 due to demand exceeding capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	5×4=20	→	3×4=12	28
1664	Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	4×5=20	→	2×5=10	31
1699	Risk of loss of service capacity at WGH due to surveys and remedial work relating to RAAC	Carruthers, Andrew	Service/Business interruption/disruption	6	5×5=25	4×5=20	↓	2×5=10	37
1328	Risk of harm to staff, patients and critical assets due to insufficient physical security measures *(reported to In-Committee Board)*	Daniel, Sharon	Safety - Patient, Staff or Public	6	4×4=16	5×4=20	↑	3×2=6	N/A
1352	Risk of business disruption and delays in patient care due to a cyber attack *(reported to In-Committee Board)*	Thomas, Huw	Statutory duty/inspections	8	4×4=16	4×4=16	→	3×4=12	N/A
1649	Risk of insufficiently skilled workforce to deliver services in Annual Plan 23/24 due to limited labour market	Gostling, Lisa	Workforce/OD	8	4×4=16	4×4=16	→	3×4=12	42
1708	Risk of increasing fragility in primary care contractor services due to recruitment challenges	Paterson, Jill	Service/Business interruption/disruption	6	3×4=12	4×4=16	↑	2×4=8	49
684	Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Carruthers, Andrew	Service/Business interruption/disruption	6	4×3=12	4×4=16	↑	2×4=8	53
1745	Risk of not being able to safely deliver services due to ageing estate and infrastructure across the Health Board	Carruthers, Andrew	Safety - Patient, Staff or Public	6	NEW	3×5=15		2×5=10	58
1531	Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	6	2×5=10	3×5=15	↑	2×5=10	61
1548	Risk to the Health Board maintaining service provision due to industrial action	Gjini, Ardiana	Safety - Patient, Staff or Public	6	4×3=12	5×3=15	↑	2×3=6	64
813	Risk of non-compliance with the Regulatory Reform (Fire Safety) Order 2005 due to ageing infrastructure	Carruthers, Andrew	Statutory duty/inspections	8	3×5=15	3×5=15	→	1×5=5	67
1350	Risk of not meeting the 75% SCP waiting times target for 2022 - 2026 due to diagnostics capacity and delays at tertiary centre	Carruthers, Andrew	Quality/Complaints/Audit	8	3×4=12	3×4=12	→	2×4=8	73
1433	Risk to the ability to maintain routine and emergency services in the event of a severe pandemic	Gjini, Ardiana	Service/Business interruption/disruption	6	3×4=12	3×4=12	→	2×4=8	76
1335	Risk to the ability to access paper patient records in a timely manner due to existing records management infrastructure	Carruthers, Andrew	Quality/Complaints/Audit	8	3×3=9	3×3=9	→	2×3=6	79

Assurance Key:

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

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

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

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

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 Equity	Minimal or no impact on our attempts to improve health equity	Minor impact on our attempts to improve health equity or low level of certainty on the impact we are having on health equity	Moderate impact on our attempts to improve health equity or a lack of sufficient information that would demonstrate this. Indications that we are not having a positive impact on health improvement or health equity	Major impact on our attempts to improve health equity. Validated data suggesting that 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

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

RISK ASSESSMENT - FREQUENCY OF REVIEW

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

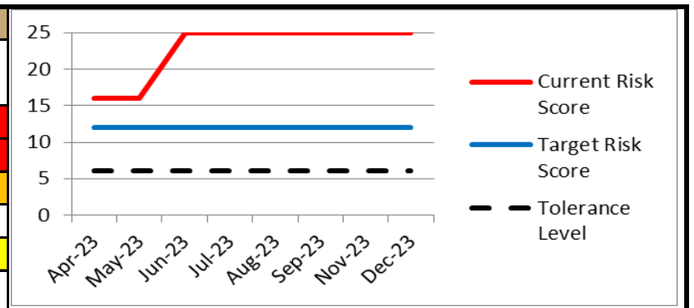
Corporate Risk Register

Date Risk Identified:	Apr-23		
Strategic Objective:			

Executive Director Owner:	Thomas, Huw	**Date of Review:**	Dec-23
Lead Committee:	Sustainable Resources Committee	**Date of Next Review:**	Jan-24

Risk ID:	**1642**	**Principal Risk Description:**	There is a risk that the Health Board deficit is unaffordable for Welsh Government. 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. This could lead to an impact/affect on the sustainability of the Health Board's financial position, with a cash funding shortfall and the ability to meet payments as and when they fall due from end of February 2024. There will also be an impact on the ability to meet Ministerial priorities of breaking even, along with 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):	5×5=25
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
The draft Annual Plan for 2023/24 of £112.9m is unacceptable to Welsh Government (WG) and has led to a further deterioration in an already unsupportable underlying deficit position which will impact future years. 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 from the end of 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. Through our 2023/24 planning process, operational plans to address the recurrent financial savings gap and operational variation have not provided sufficient assurance to mitigate the current financial trajectory. Actual delivery also falls short of submitted plans, adding further assurance concerns. In October 2023, WG confirmed conditional recurrent and non-recurrent funding to increase core allocations recognising the impact of the macro-economic inflationary pressures and COVID-19 legacy costs. This has given rise to a Target Control Total requirement of £44.8m, which includes a further £11.3m of savings requirement. This has superseded the £112.9m Annual Plan. 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.	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. 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.	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.	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~~ ~~31/08/2023~~ ~~10/12/2023~~ 29/02/2024	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. A meeting was held with WG week the week of 19th June 2023 where final deadlines and actions were agreed. The September Quarterly TI meeting was held with WG on 19th September, and WG were not yet satisfied with the organisations response to the financial improvements required to demonstrate a significant improvement in the current forecast deficit. A further requirement is imminent to be communicated, which would create a further stretch target to achieve. A control target has now been communicated to all Health Boards in Wales.

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. The Core Delivery Group (CDG) and Financial Control Group (FCG) meet on a weekly basis, led by the Director of Workforce and OD (CDG) and Director of Finance (FCG) as SROs. This reports into the Executive Team weekly, and the Escalation Steering Group (ESG) for TI, 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.	Develop a revised roadmap to financial sustainability based on the Board's agreed key priorities and revised Planning Objectives in line with our Strategy.	Thomas, Huw	~~30/06/2023~~ ~~31/08/2023~~ ~~31/11/2023~~ 31/01/2024	A focused Executive Team Away Day considered mitigating actions and their delivery; a six week action timetable has commenced. This is the first step towards developing a roadmap and will link to the clinical services plan. The current priority areas have identified a clear route to achieve a significant reduction in the planned deficit, with further work submitted and reviewed in the November 2023 Public Board meeting. In December 2023, a presentation focusing on financial roadmap to recovery was presented to Board seminar.
	Following the July meeting between the Ministers and Chief Executives, the organisation is required to develop mitigation plans to address the forecast in-year deviation from plans in addition to achieving a 10-20-30% improvement against the submitted financial plan.	Moore, Steve	31/03/2024	A recovery workshop was held on the 26 July 2023 with Executives, service and Finance leads to discuss and agree urgent actions to address the financial position. The meeting focussed on the key driver of high cost agency and locum expenditure across professional groups. Action plans were submitted to Board on the 10 August 2023 for consideration/decision ahead of the Welsh Government (WG) meeting on 11 August 2023, which were agreed and submitted. Board had endorsed the work to be delivered at pace, requesting further updates at each future meeting. Progress was reported to September Board, with the latest assurance levels of delivery not yet recovering the original planned deficit. WG have confirmed that a Ministerial and cabinet review process is underway and feedback will be provided imminently. The

					outcome from this process was communicated and received on 20 October 2023, where WG confirmed the need for all Health Boards to deliver an additional 10% improvement on their planned deficits (£11.3m for Hywel Dda), and have issued a Target Control Total of £44.8m for the Health Board. In November 2023, the Chief Executive issued control totals to each delegated Executive officer and directorate, totalling the £11.3m additional requirement. This will be monitored through the monthly financial reporting cycle, and Executive Directors are required to update the Chief Executive on their trajectory.

ASSURANCE MAP				Control RAG	Latest Papers	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level	Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance against operational plans and targets through Performance KPIs In-month financial monitoring	Performance against plan monitored through Improving Together Meetings.	1st			* Mth 2 Finance Report - Sustainable Resources Committee June 2023 * Mth 3 Finance Report - Board July 2023 * Mth 4 Finance Report - Sustainable Resources Committee August 2023 * Mth 5 Finance report - Board	None				
	Sustainable Resources Committee oversight of current performance	2nd								
	Transformation & Financial Report to Board & SRC	2nd								

WG scrutiny through monthly monitoring returns	3rd			September 2023 * Mth 6 Finance report - Sustainable Resources Committee October 2023 * Mth 7 Finance report - Board November 2023 * Mth 8 Finance Report - Sustainable Resources Committee December 2023					
WG scrutiny through revised monthly Monitoring Returns (specific supplementary templates) and through Finance Delivery Unit	3rd								
Audit Wales Structured Assessment process	3rd								

Corporate Risk Register

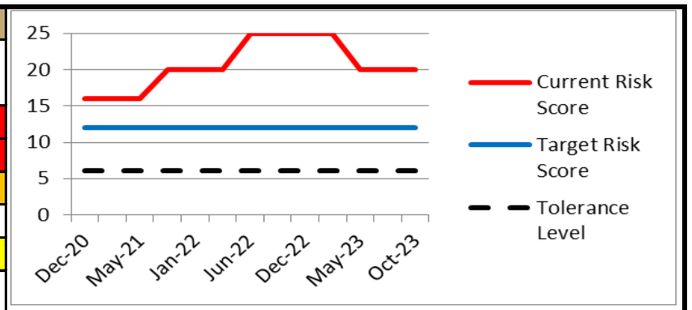
Date Risk Identified:	Nov-20		
Strategic Objective:	5. Safe and sustainable and accessible and kind care		

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Oct-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Nov-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 (including out of hours), community and social care services), related to workforce compromise and increasing levels of demand and acuity. 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?	1649, 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, 695

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. 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 was reduced to 20 based on likelihood. While performance metrics are demonstrating incremental improvements, as at October 2023 the current risk score to remain at 20.

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.	# 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'	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 GGH
		Incorporate and deliver actions that will address control gaps into the Health Board's UEC Plan.	Carruthers, Andrew	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. The Annual Recovery Plan for 2023/24 outlines the UEC improvement actions being progressed during the current financial year in support of this longer-term objective. These are overseen and monitored by the TUEC steering group, chaired by the Director of Operations.
		To implement the Standard for Discharge to Assess in accordance with the WG 6 Goals Guidance	Matthews, Rhian	Completed	This work has now been superseded by the policy goal work, with Policy Goal 5 rolled out across both GGH and PPH, led by the QIST team. Weekly progress reports are sent to the General Manager, Heads of Nursing and Senior Nurse Managers.

# Establishment of a D2A Escalation Transfer panel which provides senior oversight of delays, assesses risk of the delay to the patient and organisation in terms of flow compromise # To optimise step down bed capacity in the community across care homes and community hospitals # SRO in place to lead agreed Urgent and Emergency Care (UEC) programme # Supernumery 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).	# 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 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	To review findings of local Peer Review and data analysis to inform SDEC model 2023/24	Matthews, Rhian	Completed	A review of the findings has been completed, with proposals derived from the Peer Review agreed. Further enhancements to the site specific SDEC models will be overseen by the Managing Complexity and Conversion Workgroup, next meeting scheduled for 11th October 2023. The outcomes of this meeting will inform future actions for this risk.
		To review findings of GP Out Of Hours (OOH) Peer Review, and implement actions as part of planning objective 3A	Matthews, Rhian	Completed	Review has been undertaken, and work is ongoing as part of the TUEC programme to look at closer working links between in-hour Intermediate Care GPs and GP OOHs services, and GP OOH service having access to the community and Local Authority pathways
		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	Paterson, Jill	30/11/2023	Work is underway across the three counties.

		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 # Inconsistent clinical provision for the Out of Hours (OOH) Service # 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.				

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								

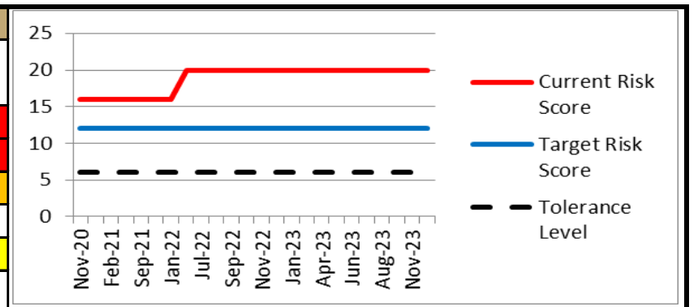
Appendix 2

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Dec-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jan-24

Risk ID:	**1032**	**Principal Risk Description:**	There is a risk to the delivery of timely diagnosis to those on the ASD waiting lists, and the commencement of interventions for Psychological Therapies (Integrated Psychology Therapies - Adult and Learning Disability) within required timescales. This is caused by an increase in referrals and increasing DNA rates, as well as recruitment challenges, and lack of appropriate estates. This could lead to an impact/affect on those currently awaiting diagnosis and intervention, resulting in delays in care and appropriate treatments in a timely manner which may lead to poorer patient outcomes, and delayed adjustments to educational needs. There will also be an impact on the ability of the Health Board to meet Welsh Government targets (diagnosis of ASD within 26 weeks, and commencement of interventions for Psychological Therapies within 26 weeks) which could lead to increased scrutiny from regulators, and escalation from Welsh Government. This in turn could result in adverse publicity and a reduction in stakeholder confidence.
Does this risk link to any Directorate (operational) risks?		138, 1249, 1286, 1287, 1392, 1455, 1422, 1524, 1290, 1260, 1699, 1745, 1414	

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 is experiencing significant waiting times as a result of increasing demand levels which are exceeding pre-pandemic levels, compounding the backlog due to Covid restrictions. Due to increasing Did Not Attend (DNA) rates, 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. As at October 2023, there are currently 2,478 clients on the waiting lists, with the longest wait noted as 215 weeks. The average wait is noted as being 74 weeks. For Autism Spectrum Disorder (ASD), a meeting took place with the Delivery Unit to establish trajectories, along with the commissioned service which since have been agreed in March 2023. The DU were unable to provide trajectories, therefore Health Board has agreed to a 1% trajectory. For psychological services a trajectory is now in place for 1% per month. This risk was reviewed on the 21/12/2023 - on the basis on improved CAMHS Part 1 position and a deterioration in ASD/ADHD, this risk score remains the same.

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.

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 Attend Anywhere 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 received in 2022/23 for ND service Services are in contact with individuals to provide information regarding mainstream/Tier 0 support, wellbeing at home and guidance should their situation deteriorate. 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. Consultation service in place within Childrens Neurodevelopmental Service and access to integrated ASD hubs Quarterly meetings with Women and Children's Service to strengthen interdepartmental working. ND 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	Estates issues remain a challenge as identified in the risk narrative. Information not currently included on Health Board website and QR codes due to IT difficulties Additional funding received in 2022/23 for ND service on a fixed term basis until 2025 Current resource does not provide sufficient capacity to meet demand	Keeping in touch processes to be in place (Adult Inpatient and Learning Disabilities Services).	Bassett-Gravelle, Ms Lisa	Completed	Psychology In May 2023, 52 (40.00%) patients out of 130 were waiting less than 26 weeks to start psychological therapy in the Learning Disabilities Psychology Service. 78 (60%) were waiting more than 26 weeks. This is a month on month 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 keeping in touch letters in easy read have been sent out to all on the waiting list. We have recruited 8b psychologist who commences in August 2023. OT Urgent referrals taking priority. • Continue to prioritise referrals and support workforce modelling as part

not materialise. Workforce Management Group has been established which meets monthly. Trajectories have been identified for IPTS and there are systems in place to monitor waiting lists at service level, through IPAR and Directorate and service level review meetings. Monthly meetings with Estates to look at accessing/leasing/enhancing the current MH estates with a view to increase MH estate footprint. 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 Integrated Autism Service. Public facing webpages with QR codes are also being developed to give further guidance and support whilst individuals are waiting. Keeping in touch template letters developed within further areas, and monitored by individual service leads. Service Leads secured 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 (3 year programme). Quarterly meetings with the NHS Executive, Welsh Government and Service Leads at the Health Board SMS functionality in place for ND and IPTS to improve attendance and decrease instances of DNA					of service improvement work underway. • 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. • 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. 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. Services developing a professional lead physio for LD JD. All LD Therapies Service Manager EOC has advised the 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.

Identify alternative venues/space to hold clinics(CAMHS & Psychological therapies).	Lodwick, Angela	~~31/03/2023~~ 30/12/2023	Challenges continue in access to Estates to undertake assessments across the three counties. Remains ongoing working with Estates and submitting capital bids to WG for monies to fund works within allocated buildings to make them fit for purpose. SBAR being developed to repurpose the use of Tudor House. RAAC issue is extenuating the estates position with some areas within Pembrokeshire/Ceredigion not being available to undertake assessments/interventions.
Identify alternative venues/space to hold clinics (Integrated Psychological Services).	Marshall, Selina	~~31/07/2023~~ 31/11/2023	Rolling programme of groups being developed to enable additional clinical capacity within the service. some groups have already been implemented.
Identify alternative venues/space to hold clinics(Commissioning /CDAT).	Richards, Matthew	Completed	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. Due to a revision of the risk narrative, this action is no longer relevant and therefore noted as complete.
Directorate to transfer all service data collection processes to WPAS.	Amner, Karen	Completed	Delays to the Dementia Wellbeing Service, Integrated Autism Service, Perinatal, Memory Assessment Service migration delayed due to capacity within the Digital team to test and develop system at required pace. As at October 2023, all data for the relevant services noted on the risk have been transferred, therefore to close action.

Review workforce skill mix in light of any potential new funding received from WG for Neurodevelopmental services.	vaughan, Catherine	31/03/2024	Workforce reviewed and skill mix within team expanded to ensure a multidisciplinary approach in order to deliver an integrated multi disciplinary service in respect of the fixed term funding for 2023/24 received on behalf of the Regional Partnership board(RPB).
Monitor the use of SIFT monies for service development. The Director of Finance has given an undertaking that this will be funded as discussed and agreed at a Directorate Improving Together Session in April.	Carroll, Mrs Liz	31/03/2024	During the budget setting process in Month 7, the £575k for procurement for EMDR and ASD was not factored into the Directorate position despite this having been agreed following agreement at Public Board in September 2022. This was raised by the Finance Business Partner during the budget setting process with Finance colleagues. This leaves a deficit in this years budget. To be reviewed in the DITS meeting on the 27th October 2023.
As a result of Reinforced Autoclaved Aerated Concrete (RAAC) found at Withybush General Hospital site and the internal major incident that has been declared, some areas previously used by the Directorate have now been withdrawn. The Directorate attend the Outpatients RAAC Subgroup (Bronze) where the impact on the Directorate and potential solutions are being worked through in collaboration with the wider Health Board. Linked to Estates Risk 1711.	Carroll, Mrs Liz	29/03/2024	08.11.23 - Bronze RAAC Sub Group have identified no impact for MHLD services due to relocating or virtual clinics.
Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic TNA that can be reviewed at regular intervals and monitored for compliance.	Temple-Purcell, Rebecca	~~30/11/2023~~ 31/12/2024	In progress, working with Workforce to develop a training needs and analysis tool. MH&LD to act as a pilot for this pending further roll out across the HB.

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) 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	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	Completed	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. Katie O'Shea has implemented this and all staff have received training and aware of expectations.
	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd					Outcome measures to be in place to measure effectiveness/quality of services provided(Adult Inpatient and Learning Disabilities Services).	Bassett-Gravelle, Ms Lisa	Completed	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. 15/06/2023 both easy read and electronic forms completed, meeting with CTLD managers taking place to roll out the new forms.

MH&LD QSE Group overseeing patient outcomes	2nd			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.		Outcome measures to be in place to measure effectiveness/quality of services provided(Commissioning /CDAT).	Richards, Matthew	Completed	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. Due to the reframing of the narrative of this risk, CDAT is now out of scope therefore action completed
Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC	2nd								
W-PAS Internal Audit (reasonable assurance)	3rd								
An update was requested by the Chair and provided for the August Quality, Safety, Assurance Committee.									

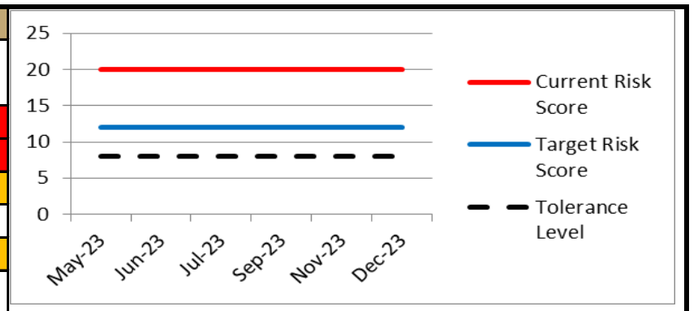
Appendix 2

Date Risk Identified:	Nov-19		
Strategic Objective:			

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Dec-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jan-24

Risk ID:	**797**	**Principal Risk Description:**	There is a risk of being unable to provide a full range of ultrasound services including antenatal across the Health Board. This is caused by the retirement and resignation of current sonography staff, low availability of sonographers UK wide, 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, 1658	

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:	8
Trend:	⇔



Rationale for CURRENT Risk Score:
Despite best efforts, the service remains fragile. There are still vacancies which remain unfilled, but there has been an improvement in recruitment due to the financial picture across Wales and the cessation of use of agency staff above AFC pay rates. Even if all vacancies were recruited to, the Health Board would still not have the capacity to meet current demand (as at December 2023 there are 1547 patients waiting 8 weeks plus for non-obstetric ultrasound). Long term vacancies exist in Withybush. There are 2 potential retirements at PPH in the near future and a number in BGH, which constitute a significant percentage of the workforce, though there are maternity returns due back in the near future. There will be an inability to secure agency staff due to the current financial climate of the Health Board. Whilst a modality lead at Withybush has been appointed and commenced in November 2023, the ability to undertake governance and audit requirements still needs to be embedded, however it is noted that a Radiology Ultrasound Governance group has been set up in June 2023. More sonographers are due to be trained from January 2024, however training takes two years to complete. 3 of the 4 vacancies as advertised in July 2023 were successfully appointed to, though this has not resulted in additional capacity to the service as roles have been given to previous locum staff.

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. Ultrasound Control Group in place	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. Ultrasound Control Group has not met since July 2023 due to operational pressures. While process in place regarding the movement in staff, due to current staffing levels and pressures this is not being implemented	Develop a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.	Jones, Keith	~~31/12/2022~~ ~~31/10/2023~~ 31/01/2024	Discussions have taken place with Head of Maternity Services. Protocols and training being developed. Implementation date to be agreed. A meeting was scheduled for 20th June 2023 with CVUHB in order to assist with the development of a training plan but there was no midwifery representation available on the day. Midwifery services approached Powys for assistance with training midwives sonographers, and appointed 2 midwives to join the ultrasound Course for January intake 2024. However, Powys are unable to support training in the same original capacity and the certainty around midwife training in January is currently unknown. Ultrasound Control Group was arranged for 7th December, but re-arranged for January 4th 2024 due to availability.
	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 November 2023, we are currently training 3 members of staff (2 at GGH and 1 at PPH) with a plan to train 1 more at GGH in September 2024. Training positions take two years to complete. Clinical Educator role has been developed, with job descriptions presented to panel in June 2023. To date, recruitment has been unsuccessful, but alternative arrangements are being explored with existing staff.

Work with the workforce planning team to build a sustainable workforce plan for ultrasound services.	Roberts-Davies, Gail	~~31/10/2023~~ 31/03/2024	Fortnightly workforce planning meetings in place with colleagues from Radiology and Workforce in attendance. Stakeholder mapping exercise being undertaken as at December 2023.
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~~ 31/01/2024	Initial contact made with workforce planning team re: establishment review work. This has been discussed in the Radiology Use of Resources Meeting. Further discussions took place about 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 December 2023, however a focussed Ultrasound Control Group has been set up, recognising the imminent loss of service. A Radiology dashboard is in place which provides activity and demand. A new dashboard is in the development stage which is aligned to ARCH developments, and currently in testing phase in December 2023. As of November 2023 there have been some significant staff changes on various sites with the loss and gain of sonographer hours. D&C needs further review and is being linked into Workforce planning.
To consider possible insourcing options to support the service	Roberts-Davies, Gail	31/03/2024	Head of Radiology has liaised with contacts in NWSSP Procurement. The tender submissions have been received and evaluation of responses to undertaken in November 2023. In December 2023, confirmation received of allocation of recovery funding for the ultrasound insourcing contract approved to the end of the current financial year.

Appendix 2

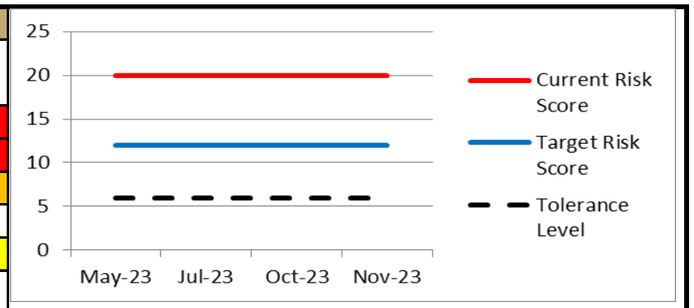
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the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

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Nov-23
Lead Committee:	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Dec-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 (UEC) 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)	
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 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.

Analysis of the impact on waiting times in respect of ministerial priorities, and without application of the recovery funding has been completed and continually reviewed. The analysis is due to be considered at the October Board Seminar, the outcomes of which will determine the requirement for a QIA to be undertaken to explore the impact on patients.

Rationale for TARGET Risk Score:

Across the UK, there is a significant challenge for health organisations in sustaining the recovery of planned care pathways post pandemic. The target score of 12 is based on the realistic assessment of the level of planned care work which could be achieved both internally across the UHB and via maximum utilisation of capacity available within the independent sector, should available resource levels support commissioning of activity to the level required.

Whilst efforts to make further progress towards the Ministerial Measures continue, the Health Board has signalled through its Annual Recovery Plan that full achievement of both the Stage 1 and Total pathway measures by the respective target dates is unachievable without additional enabling resource to support further recovery actions.

The tolerable risk (6) remains unchanged for the level highlighted during 2022/23 and reflects the longer term recovery ambitions of the Health Board to reduce waiting lists and length of wait to the lowest levels possible.

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	Completed	Partially Complete - Dedicated elective capacity in place at Prince Philip Hospital and Bronglais General Hospital. From October 2023, the day surgical unit at Withybush General Hospital has been re-established following its temporary utilisation as a medical bed surge area due to the RAAC project. Limited dedicated elective pathway capacity at Glangwili Hospital to support sufficient internal capacity for Urology & ENT surgery. Proposals for an alternative configuration of dedicated planned care capacity at Prince Philip Hospital are unable to be progressed due to overall pressure on bed capacity (part linked to the system-wide pressure associated with the WGH RAAC project).
		Workforce development and recruitment plan jointly developed between Planned Care & Workforce Team	Hire, Stephanie	~~30/06/2023~~ 30/08/2023	Continued progress achieved in recruitment of theatre staffing and consultant anaesthetic appointments, but levels remained below required WTE. Further review in August 2023.

		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~~ ~~30/08/2023~~ 30/11/2023	WG allocation of additional recovery resources (confirmed 25 July 23) is significantly below the required level reflected in the Health Board's additional recovery proposals. Impact assessment has been undertaken, and due to be presented to October Board Seminar, outcomes of which will determine further progress against this action

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**		
Performance indicators. A suite of planned care metrics have been developed to measure the system performance.	Activity volumes are reported daily on situation reports	1st			Annual Plan 2023/24 - Board (Mar23, May23, Jul23)
	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			

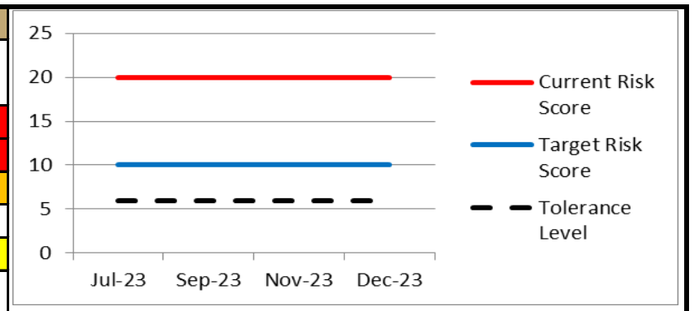
Gaps in ASSURANCES				
Identified Gaps in Assurance:	**How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
None				

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Dec-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jan-24

Risk ID:	**1664**	**Principal Risk Description:**	There is a risk to service sustainability in Ophthalmology across the Health Board, and the inability to provide timely care to patients with Glaucoma, wet Age Related Macular Degeneration (wAMD), and Cataracts. This is caused by a national shortage of Consultant Ophthalmologists and the inability to recruit to vacancies. The workforce position is exacerbated by nursing and medical staffing constraints and a reduction in service capacity due to lack of physical space, and long-term funding. Recruitment difficulties are leading to the Consultant on-call rota being covered by three substantive Consultants and a high cost Locum Consultant (Medacs) to ensure the delivery of the Ophthalmology service. This is a fragile on call structure which is impacted by sickness and annual leave. This could lead to an impact/affect on the Health Board's ability to deliver services within the Ophthalmology Referral to Treatment (RTT) plan, and delays in the NICE guidance 14-day pathway for AMD appointments, impacting on the ability to provide timely diagnosis and treatment and directly impacting on patient safety with the potential for sight loss and long-term lifestyle impacts. This will also affect the Health Board's ability to comply with Welsh Government Eye Care Measures (ECMs), and service pressures are impeding on the Health Board's ability to progress with the implementation of recommendations raised by various regulators and inspectorates. This in turn could lead to adverse publicity and reduction in stakeholder confidence, with increased scrutiny/escalation from Welsh Government. Workforce pressures could also impact staff well-being and morale.
Does this risk link to any Directorate (operational) risks?			

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



Rationale for CURRENT Risk Score:
Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for patients most at risk with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. The service has provided additional AMD sessions on a weekend, however these additional sessions have not been enough to meet the demand across all counties in the Health Board (HB). Patient delays continue across the HB. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. Additional staffing for Wet AMD was incorporated into IMTP but no funding was allocated. The service as at December 2023 has 5,922 patients (Nov 23: 5,713) that have been 100% delayed for their follow up appointment. The total new patient referrals is at 7,151 (Nov23: 5492) of which 737 (Nov23: 403) are breaching 52 weeks (the longest wait from this cohort is 75 weeks (Nov23: 67 weeks)). 4,043 patients are awaiting an Ophthalmic operation (Nov 23: 3,785) of which 35 (Nov 23:24) are breaching 104 weeks (the longest wait from this cohort is 120 weeks). The current impact has been scored as 5 because patients suffering irreversible sight loss or damage is a reality and the current Likelihood has been scored 4 as Ophthalmology is a fragile service. It is unlikely that we will be able to achieve the Board tolerance score of 6 without a regionally agreed solution.

Rationale for TARGET Risk Score:
It is unlikely that the service will be able to reduce the impact score of this risk as the consequences to the patient remains high, however due to recent re-structuring of the management team within Ophthalmology it is hoped that this will provide opportunities to review and improve service delivery with an initial focus on meeting eye care measure targets for the most high risk cohort of patients. The recent addition of a substantive WTE Consultant will help to address the longest waits. A Regional Consultant post has been recruited in Swansea Bay to provide an additional 10 sessions a week in HDUHB, however noting that s7 of these sessions relate to clinical delivery. With the above additional workforce and focused management of the waiting lists, HDUHB will potentially help to reduce the likelihood score on this risk.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS** **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Active recruitment to vacancies, x1 substantive Consultant has recently been appointed. X1 WTE post secured with Swansea Bay and x1 substantive Consultant post to go out to advert. Regional Business Case for a South West Wales Glaucoma Service. Regional discussions regarding a South West Wales Consultant On-call provision. Additional weekend working to provide Wet Age related Macular Degeneration (AMD) capacity. Currently funded for x2 all day lists per month. Lists cancelled due to AL are offered out to backfill. Review of service rota undertaken by Clinical lead to ensure stability to existing team and robust cover of emergency work. Identification of patients suitable to undergo Community Glaucoma data capture and virtual review by Consultant Ophthalmologists. Full Business Case for OpenEyes software (National Electronic Patient	Whilst recurring money has been invested into glaucoma and cataract services there still remains areas of the service (e.g. AMD, VR, plastics) that require investment. ARCH programme to be closed, with a regional conversation around a regional clinical workshop to consider opportunities for a long-term regional model. There is a pan-Wales clinical view that central investment in Estates, Infrastructure and Workforce is required to develop a sustainable service. Recovery funding was in place until March 2023. Actions have assisted the backlog number of patients waiting to be	Regional discussions to be arranged as a priority around Ophthalmology services to support a long-term sustainability plan for eye care services.	Coppack, Victoria	~~30/09/2023~~ ~~31/12/2023~~ 31/03/2024	Regional glaucoma pathway has been established. Outline discussion around regional support for a workforce development plan for HDUHB multi-disciplinary team development. Regional working for Open eyes digitalisation.
		Root and branch review of operational, workforce and sustainability models.	Coppack, Victoria	~~30/06/2021~~ ~~31/03/2022~~ ~~31/10/2022~~ ~~31/12/2023~~ 31/03/2024	Root and branch review to be undertaken through ARCH group. Regular meetings need to be undertaken for Glaucoma and Workforce plan. As at December 2023, there is potential that this group may be replaced by an alternative regional group. Outcomes of discussions relating to this proposal are awaited.

Record for Ophthalmology) approved and funding for this project has been secured for 1.0 WTE Band 7 project manager and a 0.5 WTE band 5 application support manager. This project is being aligned with SBUHB. Validation taking place through scheduled care validation team. Clinical validation of all HCQ patients being undertaken by nurses (documentation has been approved for a pilot which started in November 2023). Eye Care Collaborative Group meets quarterly to oversee performance against eye care standards. ECM Coordinators in place. Review of data quality inclusive of HRF code and clinical codes ongoing to improve data quality. 7 prescribing hubs have now been set up across the Health Board, with the aim to reduce the number of patients requiring Secondary Care Eye Services, ensuring those with the need for secondary care intervention are referred. Highly trained Optometrists working collaboratively with the Secondary Care Eye Service to reduce referrals to secondary care. Ongoing training of Optometrists within secondary care to continue to develop this service. ARCH workstreams in place - looking at Glaucoma and funding has been secured to support this development. ARCH support around Diabetic retinopathy and cataracts has been completed and pathways are in place. Ongoing arrangement of Optometrists enrolling in prescribing training. Weekly monitoring of each sites AMD demand and capacity to allow for recovery planning of breaching patient waiting times. Funding obtained in November 2023 to outsource 330 cataracts patients from the longest waits (104+) until March 2024. Transformational funding from Welsh Government is in place until March 2024.	managed in subspecialties such a Diabetic Retinopathy however other high volume areas such as AMD and Cataracts continue to see growth in waiting times. There are concerns in data quality due to referral processes and system use. The Ophthalmology service has continued to recruit over budget to sustain current services.	Roll out and implementation of National Electronic Patient Record for Ophthalmology.	Barreiro, Marta	~~30/07/2021~~ ~~07/06/2021~~ ~~31/10/2021~~ ~~31/03/2022~~ ~~31/05/2022~~ ~~30/09/2022~~ ~~31/10/2023~~ ~~31/12/2023~~ 31/03/2024	Issues identified in the planning phase around data governance. DHCW are working to resolve issues. Update provided in November 2023 that DHCW are scoping a start date for the project (potentially as April 2024), however this is subject to the outcome of procurement/contract outcomes. Regional planning scoped and aligned programme now established with Swansea Bay UHB.
		Refurbish and establish a nursing team in the Outpatient Department in Amman Valley Hospital to provide intravitreal treatment for the patients currently attending the day theatre area for their treatment. This will ensure continuity of care for those patients when cataract surgery activity is returned to day theatre.	Coppack, Victoria	~~31/01/2022~~ ~~31/03/2022~~ ~~30/04/2022~~ ~~30/09/2022~~ ~~31/10/2023~~ 31/01/2024	Capital bid was secured and work to improve physical space at Amman Valley Hospital (AVH) has been completed since March 2022. Recruitment into nurses posts to support out-patient activity has been successful and recruits are onboarding. This is currently on hold due to the space being utilised for WGH Ophthalmology patients (RAAC). However an alternate site has now been identified in Pembrokeshire, with a date for completion of works in January 2024.
		Plan for Glaucoma pathways to be implemented through ARCH.	Barreiro, Marta	~~30/06/2022~~ ~~31/10/2023~~ 30/11/2023	Business case has been approved and pathway has been implemented with support from Swansea Bay Consultant. ODCT pathway x2 has been developed, Optometrists virtual pathway for Glaucoma A patients starting in November 2023. Swansea Bay Glaucoma consultants started in HDUHB in November 2023, and further modelling work is required to recover waiting times. Action to be considered for closure once improvements in waiting times observed.

Recruitment of approx. 7 nursing staff and 2 technicians.	Barreiro, Marta	~~30/06/2022~~ ~~31/10/2023~~ ~~31/12/2023~~ 31/03/2024	2.0 WTE Technicians secured 0.8 WTE Glaucoma practitioner secured. 3.3 WTE Nurses secured Outstanding 1.9 WTE Glaucoma practitioner and 1.0 WTE Nurse which have not been recruited into, and still outstanding as at December 2023. The Health Board are looking in to developing training programme prior to advertising in conjunction with Swansea Bay.
Recruitment drive for Glaucoma Consultant.	Barreiro, Marta	Completed	x2 Consultants secured through Swansea Bay. X1 WTE equivalent to work in HDUHB. Job plan agreed with start date 20th November 2023. Both recruits are now in place, therefore action to be closed.
Remodelling the capacity and demand associated with Wet AMD and Amman Valley	Coppack, Victoria	~~31/03/2023~~ ~~31/10/2023~~ ~~30/11/2023~~ 31/03/2024	Ongoing costs associated with additional activity. Capital bid was secured and work to improve physical space at Amman Valley Hospital (AVH) has been completed since March 2022. Recruitment into nurses posts to support out-patient activity has been successful and recruits are onboarding. This is currently on hold due to the space being utilised for WGH Ophthalmology patients (RAAC). However an alternate site has now been identified in Pembrokeshire, with a date for completion of works in January 2024.
Recruitment of theatre staff and admin support to enable the optimisation of AVH theatres for cataracts.	Barreiro, Marta	~~31/03/2022~~ ~~30/08/2022~~ ~~31/10/2023~~ ~~30/11/2023~~ ~~31/01/2024~~ 31/03/2024	When IVT service relocates from AVH Theatre to AVH Outpatients Department, the ability to undertake further cataract surgery in AVH Theatre will increase.

Devise and approve plan for Diabetic retinopathy service through ARCH.	Barreiro, Marta	Completed	Funding was secured through transformational bid. Carmarthenshire and Pembrokeshire have secured timeliness of patient appointments for follow up and new patients. Ceredigion has been more challenging due to lack of Optometrist uptake. Aberaeron integrated care centre has now been secured for x1 session per week supported by a technician. The ARCH pathway as of December 2023 has ceased, with plans devised and approved. Action therefore to be closed.
Plan for Cataracts pathway to be implemented through ARCH.	Barreiro, Marta	~~30/06/2022~~ ~~30/09/2023~~ ~~30/11/2023~~ 31/03/2024	Locum Consultant secured to assist with delivery of Cataracts surgery/Substantive Consultant with specialism in plastics secured who can also undertake cataract surgery. Review of Demand and Capacity now undertaken to inform service recovery. The ARCH pathway as of December 2023 has ceased, with plans devised and approved. GIRFT review for cataracts is ongoing, with recommendations raised noted on the Audit and Inspection tracker and progress updates obtained. Action is linked to the ability to restructure service between AVH and Pembrokeshire, which is currently impacted by RAAC.
Implement virtual review clinics for patients undergoing Hydroxychloroquine (HCQ) treatment.	Coppack, Victoria	~~30/09/2022~~ ~~31/10/2023~~ ~~30/11/2023~~ 31/03/2024	Validation of HCQ patient commenced in November 2023. Longest wait HCQ patients have been identified for tech review. Virtual review process to be discussed with Clinical lead. Clinic spaces to be secured for patient review. This is an interim measure whilst community hub is being developed.

Clinical validation rota to be established within the service to ensure validation of high risk patients and longest waits is undertaken to prioritise patient reviews and safety net patients	Coppack, Victoria	~~30/09/2023~~ ~~31/12/2023~~ 30/04/2023	Validation ongoing and R1/longest wait patients booked in terms of their priority for next quarter. Co-ordinator in place, and triage and validation ongoing, however the list has not been reviewed in full as at December 2023, therefore revised action date of April 2024.
A sustainable model for AMD to be developed with continued support from performance team.	Coppack, Victoria	Completed	Demand and capacity planning for IVT service undertaken and detailed SBAR to be drawn up. Action duplication, with other actions noted on the risk relating to the AMD/AVH pathway.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Eye care measures monthly report. GIRFT review Cataracts. GIRFT review Glaucoma. Watchtower review of ministerial measures	WPAS	1st								
	GIRFT action plan cataracts	1st								
	GIRFT action plan Glaucoma	1st								
	WPAS, scheduled care performance indicators	1st								

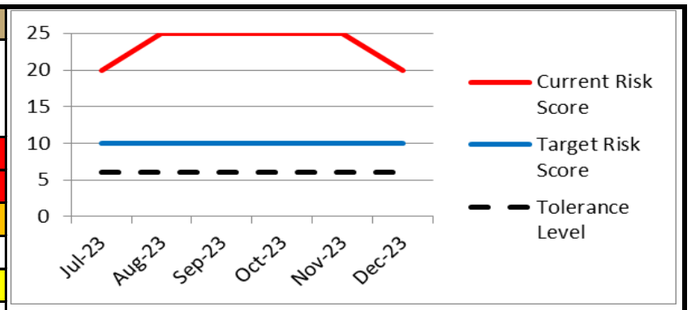
Date Risk Identified:	Jun-23
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Dec-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jan-24

Risk ID:	**1699**	**Principal Risk Description:**	There is a risk that there could be a significant loss of capacity to deliver elective, urgent and emergency and outpatient services at Withybush Hospital (WGH), and the delivery of the Health Board's Annual Plan 2023/24. This is caused by by the requirement to undertake surveys and take immediate disruptive remedial works, where necessary, to address findings of reinforced autoclaved aerated concrete (RAAC) surveys at WGH, which may result in a number of wards being concurrently closed whilst surveys and remedial works are undertaken. This could lead to an impact/affect on the ability to safely manage demand across elective, urgent and emergency inpatient and outpatient services, including patients accessing specialist areas for care (including coronary care, complex oncology, gastroenterology, respiratory and stroke), disruption to pharmacy services, and poorer patient outcomes from overcrowding in the Emergency Department resulting in delays in accessing care and treatment. This will affect the Health Board's ability to achieve ministerial priorities as set out in the Annual Plan 2023/24 (eg, improvements to ambulance response times and emergency department waiting times). There may also be increased scrutiny from key stakeholders, including Welsh Government and other regulators which may lead to the loss of public confidence, and increased pressures on current workforce.

Does this risk link to any Directorate (operational) risks?	1382, 1385, 1657, 1027, 1711, 1722

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	↓



Rationale for CURRENT Risk Score:

All RAAC affected inpatient wards vacated as of August 25th 2023. Detailed surveys complete in Wards 7,8/CCU,10, 11 & 12 with remedial work requirements identified. Works scheduled to complete in Wards 7 and 11 by December 22nd 2023. Works completed in Wards 9 & 12 and reoccupied as medical capacity from 5th October & 9th November 2023. Throughput of inpatient elective surgery, as would ordinarily be delivered from Ward 9, remains low with same day admission pathway to Day Surgery Unit (DSU), and gynaelogical elective patients on Ward 4. Medical patients vacated the DSU footprint on 5th October 2023 when it returned to service with resumption of day case surgery on site. Medical patients withdrawn from the Pembrokeshire Haematology & Oncology Day Unit (PHODU) in November following reopening of Ward 12. This enabled reinstatement of full service to PHODU. Suitability of Ward 3 to be utilised as outpatient therapy capacity is being scoped. Visual survey in Outpatients A has identified significant RAAC related issues (P1 planks). Detailed survey completed with remedial works to follow, scheduled to return to service at end of June 2024. Alternative locations for outpatient provision being coordinated and scoped by scheduled care directorate, and completed as at December 2023. Schedule for detailed survey programme for ground floor areas developed with programme to complete by March 31st 2024. Remedial works to follow detailed survey in physio/therapy area, resulting in need to decant from February - end of June 2024. Remedial works on Wards 8/CCU,10 are scheduled to commence in January 2024, and complete in March 2024. Due to the works completed to date, the likelihood score of this risk has been reduced to a 4.

Rationale for TARGET Risk Score:

Surveys being undertaken will result in appropriate project plans being put in place, which once completed will reduce the likelihood of service disruption. There are a high number of "amber" planks which will require yearly monitoring & inspection over the coming years, with the possibility that they may also deteriorate and require additional remedial work in the future.

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 Cleddau Ward (East and West) in South Pembs Hospital, to reprovide 28 non acute inpatient beds to those meeting a pre-determined criteria Implementation of different model of care in Cleddau Ward to facilitate improved patient flow Emergency pathways, reviews and developments in place to minimise admissions and length of stay (LOS) in hospital Optimising available inpatient capacity, where possible. Reduced elective surgery activity on site pending completion of remedial works Maximising use of potential bed capacity in areas across WGH not affected by RAAC. Conveyance avoidance measures in place including clinical triaging of Health Care Professional referrals to secondary care Comprehensive plan in place to undertake planned surveys - contractor on site. Fast Track Visual Surveys and detailed surveys complete. Ground floor detailed surveys commenced mid October 2023. Commenced programme of works, Pot Wash area & Wards 9 and 12 complete. Ward 7 and 11 ongoing (planned completion mid December). Potential to accommodate physiotherapy outpatient activity being scoped on Ward 3. Wards 8 & 10 due to complete works end March 2024.	Clarity on funding streams required to progress remedial works. Health Board Discretionary Capital allocation used to commence works in Wards 9 & 12. Funding has been approved to March 2024, however funding remains unapproved for FY 2024/25. To continue with this programme at pace is significantly beyond that which can be supported by our Discretionary Programme Clarity on scope and associated timelines of the required remedial works relating to physiotherapy outpatients Ability to manage impacts from loss of medical bed capacity is more challenging as numbers of bed losses increase and winter approaches Operational position on other sites does not easily support transfer of clinical pathways Ability to transport emergency and non-emergency patients to alternative sites	To explore funding options with Welsh Government to support remedial work	Davies, Lee	Completed	Funding has been approved by Welsh Government to deliver a programme of survey and remedial works to address high risk RAAC in 2023/24 and 2024/25 financial years.
		To minimise scope and level of disruption as far as reasonably practicable by combining Phase 2 Fire Works with RAACs remedial works, where possible	Chiffi, Simon	~~31/07/2023~~ ~~30/09/2023~~ 31/03/2024	The scope document to reduce extent of Fire Investment at WGH was submitted in September 2023. In advance of a decision from Fire Service on this, the decision was made to proceed with the fire requirements as proposed in the submission. This was on the basis that as long as approval was received we would avoid further disruption to the 6 wards impacted by RAAC. As we have proceeded with the RAAC work, the fire elements have been incorporated, and envisaged completion of these works by March 2024. Verbal approval received from the MWWFRS on 8th November 2023 that our scope document has been approved, and a request for formal notification has been made, and expected to be received by December 2023.

Utilising Acrowprop and/or hybrid measures to mitigate impact and reduce risk until repair works are undertaken Internal and External Communications undertaken and planned approach going forward WGH RAAC Implementation Group, consisting of key estates and service management Business Continuity Incident declared on 15Aug23, and a Command Control Structure (Gold Silver/Bronze) established to coordinate and manage Health Board response. Liaising with other hospital sites in England to understand how they've managed the situation			
Develop a programme of works at WGH to address survey outcomes	Williams, Paul	Completed	Detailed surveys complete for all the wards and ongoing for the ground floor areas, with planned completion by end of March 2024. Current timescales include the completion of works for all Wards in financial year 2023/24 and the completion of all ground floor areas by end of August 2024. Construction works completed for Wards 9 and 12. Outpatients Department A is currently being surveyed to support remedial works, scheduled to start in February 2024.
Liaise with affected services and departments to communicate the expected impact of service disruption on their areas	Andrews, Bethan	~~31/07/2023~~ ~~30/09/2023~~ ~~30/11/2023~~ ~~31/12/2023~~ 31/03/2024	Site management liaising with services to confirm requirements for detailed survey and expected disruption in relation to corridors, office & clinical space, as well as supporting service relocation for survey and works as required. This will continue whilst surveys and remedial works are undertaken.

Reviewing service delivery response and developing contingency plans in the event of losing significant clinical capacity	Carruthers, Andrew	~~30/09/2023~~ ~~30/11/2023~~ 31/12/2023	Work is being undertaken to maximise use of bed capacity in areas across WGH not affected by RAAC, with additional bed capacity being scoped and utilised in South Pembrokeshire Hospital. Increased bed capacity in Puffin Ward by further 5 beds. Alternative means of elective surgery provision being explored across Health Board and wider region. Outpatient services relocated or switched to virtual if at all possible to release capacity during survey and remedial works. Re-phasing plan to reintroduce inpatient capacity onto the WGH site whilst closing down additional capacity opened to mitigate bed loss. 13 beds in Cleddau ward to close in Dec 2023 when Ward 7 reopens. This, together with opening an additional 8 beds in Ward 12, will increase acute medical bed capacity. Pembs system bed modelling project commenced to ensure required capacity to meet demand reopens in the right place, whilst the impact of programmes in intermediate care (eg clinical streaming hub, frailty pathway, SDEC, virtual ward) are understood and considered when reopening inpatient capacity.
Scoping alternative catering arrangements for WGH	Elliott, Rob (Inactive User)	Completed	Cook freeze solution established up to implementation of temporary kitchens scheduled to be operational from early December 2023. Survey and remedial works to be arranged and main kitchen returned to operation use by August 2024.

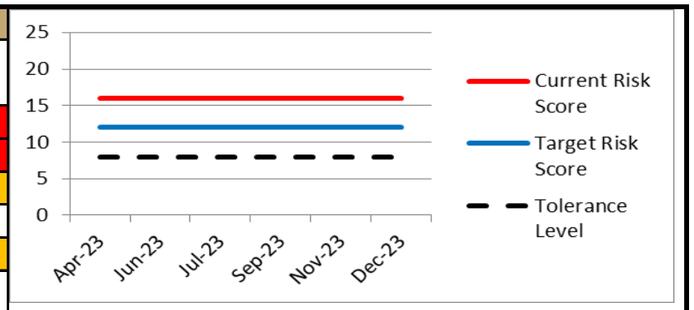
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Project plans in place dependant on outcomes of surveys, and monitored via the WGH RAAC Implementation Group	Fortnightly WGH RAAC Implementation Group meetings	1st			RAAC paper to SDODC (Apr 23) RAAC paper to HSC (Jul 2023) RAAC included in Director of Operations Report to Board (Jul23)	Unaware of the extent and impact of the risk until all surveys have been completed. All inpatient areas now surveyed as at September 2023, with P1 planks identified, and works schedule confirmed. Ground floor detailed survey have now been completed. Amber planks remain in situ and require ongoing monitoring with risk of deterioration unknown.	Urgent programme of assessment to be undertaken to assess remaining areas	Elliott, Rob (Inactive User)	30/09/2023	Risk assessments currently being undertaken by the Estates and Facilities Directorate on remaining areas, the outcomes of which will assist in the decision on next steps regarding ward closures. Fast track visual inspection commenced to rapidly identify and mitigate risks over the c. 10-week programme
	Command and Control Structure established to coordinate Health Board response	2nd								
	RAAC survey findings by external contractor	3rd								

Date Risk Identified:	Apr-23
Strategic Objective:	

Executive Director Owner:	Gostling, Lisa	**Date of Review:**	Dec-23
Lead Committee:	People, Organisational Development and Culture Committee	**Date of Next Review:**	Jan-24

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 scarce supply of healthcare professionals and a shrinking labour market, which is further exacerbated by the Health Board's current vacancy rates. This could lead to an impact/affect on the quality of care provided to patients, delays in care and poorer patient outcomes and experience. 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. And further impact on the health and wellbeing of teams.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Workforce/OD
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	8
Trend:	⟺



Rationale for CURRENT Risk Score:

This risk has been scored as 16 (the likelihood 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. However it should also be noted that due to the Health Boards current financial position and considering the wider financial context; (the extent and impact of which at this time is not fully known); this may result in the potential requirement to increase the risk score to 20 once board decisions have been finalised regarding the utilisation of agency, bank and locum staff workforce.

Rationale for TARGET Risk Score:

The Target Risk score indicates the likelihood of the risk occurring (absence target 4.8%). 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 (linked to Principal Risks 1186 and 1188).

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 deployment options based on service needs (CDG) Targeted prioritisation of recruitment/onboarding of new employees to the highest areas of risk in terms of maintaining service delivery (People | 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, medium & long term. A robust framework of competency based people planning and related	PO 2a: 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~~ 31/03/2024	On track
		Further develop training resources and capacity to support managers with workforce planning challenges to alleviate risks (PO 2c2iii)	Walmsley, Tracy	~~31/07/2023~~ ~~30/09/2023~~ 31/03/2024	Initial training programme drafted; dates in diary Jul to Dec 23. Linking with Risk Team to ensure aligned process including awareness raising and support. Bespoke programmes being developed for specific services such as Pathology & follow up workshops arranged. In process of embedding this approach as business as usual.
		Approach to future community workforce development model requires alignment to UEC, Primary Care and Community Programmes of work & teams. (PO2c.2v)	Walmsley, Tracy	~~31/07/2023~~ 31/03/2024	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", and explore opportunities to link to the Clinical Services Plan. Will utilise Clinical Services Plan workshop to inform work (2 Oct). Regroup needed with key leads to identify actions required now.

& OD Strategic Group) Temporary People Utilisation reports shared regularly to monitor levels of supply Align and iterate to implementation groups i.e. Medical retention. Annual completion and submission of Education Commissioning Plan to HEIW and critical assessment to known service level plans Digital support with workforce planning to support speed in decision making at local, regional & national levels.	training to underpin the Team around the Patient initiatives and new model development of care.	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). Discussion now needed on next steps.
		Agree actions to mitigate strategic risks of workforce supply based on assessment paper	Gostling, Lisa	31/03/2024	Risk assessment in progress. Paper received by PODCC August 2023 and further paper prepared for December 2023.
		Test "WFP" Project Support Role within a Directorate to strengthen operational and strategic workforce planning: Women & Children	Walmsley, Tracy	~~30/11/2023~~ 30/01/2024	Meeting with General Manager of W&C held to test aligned to Improving Together action identified. Initial introduction planned June 2023 for a 6 month trial period. Trial will run to January 2024. MHLD also has ongoing supported embedded in progress.
		Methodology to support new and enhanced roles to be scoped and implemented.	Walmsley, Tracy	~~30/07/2023~~ ~~30/11/2023~~ 29/02/2024	In progress - Linked to People 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. Capacity of teams to engage is challenging revised date of March 2024 proposed. Work ongoing i.e. New Clinical Role development polilcy and further scoping required.

Interrogate financial establishment/SIP to ensure "a source of truth" and align to identified and prioritised risks (operational and strategic).	Walmsley, Tracy	31/03/2024	Meeting to review risk to be set up to link in "Stabilisation" and wider Establishment Concerns (links to Principal Risk 1186). Ongoing dialogue with Finance and critical stabilisation related WOD Teams.
1a Develop an attraction and recruitment plan (which enables service sustainability) and deliver a plan which is designed to streamline and modernise processes, recruitment from different talent pools, attract and support candidates	Gostling, Lisa	31/03/2024	On track
1a.1 Redesign all JD & PS to focus on core requirements and skills	James, Michelle	~~30/06/2023~~ ~~30/11/2023~~ 29/02/2024	Schedule developed; next steps to be implemented.
1a.2 Employ new methods of advertising and appointing to roles	James, Michelle	~~30/06/2023~~ ~~30/11/2023~~ 29/02/2024	Schedule developed; next steps to be implemented.
1a.3 Develop programmes for employability support	James, Michelle	28/02/2024	Partners engaged, 3 programmes identified and being scoped fully.
1a.4 Develop attraction plan to link with offers for R&D, Service Improvement, Education etc	James, Michelle	~~30/09/2023~~ 29/02/2024	Tender action completed - work ongoing - revised timelines of plan to be developed
1a.5a Appoint to vacancies via different employment pools (resourcing)	James, Michelle	31/03/2024	Scoping for AHP & Medical roles (first action by 31 July) in progress. Various actions ongoing to March 2024
1a.5b Appoint to vacancies via different employment pools (learning & development)	James, Michelle	31/03/2024	In progress, including scoping of medical apprenticeships
1a.6 Enhance HB offer to improve lives of local population by social responsibility initiatives i.e. volunteering/employment pathways etc	James, Michelle	~~31/07/2023~~ ~~30/11/2023~~ 29/02/2024	Links to 1a.3 •Future Workforce Operational Group has been created; •Mapping & analysis of data has begun to inform future campaigns; •Choose us and Care 24 bids have been submitted.
2a.1 Identify and target development pools to support future registrant roles	Glanville, Amanda	31/12/2023	On track - development work in progress
2a.3 Reshape higher awards process to link with training needs analysis	Glanville, Amanda	31/03/2024	On track
2a.4 Develop an interprofessional education plan with full implementation plan by 2026	Glanville, Amanda	31/03/2024	On track
2a Engage with and listen to our people to ensure we support them to thrive through healthy lifestyles and relationships	Gostling, Lisa	31/03/2024	On track

2a.2 Wellbeing charters are fully embraced	Davies, Christine	Completed	On track - Task and Finish group establishes and Charter progress review underway
2b Continue to strive to be an employer of choice to ensure our people are happy, engaged and supported in work to further stabilise our services	Gostling, Lisa	31/03/2024	On track
2b.1 Improve HB education & development offer, supporting enhanced opportunities	Walmsley, Tracy	31/03/2024	On track
2b.2 Workforce Effectiveness and Stabilisation Programme to improve experience of staff by reducing reliance on agency/bank and recruiting to posts locally and by overseas means across all professions	Walmsley, Tracy	31/03/2024	Plans for nursing established, scoping of plans for other professional groups in progress. To be reviewed in line with CDG expectations and Planning Sub Group.
2b.3 Widen choices relating to contracting opportunities	Walmsley, Tracy	31/03/2024	On track
2b.4 Enable job enrichment where appropriate; core principles and design methodology developed	Walmsley, Tracy	30/09/2023	On track
2b.5 Plan developed to optimise digital opportunity and cost effective workforce agility	Walmsley, Tracy	31/03/2024	On track
2b.6 Further develop and spread people recognition formally and informally	Walmsley, Tracy	31/03/2024	On track
2c Develop and maintain an overarching workforce, OD and partnership plan	Gostling, Lisa	31/03/2024	On track
2c.1 Implement succession planning and leadership & management pipeline	Walmsley, Tracy	31/03/2024	In progress
2c.2 Further develop short and long terms plan by services and professional groups	Walmsley, Tracy	31/03/2024	In progress linked to specific actions within the risk and wider service issues/plans on capital programmes/ Capacity challenge/prioritisation needed
2c.3 Understand our people by using quantitative and qualitative data	Walmsley, Tracy	~~31/08/2023~~ 31/03/2024	Good progress, timelines may prove a challenge to integrate all - wins will be sought for impact

2c.4 Develop a process of listening and learning from staff experiences ensuring regular feedback	Walmsley, Tracy	04/04/2024	In progress
2c.5 Promote a culture of innovation and enhance the HB reputation	Walmsley, Tracy	04/04/2024	In progress
Agree actions to mitigate strategic risks of workforce supply based on assessment paper	Gostling, Lisa	31/03/2024	Risk assessment in progress as at June 2023, with paper to follow
Explore & assess alternative roles (value, barriers and future plans (MAPS, AP's APP's, CAAPS))	Walmsley, Tracy	31/03/2024	Ongoing annual cycle of PA programme - panel complete. APP working group in place, CAAPS discussions ongoing for future years; AP assessment needed going forward links to All Wales work
Completion of Education Commissioning Plan to HEIW and critical assessment to known service level plans as at March 2024 submission to Welsh Government (PO2c2ii)	Walmsley, Tracy	30/04/2024	Update to be provided at next risk review
Reiteration will be required for the Health Boards Annual Plan linked to Recovery Scenarios based on Board decisions for the development of All Professions led people plans to align to in year tactical & operational plans linked to the overarching Strategic 10 year Workforce Plan.	Walmsley, Tracy	31/03/2024	Initial considerations and work can commence following September 2023 Board Meeting and then will formulate as business as usual.

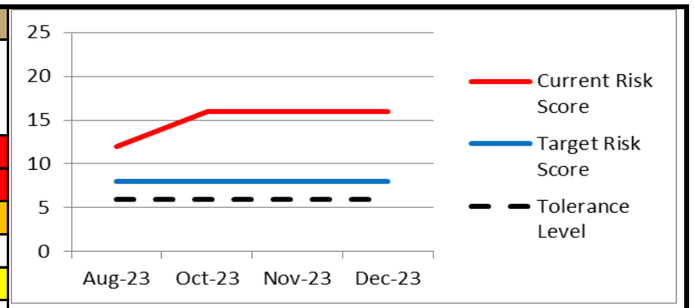
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Monitoring of workforce SIP and gaps in establishment control	1st				Assessment & continuous development mechanisms linked to Capacity and Capability (including any negative impacts on Wellbeing)	Draft Maturity Matrix and "Panel" approach to be tested	Walmsley, Tracy	~~31/05/2023~~ ~~30/09/2023~~ 29/02/2024	Draft developed to be tested with a panel and fed into PODCC for assurance/ Paper to PODCC December 2023 to set up working group.
	Strategic People Planning & Education Group	1st					Overarching Implementation Plan & Assessment of Impact (Approach defined 30/9/23) and delivered no later than 31/03/24 to link to Annual Planning cycles (identified in Audit Wales initial draft report)	Walmsley, Tracy	31/03/2024	Suggested approach to be discussed: alignment of Risk, DITS (Operational plans) and Clinical Services Plan with AHMMWW strategy (Strategic plans) underpinned by stakeholders engagement on a wider workforce strategy.
	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) April 2022	3rd								
	Wales Audit Office review of Workforce Planning (Fieldwork underway - report expected Summer 2023)	3rd								

Date Risk Identified:	Jul-23
Strategic Objective:	

Executive Director Owner:	Paterson, Jill	**Date of Review:**	Dec-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jan-24

Risk ID:	**1708**	**Principal Risk Description:**	There is a risk of increasing fragility in Primary Care Contractor services. This is caused by challenges in recruiting new clinicians into salaried or partnership roles which impacts on succession planning for contractor professions. There are further challenges in relation to premises not being fit for purpose and not having the capacity to flex to a more modern approach to service delivery e.g. MDT working. In addition, contract reform against the background of significant pressures on the wider system, and exacerbated by financial pressures for the independent contractor business model. This could lead to an impact/affect on undermining the independent contractor model, and therefore the ability for patients to access timely and local primary care services. If service users are unable to access these services, this may lead to additional pressures on other primary care services, and wider Health Board services such as Out of Hours and Urgent and Emergency Care. As a result of contract terminations, there will be a detrimental impact on the financial position of the directorate relating to dental contracts.
Does this risk link to any Directorate (operational) risks?		1688, 1451, 1403, 1164, 1660, 933	

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	↑



Rationale for CURRENT Risk Score:
As at December 2023, 8 dental contracts and 3 GMS contract have been returned to the Health Board in the last 12 months. This has resulted in 25,000 dental patients being displaced. In addition, a further 8 dental practices have not signed up to the contract reform, and signalling that they will return contracts once reform negotiations have concluded. 2 out of the 3 GMS contracts have become Health Board managed practices, resulting in additional financial pressures as the workforce is salaried, and third practice is going through the vacant practice process. It is recognised that any further managed practices would likely have a negative impact on the GMS budget. The number of complaints received from the public has increased due to returned contracts, and while the Health Board is currently containing the demand for urgent dental care, it is recognised that patients who don't fall in to this category but require a level of dental care are detrimentally impacted, and that any further contracts returned will exacerbate this situation. The capacity of the Health Board in terms of staffing to absorb further contract reform will impact on the ability to effectively deliver services, and a detrimental impact on staff welfare. With new contract implementation relating to Optometry due in January 2024, there is an expectation of a shift from hospital care to the community, however the model is untested in terms of contractor capacity and skill set. In addition the potential risk of RAAC planking in premises used by Primary Care contractors to deliver the full range of contracted services could have a further impact on service stability and sustainability. Due to the above, the current risk score remains 16.

Rationale for TARGET Risk Score:
Achievement of the target score is subject to the development and agreement of a Primary Care Strategy at Board alongside successful national contract negotiations and subsequent implementation across the Primary Care contractor professional groups.

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**
Primary Care Academy in place, which looks at workforce planning, training and development needs and opportunities 5 Facet Survey completed in 2022 to establish a baseline for the GMS estate GMS and Dental Practices undertake annual reporting which includes reviews of statutory compliance requirements 0.25 FTE Primary Care Development Manager for estates in post but with a focus on GMS Escalation tool for GMS and Community Pharmacy (SITREP) Continue effective engagement with struggling practices to support with their issues through close working relationships developed with practices. Programme of practice visits to review Estates provision, and if remedial action is required Nationally agreed Breach Management process in place for Community Pharmacies. Requests for contract variation (termination, merger, branch surgery closure etc) are considered in line with national guidance, with panels convened as stipulated. Recommendations are taken through the Primary Care Contract Review Group with papers to Board when required.	A series of patient facing videos have been developed with Pocket Medic to support patient education in accessing Primary Care Services. Requests for support on addressing the GMS sustainability agenda are with the Strategic Programme for Primary Care as a result of a review paper across all Health Boards on their sustainability pressures. National work on the development of the escalation tool for Dental and Optometry is ongoing but not live. Five Facet Survey and annual reporting of practices has highlighted non-compliance with statutory requirements such as Health and Safety, Fire and IP&C which have now all been addressed. Limited requirements for practices to disclose information to the Health Board about their sustainability pressures, and rare for practices to disclose financial details (reliant on engagement and good will as this is	Establish workforce plan and recruitment strategy in line with the development of the national Primary Care Workforce Strategy and as a component of the Primary Care Strategy.	Hughes, Samantha	31/03/2024	Workforce planning continues. GP Practice workforce plans using data from Welsh National Workforce Reporting System (WNWRS) have been pulled together at Cluster level for Collaborative consideration.
		To develop the Primary Care Strategy in consultation with statutory stakeholders and consultees, to cover areas including: •Workforce •Sustainable provision of Primary Care services •Estates •Managing contractual change •Developing pathways and new services •Improving access to services across all contractor professions	Bond, Rhian	30/09/2024	Paper submitted to Board in September 2023 setting out the scope of the Primary Care Strategy, with a further paper to be presented at Board in January 2024.
		Consider the potential to deliver a wider range of salaried NHS Dental Services through the Community Dental Service.	Owens, Mary	30/04/2024	Modelling is ongoing.

	not a contractual requirement as at June 2023). Insufficient resources to support the estates development across all Primary Care services, particularly with independent contractors. Whilst Community Pharmacy Breach Management process in place, 2 notices are currently under the appeals process - the Health Board is awaiting confirmation on the outcomes of these by Welsh Government, which to date has taken 10 months. Outcomes of these appeal will directly influence the approach taken going forward, and may result in the nationally agreed process unable to be fully implemented.	Implement the Managed Practice Strategy plan will give greater system resilience.	Swinfield, Anna	30/04/2024	Currently progressing the tender action for Neyland and Johnstown practice, anticipating contract award by April 2024.

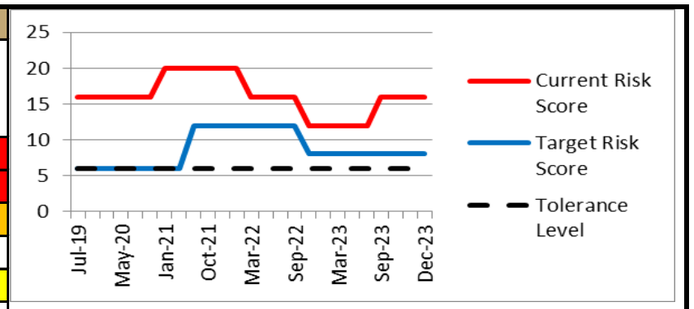
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Sustainability Matrix Contract performance to monitor volume metrics (identifies if dental practices have issues in service delivery) Monthly assurance reports and Dental Assurance Framework - Business Service Authority dashboards, to identify outliers	GMS practices are asked to complete a WG sustainability matrix every 6 months to track the main risk areas and this contributes to a heatmap. Practices are also asked to report regularly on operational pressures	1st			OQSEC Primary Care Exception Report (Jun 23)	Varying levels of engagement from practices in the regular reporting of operational pressures.				
	Dental Management Team undertake annual reviews	1st								
	GMS Practices are part of a rolling visiting programme, based on their annual return which is risk assessed against a framework of any other issues or concerns identified	1st								
	PCSMs tasked with regular discussions with Practices that report L4 to understand the issues	1st								

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Dec-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jan-24

Risk ID:	**684**	**Principal Risk Description:**	There is a risk to the radiology service provision from breakdown of key radiology imaging equipment and associated infrastructure to enable equipment to function. 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, 1668	

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):	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 risk score is noted as 16 reflecting that some equipment has been installed and is operational, however further investment is required given recent breakdowns of key imaging equipment. 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 not been secured (for financial year 2023/24). As at November 2023, confirmation on funding is awaited but early indications are that this may not be fully available, with the likelihood that it will only fund the replacement of one X-ray room.

Gamma camera at Withybush General Hospital is the only scanner of its nature in the Health Board, and has experienced a breakdown in August 2023 due to intermittent failures which resulted in several HIW reportable IRMER incidents. This item of equipment is on the current priority list of items to replace as at November 2023.

While a new CT scanner has been obtained and installed at Glangwili, the original CT scanner has had a number of breakdowns due to its age. The technology on this scanner is also now out of date, and impacts directly on the resilience of the service at our major trauma site in the Health Board.

Like-for-like replacement of existing equipment is not necessarily a cost effective method of maintaining services and in certain circumstances does not meet updated regulatory compliance or meet the requirements of maintenance warranty agreements. This means there will need to be upgraded infrastructure such as air handling units, water chiller systems and the size/accommodation for modalities at an initial increased cost but representing long term savings and service resilience overall.

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.

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. # Escalation process in place for service disruptions/breakdowns. # 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. Competing demands for replacement equipment due to RISP, as four pieces of equipment will be non-compliant No dedicated diagnostic equipment replacement funding has meant that DCP bids are having to be developed for all equipment replacement. National Imaging and Capital Priorities Group held its first meeting in September 2023 therefore in its infancy, and has a further work required to ensure a fair and robust process is undertaken to appropriately assess all imaging modalities and which understands individual HB risks to equipment replacement.	To confirm the capital funding to replace existing aged equipment for FY 2023/24	Roberts-Davies, Gail	~~31/03/2023~~ ~~30/06/2023~~ ~~31/12/2023~~ 31/03/2024	A prioritisation list of aged equipment to be replaced has been devised, however confirmation needed on funding in order to undertake the required work. Funding has been given to replace Tenby DR equipment by the end of financial year 2023/24, and a task and finish group set up to monitor.
		To confirm funding arrangements for the remaining equipment that needs to be replaced, supported by individual DCP bids or dedicated replacement funds for 2023/24.	Roberts-Davies, Gail	~~30/09/2023~~ ~~31/12/2023~~ 31/03/2024	Directorate has compiled a list of equipment requirements, which have been prioritised dependant on finance availability and functionality of the existing equipment and presented at Capital Sub-Committee in September 2023. Priority list has also been submitted to the National Imaging Equipment Capital Priorities group (NHS Executive Group) via assessment process, with outcomes currently pending as at November 2023. It is noted that funding has been given to replace Tenby DR equipment by the end of financial year 2023/24, and a task and finish group set up to monitor.
		Installation of replacement Gamma Camera, WGH	Roberts-Davies, Gail	31/03/2024	Gamma camera is 9 years old and the only scanner in the Health Board providing a regional service. Recurrent breakdowns are resulting in HIW reportable incidents. Awaiting confirmation of funding as at December 2023.

Replacement of CT Scanner at GGH	Procter, Sarah	31/03/2024	CT scanner is 11 years old, with increased failures noted and that new technologies are now available. Colleagues in Estates are currently looking at options and prices, and as at December 2023 no capital bid yet provided as awaiting works costs. Awaiting confirmation of funding as at December 2023.
Replacement of digital x-ray rooms at Tenby Cottage Hospital and South Pembrokeshire Hospital	Roberts-Davies, Gail	31/03/2024	Funding has been given to replace Tenby DR equipment by the end of financial year 2023/24, and a task and finish group set up to monitor. Awaiting confirmation of funding as at December 2023.
Replacement of ultrasound systems at BGH & GGH, image intensifier units at BGH & WGH, and Vacuum Assisted Biopsy (VAB) unit for PPH Breast Clinic	Osell, Fiona	31/03/2024	Ageing equipment with replacements required for obstetric scanning, and resilience of services provided to Theatres. DCP bids have been collated for BGH ultrasound and WGH image intensifier, and exploring opportunities for charitable funding to support VAB unit for PPH Breast Clinic. Outcomes are still pending as at December 2023.
Replacement of Fluoroscopy room, WGH	Roberts-Davies, Gail	31/03/2024	Equipment is 17 years old with significant downtime experienced. Awaiting confirmation of funding as at October 2023.
Replacement of CR A&E DR room and OPT (Dental) units, BGH	Edwards, David	31/03/2024	Ageing equipment, with the dental unit 26 years old. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract.

Replacement of CR X-ray Room 1, WGH	Roberts-Davies, Gail	31/03/2024	Ageing equipment. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. Awaiting confirmation of funding as at December 2023.
Replacement of CR X-Ray room, Llandovery Hospital	Osell, Fiona	31/03/2024	Equipment on site is incompatible with the incoming PACS system, and interim solution required. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. Awaiting confirmation of funding as at December 2023.
Replacement of Mammography Units, BGH and WGH	Roberts-Davies, Gail	31/03/2024	Ageing equipment, exacerbated by the failure of Secureview. Awaiting confirmation of funding as at December 2023.
Upgrade or replacement of MRI scanner, PPH	Osell, Fiona	31/03/2024	Ageing equipment with increasing failures, with new technologies now available. Awaiting confirmation of funding as at October 2023.
Upgrade or replacement of MRI scanner, GGH	Procter, Sarah	31/03/2024	Ageing equipment with increasing failures, with new technologies now available. Awaiting confirmation of funding as at October 2023.
Replacement of Room 3 (Digital x-ray room), BGH	Edwards, David	31/03/2024	Mobile unit currently being used. Awaiting confirmation of funding as at October 2023.
To consider alternative funding options for the DEXA unit, BGH	Edwards, David	31/03/2024	Unit is 17 years old, and previously funded via charitable funds

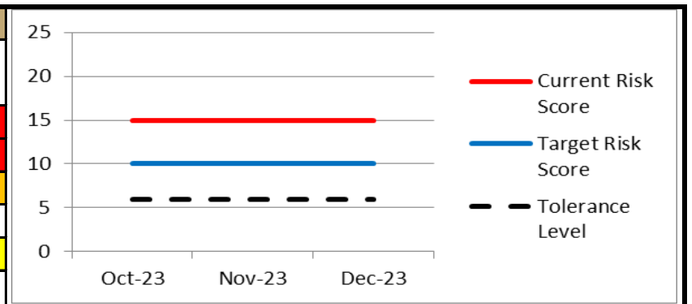
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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								

NEW	Aug-23
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Dec-23
Lead Committee:	Health and Safety Committee	**Date of Next Review:**	Jan-24

Risk ID:	**1745**	**Principal Risk Description:**	There is a risk of not being able to deliver safe, effective and timely services across the HB estate, including acute, community and mental health facilities. This risk also impacts the HB's non clinical estate, educational facilities and managed practices. This is caused by further deterioration of our aging buildings and infrastructure with significant amount of the estate beyond its life expectancy. Multiple points of failure, delays in addressing reported defects and limited capital to address the increasing backlog of estate environmental issues. This could lead to an impact/affect on on patient experience, our ability to deliver care in line with expected standards resulting in increased scrutiny and critical reports from auditors, regulators and inspectorates, such as HIW and HSE, and decreased public confidence and perception of our services, facilities and estate environment. Impacts also include increasing revenue costs to supplement the lack of capital funding available required to react to emerging issues, ability to comply with the Health and Safety at Work Act, including other legal regulations and engineering guidance documents such as Welsh Health Technical Memorandums (WHTMS).
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):	3×5=15
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	



Rationale for CURRENT Risk Score:
The current risk score is based upon the level of detailed information the Estates departments has for it's buildings, plant and infrastructure. Including external reports, risk information and Estates and Facilities Performance Management System (EFPMS) data submitted to Welsh Government (WG) clearly articulating the scale of backlog and deficiencies across the Health Board (HB). The HB has been working closely with Welsh Government (WG) for many years to develop a programme business case (PBC) to modernise its estate. In 2018/19, the Health Board (HB) developed a PBC for circa £528m for modernisation of its 4 acute sites, WG requested the HB to review this PBC to consider the A Healthier Mid and West Wales (AHMWW) programme timeframe. In 2020, a revised PBC was completed with a cost of circa £246m to keep Withybush General Hospital (WGH) and Glangwili General Hospital (GGH) operational whilst the AHMWW programme was being delivered. The investments at Bronglais General Hospital (BGH) and Prince Philip Hospital (PPH) remained the same. In 2021 a further review for WG was undertaken to carry out priority works excluding elements included in the AHMWW programme, such as ward refurbishments and fire precautions upgrades at WGH & GGH. This option was agreed and costed at circa £87m for the 4 acute sites. In 2022 WG requested a further piece of work to provide priority schemes specifically for areas of patient safety, the budget was again re-evaluated at circa £130m, this exercise was concluded in Mar23 and submitted to NWSSP-SES for draft scrutiny.

Rationale for TARGET Risk Score:
The target risk score, is directly linked to the amount of funding the Health Board (HB) will receive to address the current issues faced across the organisation and our ability to successfully deliver these improvements to reduce risk.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Planned and Preventative Maintenance regimes CAFM system to report and prioritise breakdowns across site. Questionnaires have now been included in CAFM, to measure the performance of our maintenance service. Also to feedback any suggestions on improvements. Condition appraisals (estate survey) and NWSSP-SES audits Backlog database identifies costs of works across the estate Operational Estates staff on site to deal with breakdowns (on-call 24/7) EFAB funding to support DCP (£5.5m over 2 years 2023/24 & 2024/25) Risks are identified by Estates and services and these inform prioritisation of DCP funding Skilled and trained Estates workforce in place.	Limited Discretionary Capital Programme (DCP) funding to address the £124m backlog WG support for the Major Infrastructure Programme has not been confirmed Statutory, mandatory and essential maintenance jobs are prioritised over routine helpdesk jobs (on average only 50% of helpdesk jobs are completed) Reduction in annual capital funding and statutory allocations to address key items.	Undertake general environmental monthly walkarounds across the 4 acute sites to increase understanding and proactive management of day to day estate defects.	Evans, Paul	Completed	Completed
		Development of Major infrastructure Programme for 4 main hospitals and securing external funding	Elliott, Rob (Inactive User)	31/03/2024	PBC submitted to WG in 2018 and the Health Board is working through WG feedback and availability of capital. Currently WG advisors working with Estates to co-develop next phase of identifying key priorities for the Health Board. Timescale of the completion of this action is dependent on WG feedback.
		Undertake general environmental quarterly walkarounds for all community in-patient facilities (including Mental Health facilities) to increase understanding and proactive management of day to day estate defects.	Evans, Paul	31/12/2023	Environmental Walkarounds are now a standing agenda item as part of Estates Monthly OMT meetings. Quarterly walkarounds will be fully in place before the end of December focusing on all community in-patient facilities including MH services. A standardised form will be used to record and collate the items of concern for resolution/mitigation.
		For the Health Board to continue it's journey and strategic plan through continued collaboration with all stakeholders and communities towards the creation of a sustainable and comprehensive healthcare model for the region. The vision to bring as much care as possible closer to people's homes, with plans for multiple integrated health and care centres, designed with local communities, across Carmarthenshire, Ceredigion and Pembrokeshire. In addition, our new hospital will be a pivotal piece in enhancing specialist care services in Hywel Dda and will enable us to provide a sustainable hospital model fit for future generations.	Davies, Lee	31/03/2024	The Health Board has submitted ambitious plans to the Welsh Government, in early 2022, which if successful, could result in the region of £1.3billion investment into health and care in west Wales.

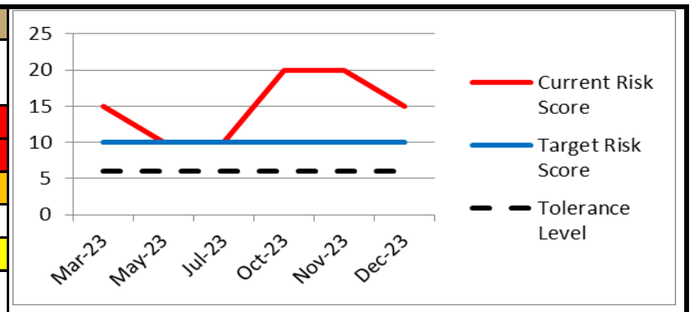
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Regular review of 'environment' themed risks identified on operational service risk registers	1st								
	Feedback questionnaire on CAFM maintenance system to measure effectiveness of maintenance service and to offer additional feedback or suggestions on all closed maintenance requests	1st								
	Health and Safety Committee review of risks above tolerance	2nd								
	Independent Member & Executive Director Walkabouts	2nd								
	External surveys are undertaken	3rd								
	NWSSP-SES Internal Audit on Estates Condition (Limited Assurance)	3rd								

Date Risk Identified:	Nov-22
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Dec-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jan-24

Risk ID:	**1531**	**Principal Risk Description:**	There is a risk of being unable to provide a safe and sustainable general surgery consultant on-call rota at WGH. This is caused by vacancies across the General Surgery Consultant rota (1:5) at WGH and one substantive consultant who is no longer taking part in the on call rota, due to health issues. There is reduced capacity to support rotas internally (BGH/GGH Consultants). This could lead to an impact/affect on the ability to provide an emergency general surgery service 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):	3×5=15
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	↑



Rationale for CURRENT Risk Score:

The risk score has remained the same, due to the Medacs locum allowing the surgical emergency service at WGH, to continue on a 1:4, 24/7 rota with 2 substantive consultants, 1 NHS locum and 1 Medacs. The 1:4 rota has been in place since 03/11/2023, with no issues to date. The rota remains fragile due to the reliance on Medacs locum cover and the cost and risks that this involves. An NHS locum consultant was appointed on 20/11/2023, this candidate has since withdrawn on 29/11/2023. There will now be a continued reliance on Medacs locum cover.

The speciality doctor rota is also being supported by a Medacs locum but a 12 months fixed term post has been appointed to which is an exit strategy for the Medacs locum on that rota.

Rationale for TARGET Risk Score:

The target risk score remains high due to the intended recruitment of a second NHS locum to fill the gap and maintain a 1:4 24/7 on call rota at WGH. However, this will not address the longer term sustainability of the rota and lack of substantive staff to fill 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**
There are currently 4 consultants on the rota, 2 substantive, 1 NHS locum and 1 Medacs locum who joined the team on 06/11/2023. An NHS locum consultant post was advertised and appointed to on the 20/11/2023 as an exit strategy for the Medacs locum. The successful candidate withdrew on 29/11/2023 and a decision on re-advertising is yet to be finalised. Current staff from WGH and GGH continue to provide backfill to maintain the rota. Continuously liaising with the rota coordinator at WGH for potential gaps on the rota.	The 1:4 model which commenced on 03/11/2023 continues to be fragile, with only 2 substantive consultants on the rota. The 4th slot on the rota is being filled by a Medacs locum which incurs additional costs. There are also risks of the locum leaving at short notice, causing the rota to collapse. An NHS locum consultant post was advertised and appointed to on the 20/11/2023 as an exit strategy for the	Recruitment of 2 x substantive and 1 x locum positions	Lewis, Caroline	20/11/2023	One NHS locum has been recruited and has been in post since 04/09/2023. Currently out to advert for a second NHS locum (following a previous withdrawal of application) Interviews are due to take place on 20/11/2023.
		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.

Proactive sickness management Escalation to clinical leads Medacs locum has been briefed on clinical pathways and procedures within Hywel Dda Health Board and expectations have been made clear by the surgical team. Engagement with WGH Medical Staff Committee and public on changes to services An interim 1:3 model with day consultant cover being provided by WGH consultants and night consultant cover being provided by BGH or GGH on a rota, came to an end on 03/11/2023. Board approval was received for a 1:4 24/7 surgical consultant on call rota to commence from 03/11/2023. The rota consists of 2 substantive consultants, 1 NHS locum, 1 Medacs locum. Clinical pathways in place and concerns are dealt with in a timely manner.	Medacs locum. The successful candidate withdrew on 29/11/2023 and a decision on re-advertising is yet to be finalised. To maintain the current rota model, we will now be reliant on the Medacs locum for a longer period. The locum consultant who started on 04/09/2023 was an associate specialist and part of the MG rota, this has now left a gap on that rota. Currently being covered by a Medacs locum. We advertised and appointed a specialty doctor but the successful candidate withdrew on 13/11/2023. The post went back out to advert and interviews were held on 01/12/2023, a successful candidate is now onboarding. Concerns raised about a transfer, which is being managed by an IMG process. Vacancies remain due to inability to appoint permanent Consultants to WGH. Risk of short notice sickness, with limited options of sourcing internal cover for this. 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.	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)	Lewis, Caroline	31/12/2023	We have now received the final GIRFT report and the action plan has been received at executive level. A full action plan is now supported and clinically led by the health board general surgical clinical lead, nursing and operational teams.
		Robust plans to be developed for transfer and repatriation of patients	Lewis, Caroline	Completed	SOP has been developed and discussed with clinicians.

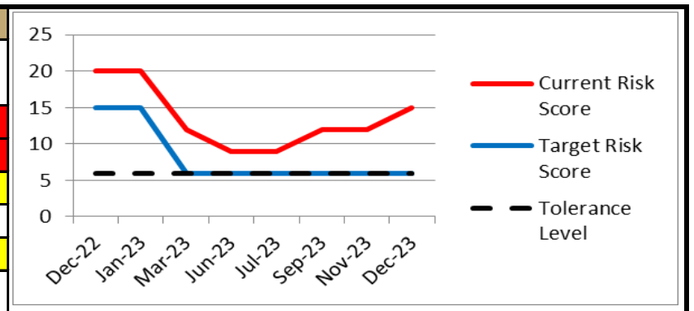
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are 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) Management team to present updated SBAR to Acute Leadership Group (Oct23) Management team to present updated SBAR to Acute Leadership Group (Nov23)	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	Completed	on 10/05/2023, an update was provided to Ben Rogers of the clinical services programme for the draft SBAR clinical services update which is what was taken to board.
	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									

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

Executive Director Owner:	Gjini, Ardiana	**Date of Review:**	Dec-23
Lead Committee:	Quality, Safety and Experience Committee	**Date of Next Review:**	Jan-24

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 Health Board staff and staff in other NHS/partner organisations, eg Welsh Ambulance Service Trust (WAST). This is caused by the British Medical Association (BMA) announcing dates of strike action following a ballot to members which received support for industrial 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, 1641, 1666	

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):	5×3=15
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	6
Trend:	↑



Rationale for CURRENT Risk Score:

The British Medical Association (BMA) have declined an offer of 5% uplift (1.5% uplift for Junior Doctors including SAS Doctors) for 2023/24 to basic pay. Ballot notices were received by employers (both Hywel Dda UHB and NWSSP) detailing that the ballot to members would run until 18 December 2023. This applies to Junior Doctors only. Confirmation has been received that the BMA reached the 50% threshold required to mandate action for the period 8th January - 17th June 2024.

Mitigation and contingency measures, together with command and control structures put in place during periods of previous action by Trade Unions resulted in a co-ordinated response to minimise impact as far as possible, and this has been re-established. The BMA have advised that they intend to take an initial 72 hours consecutive period of industrial action from 7am on 15th January to 7am on 18th January 2024. This will be a full walk out of all junior doctors including those providing emergency cover. No formal notification has been received relating to the Specialty and Specialist (SAS) Doctors or Consultants to date.

Additionally we are expecting to receive formal noticed from the British Dental Association notifying of their intention to ballot members in the new year.

Rationale for TARGET Risk Score:

The likelihood has been increased as the BMA has confirmed the ballot outcome and announced dates of industrial action. Executive ownership is joint (Directors of Public Health, Workforce and Operations) but will be supported by the Medical Director and Director of Nursing, Quality and Patient Experience as required.

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. Proactive compilation of critical service areas from a HB perspective (based on Essential Services Guide) completed. 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. Local support in place to enable accurate completion of derogation forms if required. Range of contingency measures ready should any derogations be refused. Medical representation secured for the Industrial Action Planning Group All Wales Industrial Action Workforce & Derogations Group established. All Wales Operational Planning Group established. System Resilience Planning and Response Group National Co-ordination Industrial Action Working Group established. Health and Social Services Executive Director Team (HSS EDT) Contingencies Group - Industrial Action Oversight Group established in Welsh Government.		Specific response plans will be developed following notification from the B,A on dates they intend to take strike action on. These will include early contact between NHS Employers ((on our behalf) and the BMA; derogation process; student arrangements; and links to national process. The updating of previous key controls will be instigated as necessary to prepare for the announced action dates.	Gjini, Ardiana	~~05/06/2023~~ ~~21/08/2023~~ ~~05/11/2023~~ ~~03/01/2024~~ 15/01/2024	Will progress via the Industrial Action Planning Group as dates now confirmed.
		To confirm new chair and vice chair of Industrial Action Planning Group	Gjini, Ardiana	Completed	Executive Director of Public Health has been appointed Chair of IA Planning Group, and deputised by Executive Director of Workforce.
		Range of contingency measures to be developed should any derogations be refused.	Gjini, Ardiana	15/01/2024	In progress as derogation procedure to be finalised and these will be managed centrally via NHS Employers.

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 regularly	1st								
	Regular updates to Executive Team and OPDP	1st								

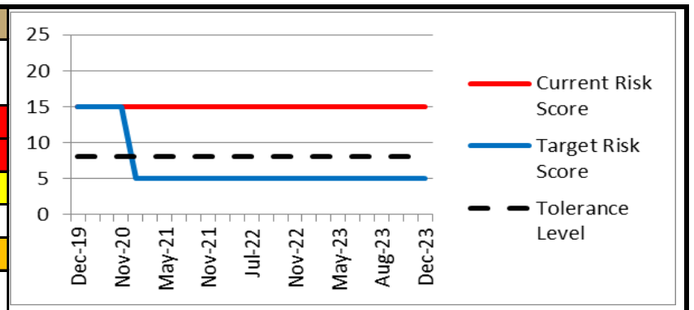
Date Risk Identified:	Oct-19
Strategic Objective:	3. Striving to deliver and develop excellent services

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Dec-23
Lead Committee:	Health and Safety Committee	**Date of Next Review:**	Jan-24

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 Mid and West Wales Fire and Rescue Service (MWWFRS) letters and Enforcement Notices. All programme dates have been agreed with the Health Board, Welsh Government (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 they are comfortable with the current position. Extensions of time particularly for WGH Phase 1 (Aug 23 to Oct 23) and GGH Phase 1 (Aug 23 to Jan 24) have been fully agreed by MWWFRS. Currently, 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 Health Board 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 Health Board in the form of expertise and technical knowledge. The Health Board 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.

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.	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.	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

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. 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.	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. 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. Whilst the new BORIS system is now in place, fire risk assessments are still being transferred from the old system as at July 2023.			

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.
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.

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. There is an improving performance in terms of uptake of training sessions across all levels.

Boris fire safety system implemented across the UHB, giving the ability to review all risks from fire risk assessments via a dashboard.

Fire Team issued recent Global communications to request additional Fire Safety Wardens, to seek engagement from staff and colleagues across the Health Board.

RAAC plank surveys are also being undertaken at the same time as the fire works to minimise the disruption to clinical services where at all possible.

WBH - Completion of Phase 1 works - For all remaining horizontal escape routes.	Elliott, Rob (Inactive User)	~~31/01/2023~~ ~~31/03/2023~~ ~~31/08/2023~~ 31/10/2023	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 October 2023.
WBH - Completion of Phase 2 works - For all departments, ward areas and risk rooms.	Elliott, Rob (Inactive User)	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 (Inactive User)	~~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 (Inactive User)	~~30/04/2024~~ 30/08/2024	Phase 2 remains on programme to be completed by August 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 (Inactive User)	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.
To ensure all fire risk assessments are transferred from NWSSP-SES system to Boris	Evans, Paul	31/03/2024	To be provided at next risk review

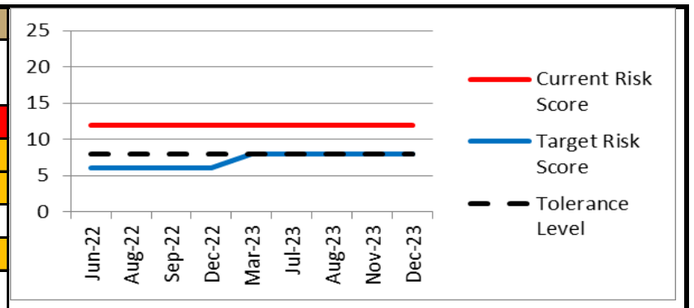
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
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:	Feb-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Nov-23
Lead Committee:	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Jan-24

Risk ID:	**1350**	**Principal Risk Description:**	There is a risk of the Health Board 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 Reduced capacity due to the impact of COVID-19 and our ability to meet the expected demand for diagnostics and treatment delays at our tertiary centre. The impact being an increased number of patients waiting in excess of 62 Days. 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, 1699, 1722, 1723	

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 impact of COVID-19 has increased the risk of being unable to meet the target. The delays are caused by diagnostic capacity issues across the health board . The main area of concern is Radiology. A decrease in capacity for appointments and results reporting within radiology, 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. The consequence of which resulted in short term planned and unplanned step down of activity within outpatients and planned surgery. This led to an increase in the backlog of patients waiting in excess of 63 days. Performance since April 2022 has been variable due to treating higher volumes of patients particularly in the Urology and LGI pathways. Performance was at 46% Sept 23. Performance is on trajectory to improve in Quarter 4 and landing at 70% March 2024.

Rationale for TARGET Risk Score:

The aim is to treat patients within target waiting times, which has now been confirmed as 75% non-adjusted 2022-2026.

The tolerance level will be met if plans to increase diagnostic capacity, utilising allocated recovery funding are realised. Publication of performance data by WG recommenced in Feb21 with health boards only reporting against the SCP, with no wait adjustment.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# A Gi Improvement Group has been established . The aim is to implement the NOP for the GI Pathways. # Fully established cancer tracking team in place to allow patients to be proactively tracked through their pathways. # A new cancer dashboard developed by Informatics with the support of Business Intelligence (BI) SCP funding from the Wales Cancer Network. This is now live with access for Cancer Services staff and Service Managers, allowing MDTs to actively monitor tumour site specific patients on a SCP. # The health board have been piloting the use of Quarterly Planning and Monitoring reports developed by the NHS Executive since July 23. This has facilitated the development of targeted improvement plans per tumour site and subsequent weekly monitoring thus providing assurance of the robustness of plans. # 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. A Straight to FIT test is being implemented within the health board, where depending on the result of the FIT test, as to whether an OPA or any further investigations are required, which will reduce the pathway by 14 days. On 6th April the health board introduced FIT10 screening into Primary care. This has resulted in a reduction in demand of 30% for first OPA. # 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 have been 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. # Weekly monitoring of Urology diagnostic improvement trajectory via Cancer watchtower. # 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). # Continue to escalate concerns regarding tertiary centre capacity and associated delays.	Anticipated significant gaps within key diagnostic services to address required levels of activity to support SCP. Key diagnostic information systems do not support effective demand / capacity planning. Need for the implementation of new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment pathways. Access to green pathways and tertiary centres fluctuates depending on COVID-19.	The Wales Cancer Network are employing Single Cancer Pathway (SCP) Project Managers for each health board across Wales to support the SCP work and the optimisation of the National Optimal Pathways	Humphrey, Lisa	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~~ ~~30/11/2023~~ 31/04/2023	Process in place to implement demand capacity modelling tool in line with SBUHB.
		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~~ 31/03/2024	The Macmillan Cancer Quality Improvement Manager is working with the teams with regards to implementing the new pathways.

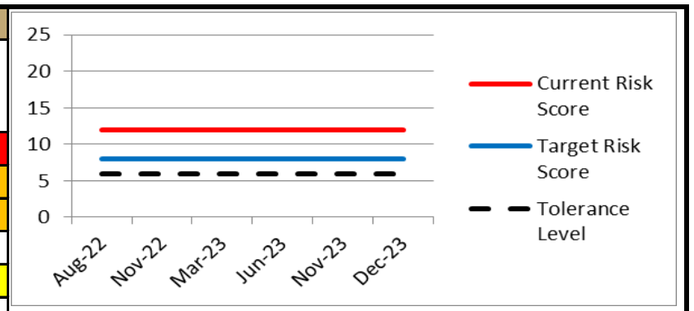
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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								

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

Executive Director Owner:	Gjini, Ardiana	**Date of Review:**	Nov-23
Lead Committee:	Health and Safety Committee	**Date of Next Review:**	Jan-24

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, this remains unaltered. 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.

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 (detailing internal command and control structures) # 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 2024 # 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 Health Group. # Health Board Pandemic Influenza Response Framework and associated plan(currently under 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 # Pandemic Planning Group re-established		Review of Pandemic Response Framework in progress which broadens remit from Influenza focus to generic pandemic events.	Hussell, Sam	31/01/2024	Draft for review currently being prepared.

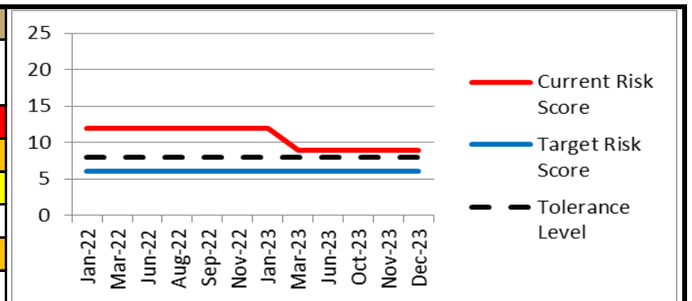
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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) including LRF workstream reports to Health & Safety Committee	1st			Vaccination Delivery Programme Update - Board via SDODC (Sep 23) Major Incident Plan - Board via HSC (Jul23)	None identified.				
	Operational pandemic reporting structures from HB to WG	2nd								
	National, regional & local command & control structures	2nd								
	National groups operational for vaccination programme planning & delivery	3rd								
	Emergency Planning Advisory Group (EPAG) Wales meetings re Pandemic response and future planning	3rd								

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

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	Nov-23
Lead Committee:	Sustainable Resources Committee	**Date of Next Review:**	Jan-24

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, and work has commenced on scanning legacy documents in to a development environment.

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 Welsh Nursing Care record 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 records management system (EDRMS) Civica. Lease of a second storage facility Scanning of 308,000 non active patient records DPIAs undertaken on the three contractors for scanning providers, with an additional DPIA being undertaken in June 2023 in relation to RICOH Local Project Steering Group, which meets fortnightly and chaired by Deputy Director of Operations and attended by the Digital Director Programme risk register reviewed at Local Project Steering Group Cataloguing exercise undertaken for the sub-contractor with RICOH	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	£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~~ ~~31/10/2023~~ 31/01/2024	Meeting to be arranged.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Information Asset Owner Registers Group	1st			Records Storage SBAR - Executive Team (Jul21)					
	Digital Health Records Project Group to oversee delivery of enabling work	2nd								
	SRC overseeing delivery of Planning Objective 5C	2nd								
	IA Records Management Report (limited - follow up (reasonable) in Health Records only	3rd								