GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	26 September 2024
TEITL YR ADRODDIAD: TITLE OF REPORT:	Corporate Risk Register
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Professor Philip Kloer, Interim Chief Executive
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Wilson, Director of Corporate Governance 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 provide assurance that the corporate risks of Hywel Dda University Health Board (the Health Board) are being assessed, reviewed and managed appropriately.

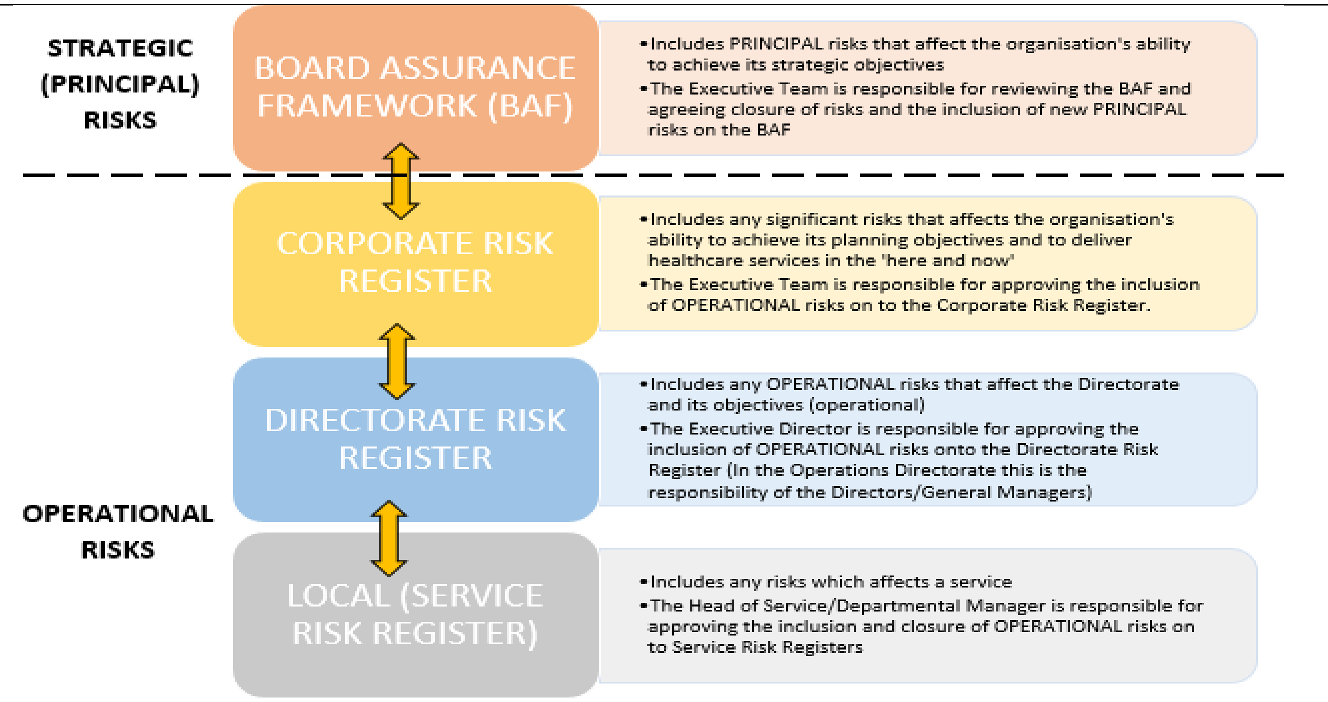
Cefndir / Background

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, via monthly Executive Team meetings, 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 CRR interacts with the principal risks on the Board Assurance Framework (BAF), and the operational risks that are on Directorate and Service risk registers.



Asesiad / Assessment

Since the CRR was previously presented to the Board in May 2024, the risks have been discussed in detail at its Board Committees, and reported to the Board via the Committee Update Reports. Where assurance has not been received that corporate risks are being managed effectively, the Committees can request a more in-depth report at a subsequent meeting.

The CRR includes significant risks associated with delivering the ‘here and now’, whilst the BAF will identify the Health Board’s principal risks to achieving its strategic objectives, and these will be long term in nature. The 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 May 2024:

Total Number of Risks as at May 2024	23	
New/Escalated	3	*See note 1*
De-escalated/Closed	5	*See note 2*
Increase in risk score ↑	2	*See note 3*
Reduction in risk score ↓	1	*See note 4*
No change in risk score →	15	
Total Number of Risks as at August 2024	21	

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 facilitate discussion and provide assurance:

- 1352 - Risk of business disruption and delays in patient care due to a cyber-attack; and
- 1860 – Management of Violence and Aggression Risks
- 1861 – Security Management Infrastructure and Security Management Systems

Details on the 18 remaining corporate risks are included in Appendix 2. Please note the following risks are currently being refreshed by the Executive Risk Owners:

- 1649 - Risk of insufficiently skilled workforce to deliver services in Annual Plan 23/24 due to limited labour market
- 1027 - Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity
- 1860 - Management of Violence and Aggression Risks
- 1861 - Security Management Infrastructure and Security Management Systems
- 1821 - Risk to the welfare of Health Board staff due to current demands

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

HYWEL DDA RISK HEAT MAP

	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 5
CATASTROPHIC 5			813 (→) 1745 (→)	1027 (→) 1531 (→) 1664 (→) 1859 (NEW)	1810 (→) 1843 (↑)
MAJOR 4			1433 (→) 1812 (↓)	684 (→) 1350 (↑) 1352 (→) 1649 (→) 1708 (→) 1861 (NEW)	797 (→) 1032 (→)
MODERATE 3			1821 (→)		1842 (→) 1860 (NEW)
MINOR 2					
NEGLIGIBLE 1					

Note 1 – New Risks

Since the previous report in May 2024, 3 new risks have been added to the CRR:

Risk	Lead Director	New / Escalated	Current Risk Score (Likelihood x Impact)	Rationale for Current Risk Score
1859 - Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration *(approved at Executive Team August 2024)*	Interim Executive Director of Nursing, Quality & Patient Experience	New	**4x5=20**	There are specific concerns relating to Glangwili General Hospital (GGH) and Withybush General Hospital (WGH) in relation to cardiac arrests and unplanned admissions. There has been an increase in Cardiac Arrest rates at GGH in the period January - July 2024 (22), compared to the period January – July 2023 (13). The GGH senior management team have agreed to audit all cardiac arrests and establish bi-monthly scrutiny meetings to review all cases and identify themes and learning opportunities. There has been a significant increase in unplanned admissions at WGH, with 60 noted in the period January - July 2024 at WGH (40 for the equivalent period of January - July 2023). Following the recent WGH RADAR (Recognition of Acute Deterioration and Resuscitation) meeting it was agreed that the Treatment Escalation Plan (TEPs) task & finish group in WGH would be re-established. There are also concerns across the Health Board as a whole relating to the National Early Warning Scores (NEWS), and appropriate escalation where required as part of observation processes. Currently working with Clinical Audit to develop an audit tool on the Audit Management & Tracking

				(AMaT) system to audit on a monthly basis NEWS charts on wards and identify good practice and areas for improvement. Work is underway investigating the opportunity to benchmark the position of Hywel Dda on an all Wales basis. Prior to COVID-19, the National Acute Deterioration Group for Wales (RRAILS) was in place, which gave direction on key initiatives such as Sepsis and NEWS, however this group is no longer supported therefore there is a lack of a consistent approach across Wales. As of July 2024, compliance rates for Level 2 and Level 3 resuscitation training were at 40%. While there is no set compliance target, compliance has never been greater than 60%. Staff availability to attend resuscitation training is problematic due to operational pressures and demand. Because of this, there is a need to identify the most appropriate training level and method to deliver training to staff, to meet the mandatory requirements.
1861 - Security Management Infrastructure and Security Management Systems *(Supersedes Risk 1328. Approved at Executive Risk Group in August 2024)*	Executive Director of Allied Health Professions and Health Science	New	**4x4=16**	*Detail reported via In-Committee*
1860 - Management of	Executive Director of	New	**5x3=15**	*Detail reported via In-Committee*

Violence and Aggression Risks *(Supersedes Risk 1328. Approved at Executive Risk Group in August 2024)*	Allied Health Professions and Health Science			

Note 2 – De-escalated / Closed Risks

Since the previous report to Board in May 2024, 5 risks have been closed or de-escalated:

Risk	**Lead Director**	**Closed / De-escalated**	**Reason**
1548 - Risk to the Health Board maintaining service provision due to industrial action	Executive Director of Public Health	Closed	The Interim Chief Executive agreed via Chair's Action to close the risk on 26 July 2024 as there are no longer active disputes with Trade Unions.
1328 - Risk of harm to staff, patients and critical assets due to insufficient physical security measures	Interim Executive Director of Nursing, Quality & Patient Experience	Closed	Formal Executive Team agreed to close this risk on 5 June 2024, and open 2 new separate corporate risks relating to security systems and violence and aggression (detail on these 2 new risks is reported via In-Committee)
1822 - Risk to the welfare of senior management due to current demands	Executive Director of Workforce & OD/Interim Deputy CEO	Closed	Formal Executive Team agreed to close this risk on 3 July 2024. Risk 1821 has been reviewed to be inclusive of all levels of staff.
1699 - Risk of loss of service capacity at WGH due to surveys and remedial work relating to RAAC	Chief Operating Officer	De-escalated	Formal Executive Team confirmed the de-escalation of this risk at its meeting held on 5 June 2024 to Directorate level, accepting that a number of services were still displaced.
1335 - Risk to the ability to access paper patient records in a timely manner due to existing records management infrastructure	Chief Operating Officer	De-escalated	Formal Executive Team agreed the de-escalation of this risk to Directorate level on 7 August 2024. Progress has been made in mitigating this potential risk as a result of the lifting of medical record destruction embargoes, and the dispatch of 400,000 records for external scanning.

Note 3 – Increase in Current Risk Score

Since the previous report to Board in May 2024, the score of 2 risks have increased:

Risk	Risk Owner	Previous Risk Score: May 2024 (Likelihood x Impact)	Risk Score: Aug 2024 (Likelihood x Impact)	Date risk reviewed	Rationale for Current Risk Score
1843 - Risk that the cash consequences of the Health Board deficit cannot be covered due to significant deficit position	Executive Director of Finance	4x5=20	5x5=25 (↑)	12/09/24	The annual plan for 2024/25 is unacceptable to the Board and to Welsh Government. The Board have been involved in the discussions and decisions in the development of the plan through our Committees, Board Seminar sessions, and Public Board meetings. The Board, at its meeting on the 28 March 2024, endorsed the annual plan, recognising the forecast financial outturn remains unacceptable and in breach of the Health Board's statutory requirement to achieve financial balance. Without further support, the Health Board will require further cash-backed support as the extent of the cash allocation will be insufficient to pay our liabilities as they fall due in February and March 2025. Through our 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. Efforts to de-risk the plan during Q1 have not delivered the required impact, however, these efforts did accelerate during Q2.

					The financial position in Month 5 has represented an improvement over the position up to Month 4; that said, the run rate remains in excess of the plan. The Board Seminar on 11 September was provided with actions which will be taken to improve the deficit to deliver £64m, but there is limited assurance at this stage that those actions have been operationally embedded. Once assurance can be gained over this position, and once confirmation over the cash support from Welsh Government is obtained, it is anticipated that this risk can be reduced.
1350 - Risk of not meeting the 75% SCP waiting times target for 2022 - 2026 due to diagnostics capacity and delays at tertiary centre	Chief Operating Officer	**3x4=12**	**4x4=16**	23/08/2024	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 and impact of industrial action 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.

Note 4 – Reduction in Current Risk Score

Since the previous report to Board in January 2024, the score of 1 risk has reduced:

Risk	Risk Owner	Previous Risk Score: May 2024 (Likelihood x Impact)	Risk Score: Aug 2024 (Likelihood x Impact)	Date risk reviewed	Rationale for Current Risk Score
1812 - Risk of non-compliance with Medical Examiners (Wales) regulations due to the failure to fully resource internal processes	Interim Executive Medical Director	**4x4=16**	**3x4=12 (↓)**	30/07/24	New processes are in place for mortality review, in line with the All-Wales Learning from Mortality Framework, supported by the Clinical Lead for Mortality and Mortality Review and Improvement Facilitator. As at July 2024, 2 wards remain outstanding at GGH who require training, with this envisaged to be completed by mid-August 2024, therefore increasing scanning capacity. As of July 2024, the risk score has been reviewed and revised to 12, with the likelihood score reduced reflecting the increased capacity to scan, along with a review of existing processes and procedures to ensure compliance with Medical Examiner requirements. The capacity for clinical scanning remains below the required level, however it has increased recently due to the appointment of a Clinical Effectiveness Co-ordinator, and the Directorate will continue to review ongoing capacity requirements. GGH scanning staff are currently scanning some of Prince Philip Hospital (PPH) case notes and all GGH wards. In line with the above screening resources, the Directorate will monitor the current backlog and develop contingency plans where required.

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.

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) defines **risk tolerance** as 'the organisation's readiness to bear a risk after risk treatment in order to achieve its objectives', however it can be simpler to see it as a series of limits such as lines in the sand beyond which the organisation does not wish to proceed.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Team

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

Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Aug-24	Trend	Target Risk Score	Risk on page no...
1843	Risk that the cash consequences of the Health Board deficit cannot be covered due to significant deficit position	Thomas, Huw	Finance inc. claims	6	4×5=20	5×5=25	↑	3×4=12	6
797	Risk to the ability to deliver ultrasound services due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	5×4=20	→	3×4=12	10
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	15
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	22
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	26
1859	Risk of poor patient outcomes and experience due to inability to effectively recognise and manage acute deterioration	Daniel, Sharon	Safety - Patient, Staff or Public	6	N/A	4×5=20	New risk	2×3=6	30
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	4×5=20	4×5=20	→	1×5=5	36
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	40
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	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	4×4=16	4×4=16	→	2×4=8	53
1708	Risk of increasing fragility in primary care contractor services due to recruitment challenges	Paterson, Jill	Service/Business interruption/disruption	6	4×4=16	4×4=16	→	2×4=8	60
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	3×5=15	3×5=15	→	2×5=10	64
1842	Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 24/25 due to demand exceeding capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×3=15	5×3=15	→	3×3=9	67
1810	Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS.	Paterson, Jill	Service/Business interruption/disruption	6	3×5=15	3×5=15	→	1×5=5	70
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	74
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	80
1812	Risk of non-compliance with Medical Examiners (Wales) regulations due to the failure to fully resource internal processes	Henwood, Mr Mark	Quality/Complaints/Audit	8	4×4=16	3×4=12	↓	2×2=4	83
1821	Risk to the welfare of Health Board staff due to current demands	Gostling, Lisa	Workforce/OD	8	3×3=9	3×3=9	→	3×2=6	87

Assurance Key:

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

Key - Assurance Required		*NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you*
(blue)	Detailed review of relevant information	
(pink)	Medium level review	
(purple)	Cursory or narrow scope of review	

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

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

	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 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

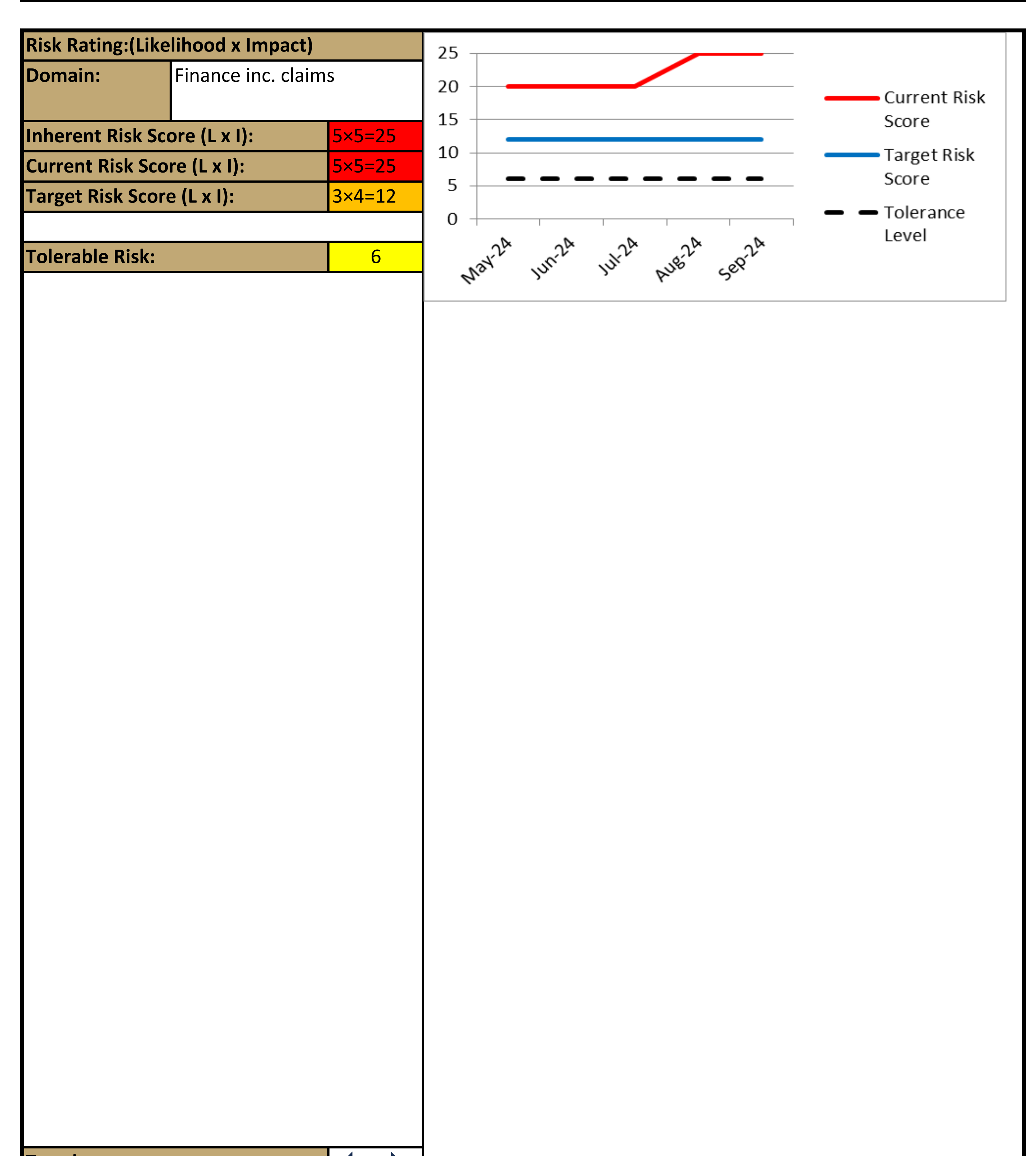
RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	Extreme	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A 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.

Date Risk Identified:	Apr-24
Strategic Objective:	6. Sustainable use of resources

Executive Director Owner:	Thomas, Huw	Date of Review:	Sep-24
Lead Committee:	Sustainable Resources Committee	Date of Next Review:	Sep-24

Risk ID:	1843	Principal Risk Description:	There is a risk that neither the Health Board or Welsh Government (WG) are able to fully cover the cash consequences of the Health Board deficit. This follows WG feedback stating that the Health Board deficit is unaffordable and unacceptable. This is caused by This is caused by the financial plan for 2024/25 setting a £64m deficit plan against a WG control total of £44.8m, which is itself a consequence of: 1. Continued significant growth in expenditure across our unscheduled care services; 2. Staffing pressures and reliance on locum and agency staff to fill gaps; 3. Continued pressure across services and sites as demand exceeds capacity, compromising patient flow and elective pathways; 4. The embedded impact of recent inflationary pressures on the costs of goods, drugs and services from providers; 5. Capacity and capability amongst budget holders and service leads to adequately engage with the financial agenda. Despite efforts to de-risk the financial plan in Q1, the plan has not been fully de-risked and as a consequence, the current financial trajectory represents a risk projection of £68m for the year. The recovery of the financial position has been hampered by insufficient assurance over the identification and operational delivery of the required level of savings; and by insufficient controls in place on the operational drivers of expenditure, most significantly in the management of beds, rostering controls and drugs expenditure. Given the scale of the deficit, transformational change is required at a pan Health Board level in addition to ensuring there is a robust control environment at a Directorate level. The savings schemes put forward by Directorates to date do not capture the scale of change and financial impact required. This could lead to an impact/affect on 1. An inability to meet the Ministerial priority of operating within our budget; 2. An inability to develop an approvable Integrated Medium Term Plan; 3. A likely impact that the Health Board has insufficient cash available to make payments to suppliers in February and March 2025; 4. A likely impact on the delivery of WG performance measures and consequential impact on patients having to wait longer for care or treatment; 5. A potential impact that the Health Board will be escalated further from Targeted Intervention to Special Measures.
Does this risk link to any Directorate (operational) risks?			

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:
The annual plan for 2024/25 is unacceptable to the Board and to Welsh Government. The Board have been involved in the discussions and decisions in the development of the plan through our Committees, Board Seminar sessions, and Public Board meetings. The Board, at its meeting on the 28 March 2024 endorsed the annual plan, recognising the forecast financial outturn remains unacceptable and in breach of the Health Board's statutory requirement to achieve financial balance. Without further support, the Health Board will require further cash-backed support as the extent of the cash allocation will be insufficient to pay our liabilities as they fall due in February and March 2025. Through our 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. Efforts to de-risk the plan during Q1 have not delivered the required impact, however, these efforts did accelerate during Q2. The financial position in Month 5 has represented an improvement over the position up to Month 4; that said the run rate remains in excess of the plan. The Board Seminar on 11 September were provided with actions which will be taken to improve the deficit to deliver £64m, but there is limited assurance at this stage that those actions have been operationally embedded. Once assurance can be gained over this position, and once confirmation over the cash support from Welsh Government is obtained, it is anticipated that this risk can be reduced.

Rationale for TARGET Risk Score:
Given the historic challenges relating to operational controls of the drivers of our expenditure, and the operational delivery of savings schemes; it is unlikely that the risk tolerance or target will be achieved in year. Further work is needed to provide assurance that this risk target is achievable over the medium term.

Key CONTROLS Currently in Place:
(The existing controls and processes in place to manage the risk)
1.Timely financial reporting to Directorates, Sustainable Resources Committee, Board and Welsh Government on the finances to inform central and local scrutiny, feedback and decision-making. 2.Oversight arrangements in place at Board level and through the Executive Team structure, including through: a. Value & Sustainability group b. Integrated Quality, Finance, Performance and Delivery (IQFPD) Group c. The Executive Team Escalation framework. 3.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. 4.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

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**
The control of the operational drivers of financial risk has been a significant historic gap in control. This has included: 1. The effective management of rostering; 2. The effective management of beds; 3. Effective contract management arrangements; 4. Oversight arrangements over commissioned services. The delivery of savings plans through the effective and timely oversight of projects and the resulting corrective actions and decisions required.	The implementation of a rostering system across medical staff, and the extension of rostering to other staff groups.	Hill, Carly	~~30/09/2024~~ 31/10/2024	Rostering steering and delivery group established, and chaired by the Interim Deputy Chief Executive / Executive Director of Workforce and OD, to monitor implementation in line with the 100 day plan, with first meeting scheduled for 16 August 2024. However due to recruitment delays, implementation will commence in October 2024.
	Operational adoption of the Welsh Patient Administration System (WPAS) Bed Module and its incorporation into daily site management meetings.	Carruthers, Andrew	31/10/2024	Progress to be provided at next risk review

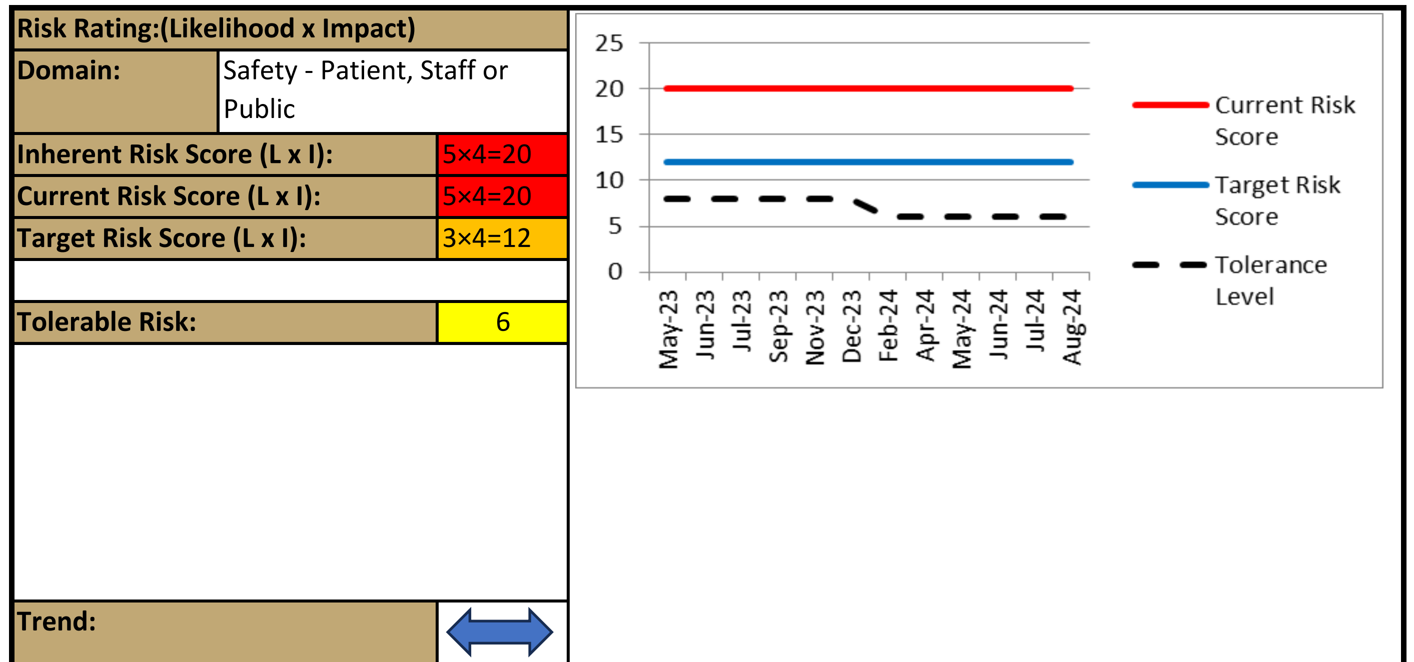
shaped by the Health Board's strategy, “A Healthier Mid and West Wales", and align to the design assumptions set out in that. These have been translated into a series of '100 day cycles' which are due to reach fruition by the end of Q2, and further action taken during August 2024 within operational teams. These are being translated into revised savings plans. 5.Accountability agreements in relation to the Opening Directorate Budgets issued to the Executive Team in April 2024. 6.Delivery of our Planning Objectives and the subsequent financial benefits.		Implementation of a new contract management approach to ensure that services are provided in line with purchasing intentions.	Davies, Rhian	30/09/2024	Following a high-level review of the Health Board’s expenditure, we have assessed the procurement of agency nurses and pharmaceutical supplies as suitable categories of expenditure in respect of which to implement a trial run of an AI contract management solution. We are working through the next steps of procuring this service with procurement and are aiming to have started this process in September.
		Implementation of new oversight arrangements across commissioned services.	Davies, Lee	~~30/09/2024~~ 31/12/2024	As of August 2024, terms of reference are currently being drafted.
		Informed by intelligence within the organisation, incuding the Compendium of Variation, a recovery plan has been framed by the Finance Department as part of efforts to de-risk the original Annual Plan. This has resulted in the development of 100 day cycles which will conclude in September 2024.	Ayres, Shaun	30/09/2024	100 day cycles through the summer months to review and assess the opporunities presented e.g. Bed configuration and Critical care, with a view to realising the delivery of plans within the 100 day period, to enable financial improvement in last 6 months of 24/25 and recurrently.
		Financial Savings and Choice workshops undertaken across Operational Teams in August to facilitate more robust planning between interdependent services.	Jones, Keith	Completed	Aim of framing priority schemes to close the £10.7m saving gap based on Q1 results.
		The cash management strategy will be updated and presented to the SRC for reassessment in October alongside a formal reassessment of the financial trajectory for the year to fully understand the scale of the cash risk which may be experienced.	Davies, Rhian	30/11/2024	This will represent the actions which the HB can undertake to mitigate the residual cash risk following recovery actions within Operational Teams.
		The plans presented at Board Seminar on 11 September, and following approval and due process, are operationalised through our savings tracker. This needs to be completed during September to inform the forecast reassessment for Month 6 in early October 2024.	Thomas, Huw	30/11/2024	Reassessed forecast will be shared with the Board based on the Month 6 position.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Performance against operational plans and targets through Performance KPIs In-month financial monitoring	Performance against plan monitored through Improving Together Meetings.	1st			Mth 1 - Paper to May 2024 Board Mth 2 - Paper to SRC June 2024 Mth 3 - Paper to Board July 2024 Month 5 financial report provided to the Board in September 2024	None				
	Value and Sustainability Group	2nd								
	Sustainable Resources Committee oversight of current performance	2nd								
	Transformation & Financial Report to Board & SRC	2nd								
	WG scrutiny through monthly monitoring returns	3rd								
	WG scrutiny through revised monthly Monitoring Returns (specific supplementary templates) and through Finance Delivery Unit	3rd								
	Audit Wales Structured Assessment process	3rd								

Date Risk Identified:	Nov-19	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Aug-24
Strategic Objective:		Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Sep-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:	6
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 end July 2024 there were 555 patients waiting 8 weeks plus for non-obstetric ultrasound (Dec 2023:1547, February 2024:1288, March 2024:917, April 2024:962,May 2024:731,June 2024 608), with the reduction a result from the use of insourcing and a small amount of overtime by substantive staff (utilising recovery monies).

Long term vacancies exist in Withybush with an impending maternity leave in summer of 2024. There are 2 potential retirements at PPH in the near future and a number in BGH, which constitute a significant percentage of the workforce. There will be an inability to secure agency staff due to the current financial climate of the Health Board.

Three Radiographer sonographers and two Midwife sonographers commenced training in January 2024, however training takes two years to complete for Radiographer Sonographers and 1 year for midwife sonographers (obstetric only).

Only 20% of USC's carried out in 7 days, 49% carried out in 14 days at June 2024

Increased capacity thorough conversion of room for US use

Rationale for TARGET Risk Score:

The actions below will not in themselves reduce this risk significantly. Demand and capacity and the current establishment review is being undertaken by the Ultrasound control group via a needs assessment and is due to be complete by the end of Autumn. 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 where possible. Conversion of room to increase capacity (2022) @ GGH Ultrasound Control Group reconvened in Jan 2024 after having not met since July 2023 due to operational pressures. Meetings take place on a bi-monthly basis. Employment of Physiotherapists and Midwives to undertake scanning within scope of expertise The PPH modality lead vacancy was filled (Feb 2024) Utilising insourced ultrasound service to reduce backlogs of patients waiting >8weeks subject to the availability of recovery funding. Increase in hrs of an existing sonographer at WGH from 0.6 to 0.8 for a period of 6 months from August 2024. Advertise bank sonographer posts to assist on an ad hoc basis, subject to availability at WGH in line with vacancy. Clinical Educator recruited and in post which will facilitate the expansion of training across site.	Inability to release existing staff to train and develop to undertake sonography and growth scans. Inability to recruit and retain staff. While process in place regarding the movement in staff, due to current staffing levels and pressures this is not being implemented, however the teams across sites are collaborating and look at all possibilities when gaps in rota arise and are foreseen.	Develop and implement a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.	Humphrey, Lisa	~~31/12/2022~~ ~~31/10/2023~~ ~~31/01/2024~~ ~~30/06/2024~~ 31/01/2025	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. This training will be brought back to Hywel Dda once the newly appointed Clinical Educator commences post in July 2024. The date of completion of this action has been changed to 31/01/2025 as the current cohort of midwives that are training will qualify. Maternity and child health are required to advise of the plan to utilise the skills of the two trainee midwives and also any plans to train more staff and therefore the owner of this action has been changed to the General Manager for Women and Children's Services. The next Ultrasound Control Group Meeting is in the process of being arranged for September 2024, where the Ultrasound Needs Assessment will be presented.

Action	Lead	Due Date	Progress
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) along with 2 Midwife Sonographers who are currently undertaking clinical training in Powys. Clinical Educator role has been developed and recruited to with the successful candidate due to commence employment on 01/06/2024. This will allow us to expand Ultrasound training an all sites and advertise existing vacancies in ultrasound as training positions under Annex 21 rules. As of August 2024, the Site Leads at WGH and BGH are in the process of obtaining necessary permissions and seeking support to composed appropriate adverts for external advertisement. The action completion date is reflective of the time required to train any successful persons appointed in late 2024.
Work with the workforce planning team to build a sustainable workforce plan for ultrasound services.	Roberts-Davies, Gail	~~31/10/2023~~ ~~31/03/2024~~ ~~31/07/2024~~ 31/10/2024	Fortnightly workforce planning meetings in place with colleagues from Radiology and Workforce in attendance. Stakeholder mapping exercise being undertaken as at December 2023. Work is ongoing in this area and is currently concerned with the Clinical Services Plan issues paper along with the Radiology Annual plan (Jan/Feb 2024) and the Ultrasound needs assessment. A draft operational workforce plan has been developed as of June 2024 and requires revision prior to sign off. This has been delayed due to workload as a result of urgent TI actions and operational pressures during which workforce meetings ceased. This work will be undertaken in late September/early October 2024.

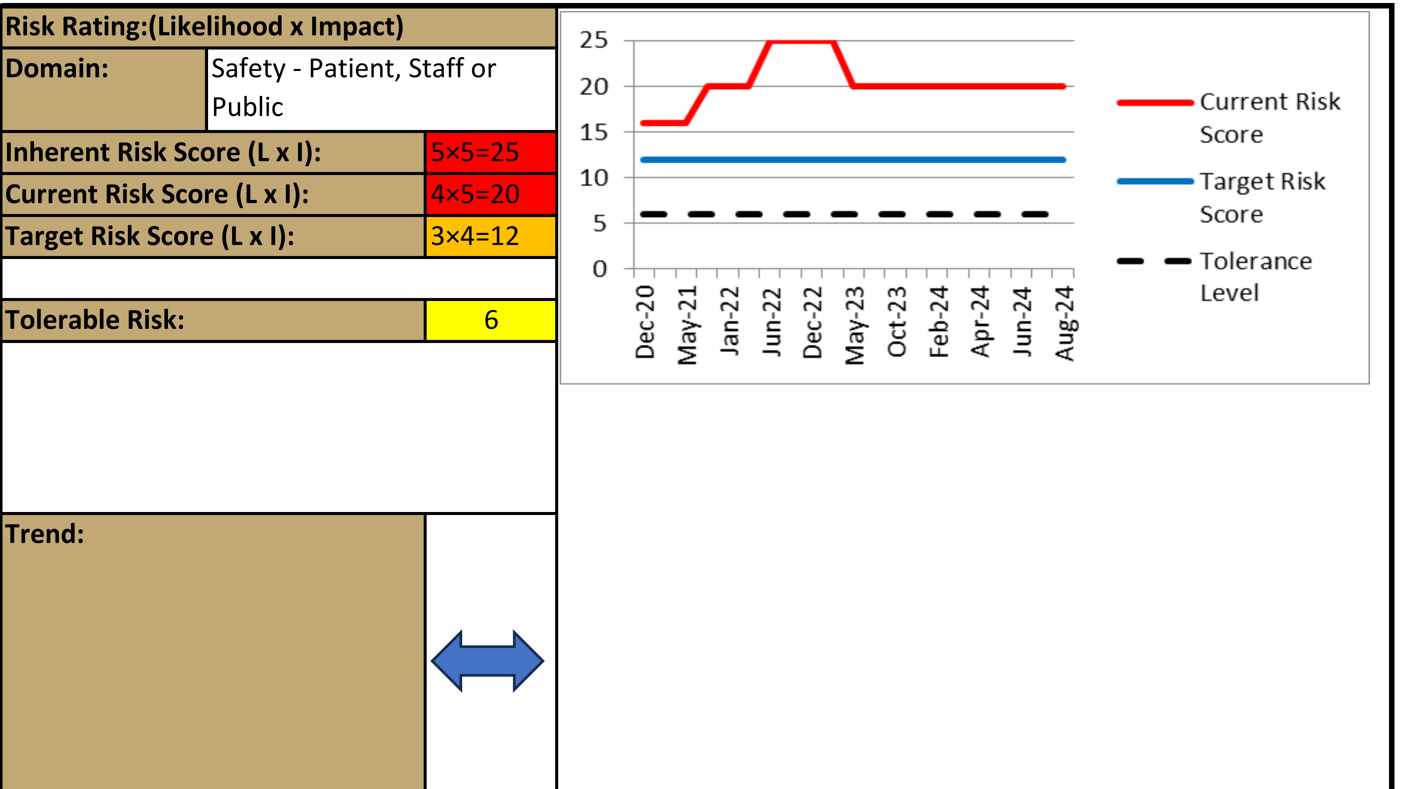
		Seek support to undertake a demand and capacity (D&C) review and detailed establishment review of the radiology service.	Jones, Keith	~~30/06/2022~~ ~~30/11/2022~~ ~~31/03/2023~~ ~~30/08/2023~~ ~~31/01/2024~~ ~~31/05/2024~~ ~~31/07/2024~~ 31/10/2024	Initial contact made with workforce planning team re: establishment review work. This has been discussed in the Radiology Use of Resources Meeting. A Radiology dashboard is in place which provides activity and demand. A new dashboard was published in Jan 2024 which is aligned to ARCH development. 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. Workforce planning work is taking place and as of Jan 2024 and concerned with the operational workforce plan and annual plans. An ultrasound needs assessment is currently being undertaken via the Ultrasound Control Group. The next Ultrasound Control Group Meeting is in the process of being arranged for September 2024, where the Ultrasound Needs Assessment will be presented which will further inform the ultrasound workforce plan.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Non-Obs ultrasound - longest wait 28 weeks as at end July 2024 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 (20% of USC carried out in 7 days, 49% carried out in 14 days at June. 2024), 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:	Nov-20	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jun-24
Strategic Objective:	5. Safe and sustainable and accessible and kind care	Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Jul-24

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:	Rationale for TARGET 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, whilst positive progress has been achieved during 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; this has not been sustained through the winter 2023/24 period, with a significant re-emergence of system-wide capacity pressures. Notwithstanding continuing progress in delivering the Health Boards TUEC objectives, there has been a notable increase in the volume of patients with lengths of stay (LOS) in excess of 21 days across all hospital locations during this period. With specific reference to Withybush Hospital, UEC performance has been significantly impacted since the Summer of 2023 due to the extent to which the RAAC infrastructure improvement project has reduced capacity. The completion of improvement works in closed wards areas has enabled the return of previously closed capacity at the hospital and it is anticipated this will support performance, quality and patient experience improvements from April 2024. Whilst recent experience suggests early signs of improvement against key UEC metrics, these remain outside target requirements and therefore the risk score remains unchanged as at June 2024, pending further review.	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. Plans for improvement during 2024/25 are reflected in the HB's Annual Plan, approved by the Board in March 2024.

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. # 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.	# 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. # 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	Develop plans to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	~~31/03/2024~~ 30/06/2024	Please refer to risk 1649 on the corporate risk register which provides detail on actions to address insufficient workforce to support delivery of essential services.

# 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. # 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 # Integrated whole system, urgent and emergency care plan agreed. # Establishment of a Discharge to Assess (D2A) Group which reports to the Unscheduled Care group. # Establishment of a D2A Escalation Transfer panel which provides senior oversight of delays, assesses risk of the delay to the patient and organisation in terms of flow compromise # To optimise step down bed capacity in the community across care homes and community hospitals # SRO in place to lead agreed Urgent and Emergency Care (UEC) programme # Supernumery HCSWs aligned to the acute response teams to support failing community care capacity # Support for complex discharge caseload management tool (SharePoint) appointed # SDEC models continuously reviewed and refined to maximise impact on admission avoidance. # 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.	# Effective and timely communication to the public at times of pressure but also of safe alternatives to hospital admission / ED presentation that will contribute to changing public mind set / expectation and culture in terms of use of NHS resource and 'Home First' # Education and training for best practice in frailty management mandated to effect culture of 'unsafe to admit' for our very / severely frail # Supporting staff to be able to better 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	Incorporate and deliver actions that will address control gaps into the Health Board's UEC Plan.	Carruthers, Andrew	31/03/2025	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, with progress reported regularly to Board Committees.
		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.

# 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).		sufficient analytical support # the ability to risk stratify for people at moderate to high risk of admission in the community to implement proactive anticipatory care plans to support avoidance of exacerbation / decompensation and hence increased risk of hospital admission # Optimising our bedded facilities in the community i.e we should aim for ‘step up’ from community and from ‘front door’ hospitals (within 72 hours) rather than as a ‘step down’ from acute hospitals after long length of stay. LOS should be no more than 10 days # Bespoke recruitment targeted at critical posts that will deliver improvements in UEC eg ANPs, APPs, PAs etc. and accept risk to permanently fund such posts i.e should not be temporarily funded. # Frailty screening by staff in ED and reporting into WPAS to support risk stratification of patient cohorts who should spend no more than 10 days in hospital. Majority should be turned around in 12 hours and < 72 hours. # Frailty screening and reporting into WPAS of inpatients who either have formal care in place on admission or whose level of frailty on admission suggests a need for care and support on discharge. This will support risk stratification to support discharge planning and coordination. # Consideration of workforce development for existing staff but also bespoke opportunities for non clinical				

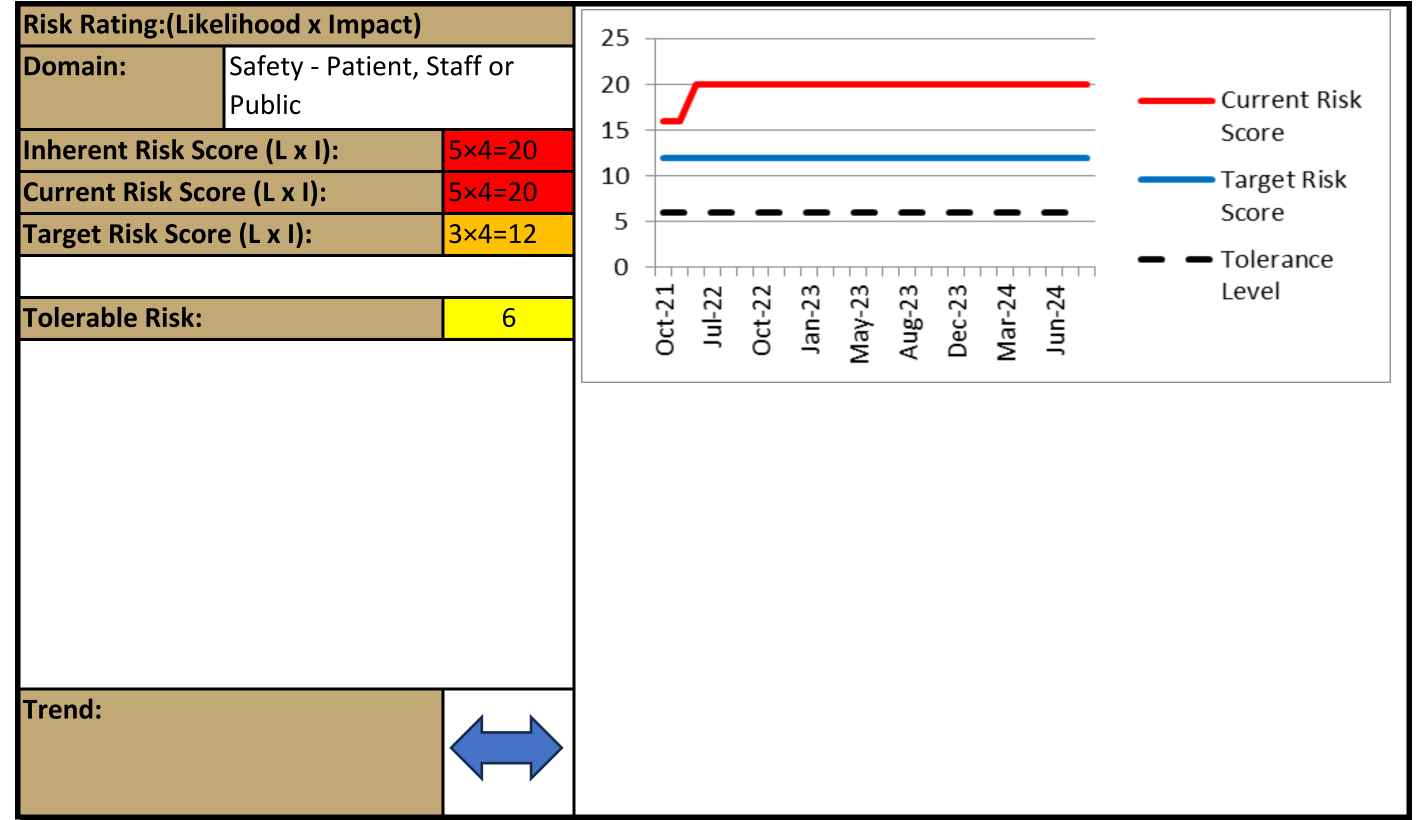
	bespoke opportunities for non clinical roles that releases clinical time for 'clinicians to only do what they can do' # Reduce service duplication across sites # Inconsistent clinical provision for the Out of Hours (OOH) Service # Development of 24/7 urgent primary care service that integrates urgent primary care service in the day and GP OOH 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 SDODC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	IPAR Performance Report to SDODC & Board	2nd								
	WAST IA Report Handover of Care	3rd								
	11 x Delivery Unit Reviews into Unscheduled Care	3rd								
	Delivery Unit Report on Complex Discharge	3rd								

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Aug-24
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Sep-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, 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 of July 2024, there are 3,356 on the waiting list. Recommendations received from NHS Executive in relation to Children's ND services are in the process of being implemented. The Directorate is working with Women and Children's Directorate to implement these.

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% monthly improvement trajectory. For psychological services a trajectory is now in place for 1% per month.

Rationale for TARGET Risk Score:

The Directorate is prioritising implementation of WPAS in key areas within MHLD and this will enable improved reporting and waiting list management and enable forward trajectories of improvement in waiting times to be determined.

The target risk score will be dependent on securing recurring funding for the IAS and Children's ND service as well as having access to appropriate clinical venues and other agencies being able to undertake their associated assessments.

While trajectory plans are in place as of March 2024, there is recognition that the Health Board will not achieve WG targets. The end of procurement contracts with external providers will further negatively impact trajectories

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 WG funding received in 2022/23/24/25 for ND services 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. Autism Advice Hubs and pre-assessment workshops in place for Children and adults Neurodevelopmental Service Rolling programme of workshops offering advice and support around neuro-divergence for parents of children aged 2-11 years and 12 years and over awaiting diagnostic assessment. Monthly meetings to meet recommendations of NHS Executive's Action Plan in respect of CYP ND services in place. ND Service Delivery Managers appointed and in place. All posts recruited in to Children's ASD service. With the exception of clinical psychology in adult autism services, all clinical substantive posts recruited in to, with no retention issues	Although dedicated premises have been sourced for ASD services, there is limited clinical space and Estate issues remain a challenge as identified in the risk narrative. Information not currently included on Health Board website or QR codes due to IT difficulties Additional funding received in 2022/23 for ND service on fixed term annual basis until 2025 Current resource does not provide sufficient capacity to meet demand Unable to recruit in to Clinical psychology in adult ASD service Current procurement exercise to outsource portion of diagnostic assessments to external provider for children and adult services ends March 2025 and will further negatively impact trajectory.	Identify alternative venues/space to hold clinics (Integrated Psychological Services).	Homfray, Andrew	~~31/07/2023~~ ~~31/11/2023~~ ~~31/08/2024~~ 30/09/2024	As many groups as possible are being set up to utilise online facilities and third sector venues to support any face to face meetings, ensuring that costs are managed appropriately. Phase 1 of groups completed in February 2024, targeting waiting lists. Phase 2 of group implementation to implement a tiered approach to intervention commenced 27th May 2024 following further staff training, with full implementation expected by September2024.
		Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic Training Needs Analysis 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. Ongoing.
		ND specific HB internet and intranet pages in development to give guidance and support whilst neuro-divergent individuals and parent carers are waiting.	vaughan, Catherine	31/10/2024	Series of meetings held with Communications team and ND services prioritised to include children's ADHD, Adult ADHD, Integrated Autism Service and Children's ASD service

Workforce Management Group has been established which meets monthly. Trajectories have been agreed for IPTS and Children's ND by NHS executive and there are systems in place to monitor waiting lists at service level performance-management meetings, IPAR and Directorate service review meetings. Monthly meetings with Estates to look at accessing/leasing/enhancing the current MH estates with a view to increase MH estate footprint. Use of HB Third Party Contractor to send out Keeping in touch letters and sent to those on ASD waiting lists on a 3-4 monthly basis confirming place on waiting list and signposting to sources of support including access to ND services while waiting. Service Leads secured opportunities for outsourcing for ASD services and Psychological Therapies. Commissioned external provider for ASD services across all ages, similar contract out to tender for Psychological Therapies. 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		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).	Carroll, Mrs Liz	31/12/2024	New action

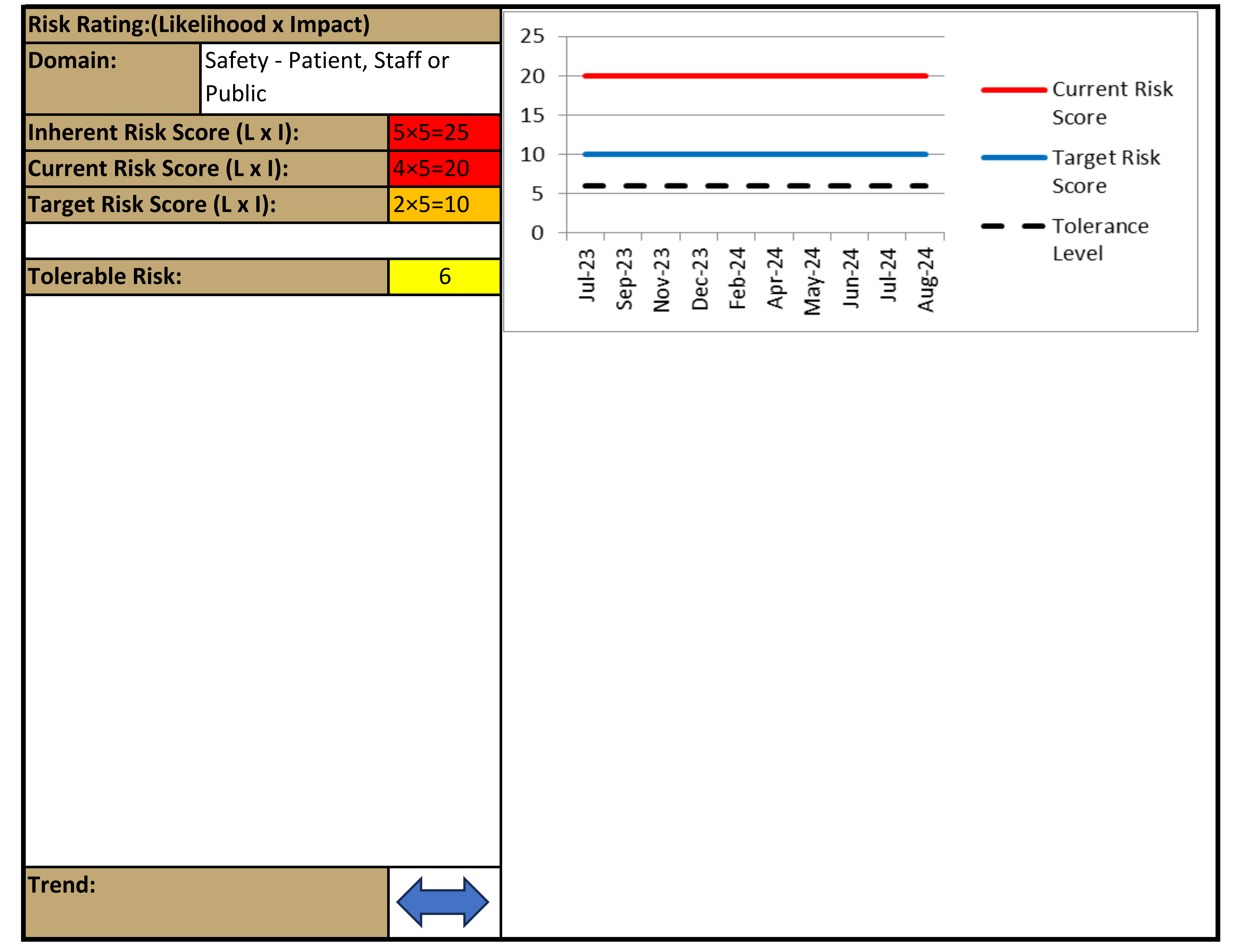
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
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	System to improve analysis of patient experience				
	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd								
	MH&LD QSE Group overseeing patient outcomes	2nd								

Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC	2nd			been presented at the Quality Safety and Experience Assurance Committee with a further update paper provided for the December 2021 meeting outlining control measures to manage the waiting times that the Directorate have at present. A paper was presented at Board Seminar in June 2022 to provide assurance on current waiting times and control measures.					
W-PAS Internal Audit	3rd								
An update was requested by the Chair and provided for the August Quality, Safety, Assurance Committee.	2nd								

Date Risk Identified:	May-23	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Aug-24
Strategic Objective:	5. Safe and sustainable and accessible and kind care	Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Sep-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:	Rationale for TARGET 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 February 2024 has 6,383 patients (Nov 23: 5,713) that have been 100% delayed for their follow up appointment. The total new patient referrals is at 7,088 (Nov 23: 5492) of which 713 (Nov 23: 403) are breaching 52 weeks (the longest wait from this cohort is 84 weeks (Nov 23: 67 weeks)). 4,040 patients are awaiting an Ophthalmic operation (Nov 23: 3,785) of which 46 (Nov 23: 24) are breaching 104 weeks (the longest wait from this cohort is 130 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.	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 7 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.

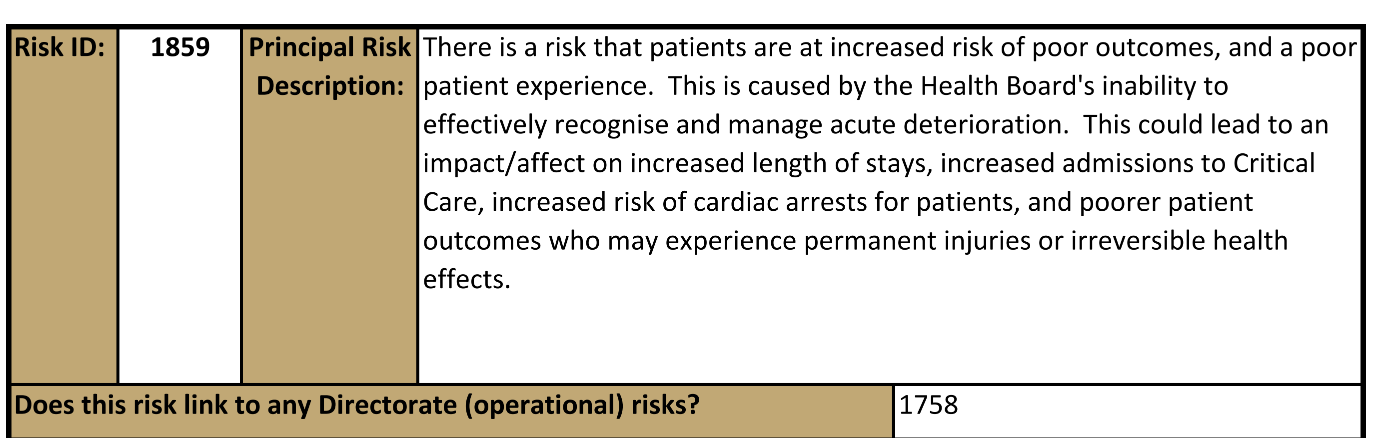
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)
Active recruitment to vacancies Collaborative working with Swansea Bay to deliver a South West Wales Glaucoma Service. On call rota in place Additional weekend working to provide Wet Age related Macular Degeneration (AMD) capacity. Currently funded for x2 all day lists per month. Lists cancelled due to AL are offered out to backfill. Identification of patients suitable to undergo Community Glaucoma data capture and virtual review by Consultant Ophthalmologists. Validation taking place through scheduled care validation team. Eye Care Collaborative Group meets quarterly to oversee performance against eye care standards. ECM Coordinators in place. Review of data quality inclusive of Health Risk Factor (HRF) code and clinical codes ongoing to improve data quality. Prescribing hubs 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. Pathways in place for Diabetic retinopathy. 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 via recovery funding in April 2024 to outsource 797

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**
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 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 is reviewed annually. 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 via high-cost agency locum. Fragility of on-call rota due to current workforce pressures	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~~ ~~30/06/2024~~ 31/03/2025	As of August 2024, an alternative regional group has been set up between the Health Board and Swansea Bay to develop and deliver a regional approach in the absence of a specific ARCH project.
	Roll out and implementation of National Electronic Patient Record for Ophthalmology.	Barreiro, Marta	~~30/07/2021~~ ~~31/03/2022~~ ~~31/05/2022~~ ~~30/09/2022~~ ~~31/10/2023~~ ~~31/12/2023~~ ~~31/03/2024~~ ~~15/07/2024~~ 31/03/2027	Issues identified in the planning phase around data governance. DHCW are working to resolve issues. Update provided by the DHCW in January 2024 outlining options available. Regional planning scoped and aligned programme now established with Swansea Bay UHB. Timeline to be established when options appraisal completed. July 2024 - issues with software solution, DHCW trying to source a resolution. Not likely to be implemented before 2027.
	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~~ ~~30/09/2022~~ ~~31/10/2023~~ ~~31/01/2024~~ ~~31/03/2024~~ 15/07/2024	Capital bid was secured and work to improve physical space at Amman Valley Hospital (AVH) has been completed since March 2022. As at August 2024, workforce pressures remain in relation to the nursing team, with concerns remaining around the nursing establishment being correct in order to meet current service demand. Work continues as part of the CSP to review all options for the delivery of the service going forward.

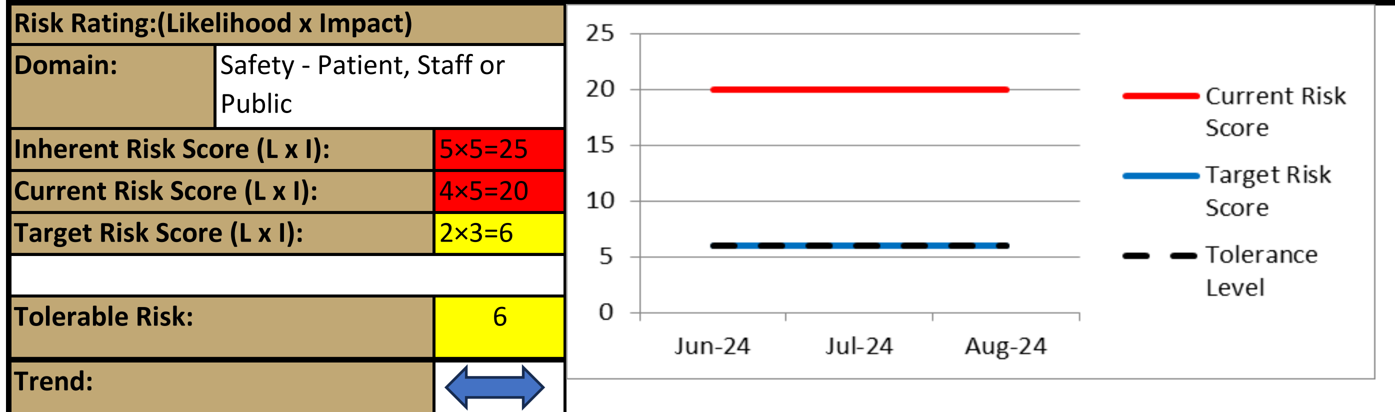
cataracts patients from the longest waits (104+) until March 2025. GIRFT review undertaken on the Ophthalmology service. The service is included within the Health Board's Clinical Service Plan (CSP).		Remodelling the capacity and demand associated with Wet AMD and Amman Valley	Coppack, Victoria	~~31/03/2023~~ ~~31/10/2023~~ ~~30/11/2023~~ ~~31/03/2024~~ ~~15/07/2024~~ 31/03/2025	Ongoing costs associated with additional activity. July 2024 - IVT activity from Pembrokeshire back to base in WGH, although with current staffing pressures there isn't enough staff to cover additional activity in AVH OPD.
		Implement virtual review clinics for patients undergoing Hydroxychloroquine (HCQ) treatment.	Coppack, Victoria	~~30/09/2022~~ ~~31/10/2023~~ ~~30/11/2023~~ ~~31/03/2024~~ ~~30/06/2024~~ 30/09/2024	Validation of HCQ patient commenced in November 2023. Longest wait HCQ patients have been identified for tech review, however workforce pressures are negatively impacting on service delivery. Clinic spaces to be secured for patient review. This is an interim measure whilst community hub is being developed.

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.	WPAS	1st			Ophthalmology 'Deep Dive' paper to ARAC (Dec 2023)					
GIRFT review Cataracts.	GIRFT action plan cataracts	1st								
GIRFT review Glaucoma.	GIRFT action plan Glaucoma	1st								
Watchtower review of ministerial measures	WPAS, scheduled care performance indicators	1st								

Date Risk Identified:	May-24	Executive Director Owner:	Daniel, Sharon	Date of Review:	Sep-24
Strategic Objective:		Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Oct-24



Risk ID:	1859	Principal Risk Description:	There is a risk that patients are at increased risk of poor outcomes, and a poor patient experience. This is caused by the Health Board's inability to effectively recognise and manage acute deterioration. This could lead to an impact/affect on increased length of stays, increased admissions to Critical Care, increased risk of cardiac arrests for patients, and poorer patient outcomes who may experience permanent injuries or irreversible health effects.
Does this risk link to any Directorate (operational) risks?			1758



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):	2×3=6
Tolerable Risk:	6
Trend:	⟷

Rationale for CURRENT Risk Score:

There are specific concerns relating to Glangwili General Hospital (GGH) and Withybush General Hospital (WGH) in relation to cardiac arrests and unplanned admissions. There has been an increase in Cardiac Arrest rates at GGH in the period January - July 2024 (22), compared to the period January - July 2023 (13). GGH senior management team have agreed to audit all cardiac arrests and establish bi-monthly Scrutiny meetings to review all cases and identify themes and learning opportunities.

There has been a significant increase in unplanned admissions at WGH, with 60 noted in the period Jan - July 2024 at WGH (40 for the equivalent period of Jan-July 23). Following the recent WGH RADAR meeting is was agreed that the Treatment Escalation Plan (TEPs) task & finish group in WGH would be re-established.

There are also concerns across the Health Board as a whole relating to the National Early Warning Scores (NEWS), and appropriate escalation where required as part of observation processes. Currently working with Clinical Audit to develop an audit tool on AMAT to audit on a monthly basis NEWS charts on wards and identify good practice and areas for improvement.

Work is underway investigating the opportunity to benchmark the position of Hywel Dda on an All Wales basis. Prior to Covid-19, the National Acute Deterioration Group for Wales (RRAILS) was in place, which gave direction on key initiatives such as Sepsis and NEWS, however this group is no longer supported which poses the risk on a national level regarding a disjointed approach across Wales.

As of July 2024, compliance rates for Level 2 and Level 3 Resuscitation Training are at 40%. While there is no set compliance target, compliance has never been greater than 60%. Staff availability to attend resuscitation training is problematic due to operational pressures and demand, therefore, need to identify the most appropriate training level and method to deliver to meet mandatory requirements.

Rationale for TARGET Risk Score:

The full implementation of the actions noted in the risk action plan will support the reduction in the likelihood and impact score of this risk to a target risk of 6.

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**
Governance structures in place eg RADAR Group Recognition of Acute Deterioration and Resuscitation, T&F Group chaired by HB RADAR Lead with focus on Sepsis, DNA/CPR group chaired by Deputy Medical Director. RADAR directly reports to Operational QSE. Health Board Resus policy in place (currently out of date requiring updating - however waiting on national guidance) All Wales DNA/CPR policy in place, which is due for update in 2024 Lead for Acute Deterioration Dedicated Resusciation Team in place, consisting of 5 full time and 2 part time employees Networks in place across the wider HB, including support from QIST Organisational training plan in place, including mandatory training Critical Outreach Services in GGH and WGH (not in place at PPH / BGH), managed by Planned Care Directorate (i.e not fully linked to Acute Deterioration resource) New Acute Kidney Injury (AKI) Lead appointed for GGH (12 months) Dedicated resource in Quality Improvement Team monitoring AKI alerts for the HB	No treatment escalation plans in place No call for concern in place Training demand outstrips capacity to deliver, with time limited in training sessions Inconsistent application of policies and processes eg DNA/CPR, new escalation policy, sepsis assessment tool, National Early Warning Score (NEWS). Reliance on manual / paper based documentation to record patient deterioration and subsequent escalation Critical Outreach Services not in place at PPH / BGH Inability to release staff to complete L2 and L3 training	Health Board Recognition of Acute Deterioration and Resuscitation (RADAR) group to develop a workplan to address gaps in control to improve the recognition and management of acute deterioration across the Health Board.	Davies, Mandy	~~30/09/2024~~ 30/11/2024	Quarterly meetings in place, and sub-groups being established to report to Recognition of Acute Deterioration and Resuscitation (RADAR) group on sepsis, NEWS, treatment escalation plans, call for concern (Martha's Law) DNA/CPR, acute kidney injury (AKI). Agenda at August meeting didn't allow for discussion on the development of a workplan. Plan is to confirm RADAR Action Plan at next meeting in October 2024. To reflect impact of the workplan in risk actions.
		Develop an organisation-wide training needs analysis to appropriately identify staff across all staff groups complete the most appropriate level of training to improve recognition and management of acute deterioration.	Wastell, David	30/09/2024	The directorate is working with ESR to ensure that staff training attendance is accurately recorded. Work is ongoing with individual line managers to identify the training needs of all their staff groups across all four sites and community. Meetings commenced with all senior nurse managers to discuss current training uptake and training needs to identify the most appropriate training for each staff group across acute and community. Meetings are to be arranged with Heads of Service for other clinical services. As at June 2024, it has been identified that 84 ILS sessions are required in order to ensure compliance with targets for GGH alone. Heads of Nursing requested to discuss training attendance with all ward sisters, and to appropriately prioritise.

					Monthly analysis of training available, and attendance to be shared with Heads of Service and Senior Nurse Managers. The provision of training continues at current levels, given current resource availability.
		To implement an electronic observations systems across the Health Board to capture real-time bedsite capture of patient assessments and monitoring, in line with the Health Board's Digital Plan	Williams, Caroline	30/09/2025	Tender process currently ongoing. Business case to be presented to Board in July 2024, with a view to implement on a site by site basis over in 18 months, in line with the current Digital Plan.
		As part of the Quality Dashboard, agree the matrix needed for patient deterioration. Include these matrix in the Health Board Quality Dashboard to inform escalation and create a specific dashboard for RADAR (Recognition of Acute Deterioration and Resuscitation).	Wastell, David	30/05/2025	Meeting of 25th July 2024 has identified the following supporting metrics for the dashboard: sepsis, AKI, NEWS audits, cardiac arrests, number of MET calls, treatment escalation plans are in place, call for concern rates and training compliance for ILS and BLS for each Directorate. DW to work with Performance Team to agree the process for data collection to inform the Dashboard. DW met with Performance Team on 28th August 2024. Work ongoing.
		Put in place process for Health Board compliance with Martha's Rule by establishing a Task and Finish Group to implement Call for Concern	Wastell, David	31/03/2025	Task and Finish Group is in place, chaired by Ceri Griffiths. An SOP Patient leaflet is being developed and a pilot to commence in GGH in October 2024. Approval is being sought from Operational QSEC w/c 9th September. This pilot will test the process to roll out across the organisation for Adult Inpatients.

			Put in place All Wales Policy for treatment escalation plans to enable safe and effective care management when patient deteriorating.	Wastell, David	31/12/2024	Discussed at Health Board Recognition of Acute Deterioration and Resuscitation (RADAR) group Group (March 2024) - no agreement to move forward with proposed pilot in Withybush. Discussed at Withybush RADAR meeting in July 2024 where agreement reached for pilot. Task and Finish group being established by Lead for Critical Care Outreach in Withybush to devise an implementation plan. RADAR to review following evaluation and consider roll out across other sites.
			Implement a model for CASCADE training for basic life support and monitor impact on basic life support training compliance rates.	Wastell, David	31/03/2025	Model devised by Resuscitation Team - first training session held. 6 Cascade Trainers from across the Health Board Community Teams, trained in July 2024. Training will continue. Training session planned for Midwife Cascade Trainers in September 2024. Plans for health visitors and school nurses for January 2025.
			Assess and interpret All Wales Direction on patient safety in relation to acute deterioration.	Wastell, David	30/09/2024	Launch of this initiative anticipated on 17th September 2024 (World Patient Safety Day).
			Work to improve compliance with Sepsis Bundles at the front door.	Wastell, David	31/12/2025	Ongoing quality improvement in place. Has demonstrated improvements in Glangwili and Prince Phillip and now being used in Withybush.
			Monitor cardiac arrest rates and learn lessons from review of cardiac arrests.	Wastell, David	30/09/2024	Scrutiny Meetings have been set up in GGH to review Cardiac arrests, bi monthly. First meeting 5th September 2024. The lessons learned will be transferred across other sites, if applicable. Cardiac arrest reviews being presented at Medical Education sessions and plan to present at PPH Grand Round.

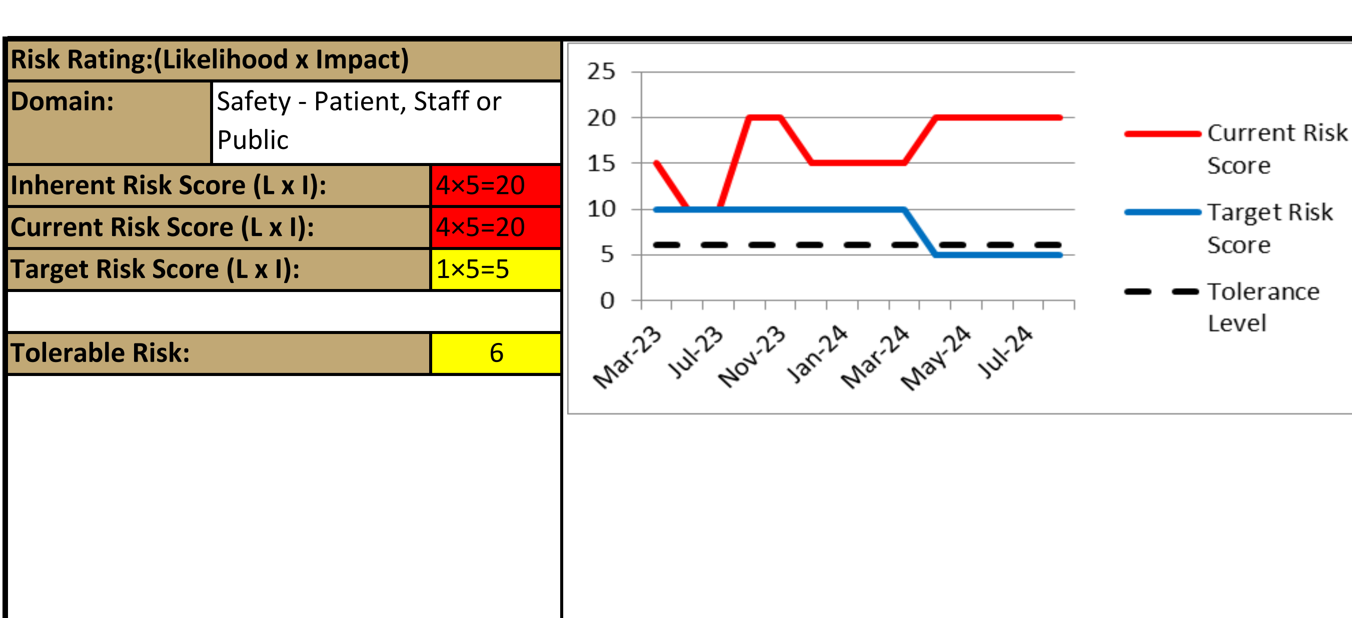
		Action	Owner	Due Date	Progress
		Improve compliance with DNACPR National Guidance	Steele, Cathie	30/10/2024	DNACPR Review Group in place, a sharepoint page is being developed and we are anticipating an updated All Wales policy in September 2024. An EQiP Project Team has been established to develop and implement an improvement plan in relation to DNACPR processes.
		Development of an Acute Deterioration Sharepoint page for all advice, guidance, updates, for staff on issues relating to resuscitation, DNACPR, sepsis, call for concern, MET calls, training, etc.	Wastell, David	31/05/2025	New Action
		Trial starting in October 2024 for 3 months re NEWS Audit, NEWS Charts - 5 charts every ward, every month on every site utilising the AMaT system. To review compliance and whether escalation processes are being followed with outcomes being fed back to wards.	Wastell, David	31/01/2025	New Action
		Acute Deterioration E-learning modules - topics include NEWS, sepsis, DNACPR and A-E assessment being developed by the Lead Nurse for Acute Deterioration in conjunction with NHS Executive and other leads. Work to develop a process for using these modules with clinical areas in response to issues of concern.	Wastell, David	31/01/2025	New Action.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Training compliance via ESR Cardiac Arrest Audits	RRAILS Audits undertaken by ward staff monthly, and inform the Nursing dashboards	1st			RADAR Group Update to OQSEC, Feb-24	Ward based NEWS audits in place but may be unreliable as self assessed.	Once dashboards in place, to develop a monthly audit process to address key hotspots / areas of concern relating to RAILS	Wastell, David	30/09/2025	Next RADAR meeting - October 2024.
	Review of DATIX incidents, complaints, cardiac arrest reports and Medical Examiners reports relating to acute deterioration	1st								
	Outreach review all unplanned admissions to Intensive Care	1st								
	RADAR Group	2nd								
	T&F Group chaired by HB RADAR Lead with focus on Sepsis	2nd								
	DR/CPR group chaired by Deputy Medical Director	2nd								

Date Risk Identified:	Nov-22	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Sep-24
Strategic Objective:		Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Oct-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 and GGH. This is caused by One vacancy and one substantive consultant who is no longer taking part in the on call rota, due to health issues, on the General Surgery Consultant rota at WGH (1:5). This is now running as a 1:4 rota with one Medacs and one NHS Locum filling the gaps. One vacancy, one retire and return consultant, at the time of retirement the clinical director and GS team at GGH supported the retirement with the agreement they would cover the out of hours on call through ADH. This was not a cost pressure, as the reduction in job plan sessions offset the internal locum cover. There is also one consultant on the General Surgery Consultant rota at GGH who has is now only doing weekday on calls, due to health reasons, The weekends are covered by ADH. GGH is now running as a 1:5.5 which is not sustainable. This could lead to an impact/affect on the ability to provide an emergency general surgery service at WGH and GGH affecting patient experience, causing clinical delays and poor outcomes for patients. The wellbeing of remaining consultants who are already working to full capacity is also affected and there is an 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):	4×5=20
Target Risk Score (L x I):	1×5=5
Tolerable Risk:	6
Trend:	⇔



Rationale for CURRENT Risk Score:

The risk score remains the same as the inherent risk score. This is based on recent short notice absences in addition to the existing gaps on both rotas (GGH & WGH), where the rotas have come close to collapse, 3 times in the last month and with the rota has been covered at the eleventh hour at an enhanced rate. This has further highlighted the fragility of these rotas. Due to the financial situation, there is an expectation to reduce variable pay and exit Medacs locum agencies. The rotas will collapse without the support of these and it will be a withdrawal of the control measures we have put in place. The appointment of a locum consultant to GGH will not change the risk score as the candidate has not started yet and there is always a risk of withdrawal. The rotas will remain fragile if they remain as two separate rotas.

Rationale for TARGET Risk Score:

The target risk score is based on the work currently being undertaken as part of the Clinical Services Plan to identify and approve a more sustainable solution in order to reduce the likelihood of rota collapse and reduce the risk of not being able to provide a safe and sustainable emergency general surgery service to patients in the south of the health board.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)
The WGH General Surgery consultant on call rota currently runs as a 1:4. 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. A job description for an emergency general surgeon is currently being developed for WGH. However, as the EGS rota is part of the CSP, it was decided by the clinical director of scheduled care not to advertise for WGH for the time being. The 2.5 gaps on the 1:8 General Surgery consultant on call rota at GGH is currently being covered by internal staff on a locum basis at the HB locum card rate. A locum Upper GI consultant has been recruited to GGH on 22/08/2024, with a hope of starting in 6-8 weeks. This will take the rota to a 1:8 with 6.5 consultants on the rota. Continuously liaising with the rota coordinator at WGH for potential gaps on the rota. When there is sickness or unexpected leave, due to emergency circumstances, the management team work to cover as follows: 1. Internal ADH on the site with the gap. 2. Internal ADH from the other sites across the health board. 3. In the event of steps 1 & 2 being unsuccessful, the service would

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**
The 1:4 model at WGH, which commenced on 03/11/2023 continues to be fragile, with only 2 substantive consultants on the rota. The 4th slot on the WGH 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. With current financial situation and the expectation to reduce variable pay, there is a risk that the service will be asked to terminate the Medacs locum. The locum consultant who started on 04/09/2023 was an associate specialist and part of the SAS level rota at WGH. This has now left a gap on the SAS level rota. This is 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 we appointed on 01/12/2023. This	Recruitment of 1 Consultant upper GI surgeon for GGH. Agreement to recruit 1 consultant emergency general surgeon for WGH or 1 consultant general surgeon for GGH.	Lewis, Caroline	Completed	One NHS locum has been recruited to WGH and has been in post since 04/09/2023. Following previous withdrawals and a further vacancy in GGH. The plan for recruitment has changed with a consultant upper GI surgeon post to be advertised for GGH in April 2024. A job description for a consultant emergency general surgeon is being devised for WGH, if rotas are amalgamated, a consultant general or upper GI surgeon could be appointed to the new rota. 22/08/2024 - One NHS Locum upper GI consultant was recruited to GGH and is currently onboarding with a hope to start in 6-8 weeks time.
	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.

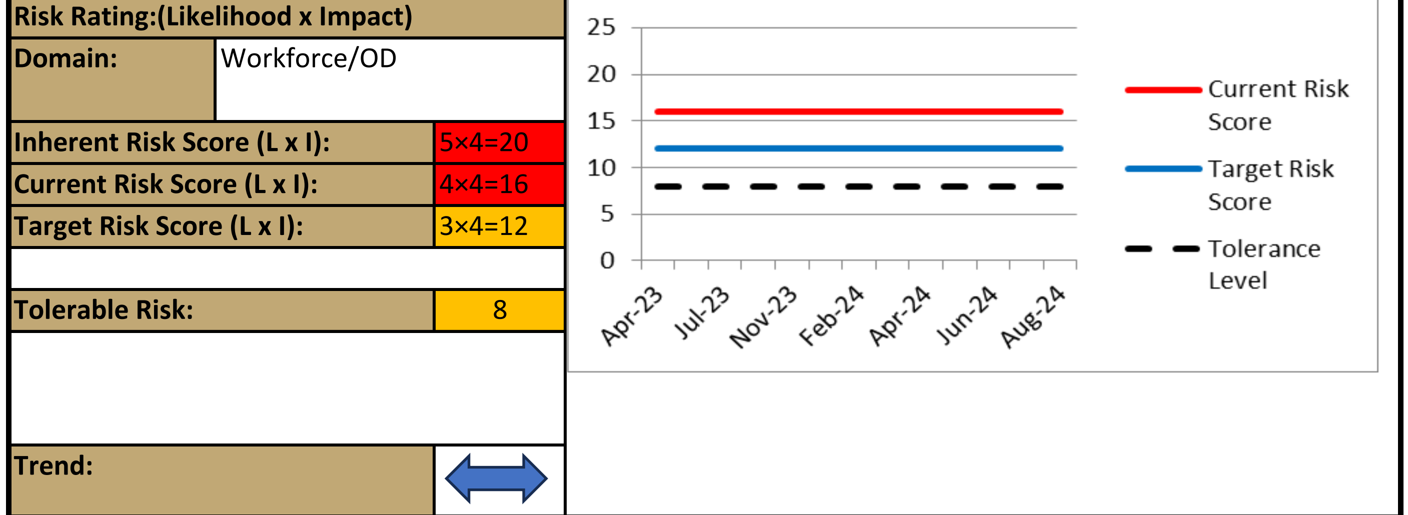
escalate for agreement on transferring the surgical out of hours on call take to another site. (WGH to GGH) 4. Ensuring that all stakeholders are aware, including site teams, medical teams, WAST, any supporting services as appropriate. Proactive sickness management Escalation to clinical leads Medacs 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 In response to the fragility of the rotas and the recruitment difficulties that have been faced. A plan for relocating emergency surgical on call from WGH has been submitted as part of the directorates annual plan and the health board Clinical Service Plan. In April 2024, an updated SBAR was populated to go to board with the recommendation of amalgamating the two on call rotas to 1 site to either a 1:12 or a 1:10. There is clinical belief that these changes provide a more sustainable service and would make recruitment more attractive, when comparing to other health boards across Wales who provide emergency general surgery cover in this way. The condition of this change would be that consultants would be expected to change their base of work to participate in the amalgamated rota, this is likely to require an OCP. One of the GIRFT recommendations was to reduce the number of surgical on call takes across the Health Board from 3 to 2 sites.	person withdrew on 07/02/2024. The post went back out to advert in April 2024 with no successful candidates. We have successfully appointed to this post on 15/08/2024, candidate is currently onboarding. GGH consultants offer to cover the WGH gaps when required, on ADH, however WGH have never offered to cover any other site. There is a risk of consultants requesting rates that are higher than the HB card rate, going forward as they have been covering multiple gaps on the rota for a prolonged time. An increase in consultants at GGH, working additional on call locum weeks is resulting in a reduction in elective activity in OPD, endoscopy and theatre. This will have a negative impact on RTT and SCP targets. The fragility of the GGH rota and it's impact on elective activity has become evident this month with further short notice sickness in the team, causing a further reduction in activity. A prolonged unsustainable service could impact on the training of surgical doctors and, in turn, increase the number of HEIW vacant posts, leaving the SAS and junior rotas at risk of collapse. 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	Completed	The senior consultant leads for general surgery have suggested that the WGH and GGH on call rotas are amalgamated to one site. This would provide an increase of consultants on the rota to either a 1:10 (the 3 WGH consultants and the 7 GGH consultants) or a 1:12 (the 3 WGH consultants, 7 GGH consultants and 2 newly recruited posts). This recommendation is in line with the GIRFT report. SBAR's have bee drafted by the service to describe the fragility of the rotas.
		Robust plans to be developed for transfer and repatriation of patients	Lewis, Caroline	Completed	SOP has been developed and discussed with clinicians.

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
	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 & (Nov23) Management team to present updated SBAR to Corporate Directorate Group (Apr24)	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	3rd								

Date Risk Identified:	Apr-23	**Executive Director Owner:**	Gostling, Lisa	**Date of Review:**	Jul-24
Strategic Objective:		**Lead Committee:**	People, Organisational Development and Culture Committee	**Date of Next Review:**	Aug-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 Mar-24 compared to pre-Covid levels (c1-2% 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 Professional Leaders Forum now in place and Medically Associated Professionals Task & Finish Group alongside instigation of Allied Health professionals Performance, Planning and Utilisation Group (Check name) In addition the Variable Pay Group is leading on the WHC 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	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, c) data management issues in ESR, eg, single employer status for our medical workforce and d) Changes in the funded establishment not reflective of "on the ground" situations. 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).	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	Completed	Complete. This was the scoping exercise and this is now complete and managed as business as usual through the SPPEG group.
		Further develop training resources and capacity to support managers with workforce planning challenges to alleviate risks (PO 2c2iii)	Walmsley, Tracy	Completed	Complete - Resources and Training have been developed to support managers and will continue to be developed. Courses delivered as stand alone and integrated into Leadership programmes.
		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~~ 30/09/2024	Difficulties remain in understanding the workforce model for UEC and needs input from programme. Engagement ongoing. Primary Care Workforce Planner has been successfully bid for by Primary Care and will align to this work. A job description has been developed, with the expectation that the post will be appointed to by September 2024. Action to be revised for 2024/5 to align with Clinical Services Plan and wider programmes.

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 & 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. Corporate Risks have been developed linked to Wellbeing as part of Risk Management approach. Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.	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 training to underpin the Team around the Patient initiatives and new model development of care. Essential and necessary reliance on educational frameworks rather than new role development, which is an evolutionary aspiration. Practical next steps will be assessed linking into skills gaps within the workforce and the educational infrastructure to support. This will inform Workforce Plan.	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~~ 31/03/2024	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. Action superseded by current events/feedback from WG & TI. To be revised and aligned to Clinical Services plan and Stabilisation work.
		Agree actions to mitigate strategic risks of workforce supply based on assessment paper	Gostling, Lisa	Completed	Detailed paper aligned to Workforce Plan to be issued to PODCC for meeting on 15 April 2024 (Submitted 27 March 2024).
		Test "WFP" Project Support Role within a Directorate to strengthen operational and strategic workforce planning: Women & Children	Walmsley, Tracy	Completed	Complete- evaluation to commence April 2024.
		Methodology to support new and enhanced roles to be scoped and implemented.	Walmsley, Tracy	Completed	Completed- New Clinical Role development policy signed off at SPPEG February 2024. Further work will be needed and will form part of the Workforce Plan for 2024/5.

Action	Owner	Due Date	Progress
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. Based on Operational Workforce Plan discussions a paper to be drafted and presented to Executive Team April 2024 to outline challenges. Revision of Risk needed in line with this action i.e. "confidence in integrity of alignment of data sets". As per July 2024, meeting with Financial Business Partners assigned to teams across the organisation to ensure CIP plans are robust and recurring.
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	Completed	Completed- Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment Plan.
1a.1 Redesign all JD & PS to focus on core requirements and skills	James, Michelle	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment Plan.
1a.2 Employ new methods of advertising and appointing to roles	James, Michelle	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment Plan.
1a.3 Develop programmes for employability support	James, Michelle	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment Plan.
1a.4 Develop attraction plan to link with offers for R&D, Service Improvement, Education etc	James, Michelle	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment Plan.

Action	Lead	Due Date	Progress
1a.5a Appoint to vacancies via different employment pools (resourcing)	James, Michelle	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment Plan.
1a.5b Appoint to vacancies via different employment pools (learning & development)	James, Michelle	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment Plan.
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~~ 31/03/2024	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	Completed	The scoping paper has been completed and this is now business as usual through the SPPEG workplan.
2a.3 Reshape higher awards process to link with training needs analysis	Glanville, Amanda	Completed	Completed and being sent to SPPEG for Approval 20/02/24.
2a.4 Develop an interprofessional education plan with full implementation plan by 2026	Glanville, Amanda	Completed	Completed and being sent to SPPEG for Approval 20/02/24.
2a Engage with and listen to our people to ensure we support them to thrive through healthy lifestyles and relationships	Gostling, Lisa	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
2a.2 Wellbeing charters are fully embraced	Davies, Christine	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plan.

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	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
2b.1 Improve HB education & development offer, supporting enhanced opportunities	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
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	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
2b.3 Widen choices relating to contracting opportunities	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
2b.4 Enable job enrichment where appropriate; core principles and design methodology developed	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
2b.5 Plan developed to optimise digital opportunity and cost effective workforce agility	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
2b.6 Further develop and spread people recognition formally and informally	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.

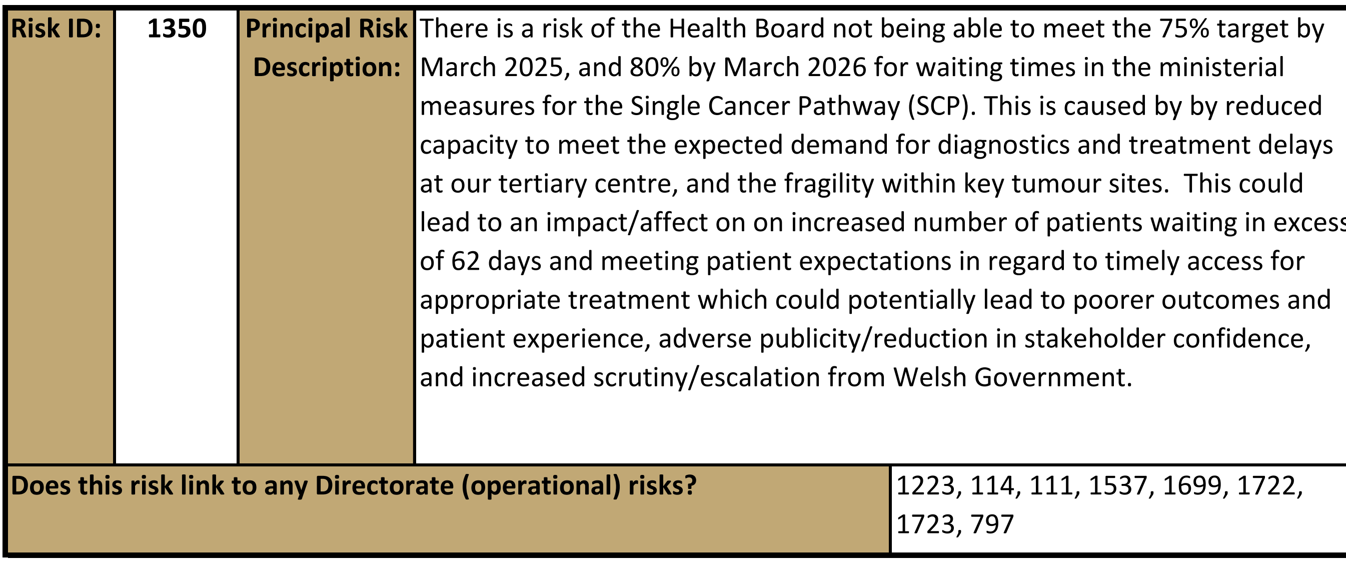
		2c Develop and maintain an overarching workforce, OD and partnership plan	Gostling, Lisa	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
		2c.1 Implement succession planning and leadership & management pipeline	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
		2c.2 Further develop short and long terms plan by services and professional groups	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
		2c.3 Understand our people by using quantitative and qualitative data	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
		2c.4 Develop a process of listening and learning from staff experiences ensuring regular feedback	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
		2c.5 Promote a culture of innovation and enhance the HB reputation	Walmsley, Tracy	Completed	Paused for 2023/24. Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
		Agree actions to mitigate strategic risks of workforce supply based on assessment paper	Gostling, Lisa	Completed	Detailed paper aligned to Workforce Plan to be issued to PODCC for meeting on 15 April 2024 (Submitted 27 March 2024).

	Explore & assess alternative roles (value, barriers and future plans (MAPS, AP's APP's, CAAPS))	Walmsley, Tracy	Completed	CAAPS discussions ongoing for future years; AP assessment needed going forward links to All Wales work. MAPS inluded in Paper to SPPEG February 2024; Workforce Plan, Education Commissioning and Professional Leaders Forum now in place for scrutiny for 2024/25.
	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	Completed	To be submitted to WG 28 March following Executive scrutiny on 27th March 2024. Professional Leaders Forum held on 15 March to assess.
	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	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.

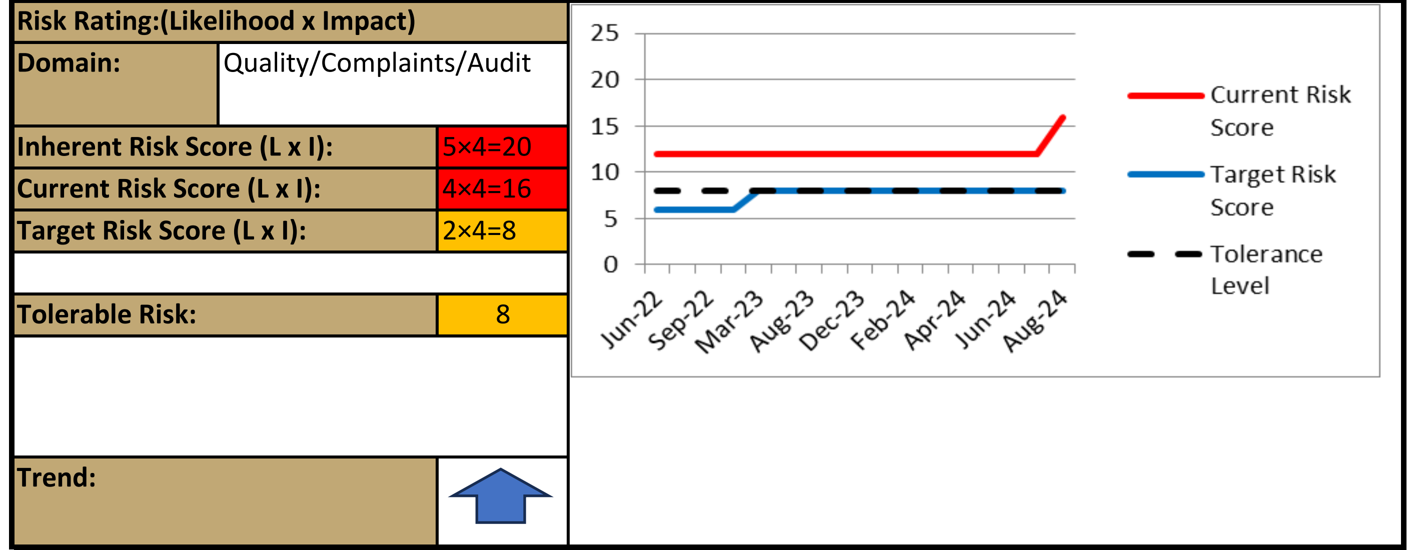
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
	Risk management approach to Workforce themed Risks	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	Completed	Workforce Plan will take account of the needs to address the actions in the Wales Audit Office Report.

	Strategic People Planning & Education Group	1st						Maturity Matrix to be tested with an external panel and assessed for 3rd part scrutiny within HB.	Walmsley, Tracy	31/05/2024	External stakeholder engagement ongoing i.e. other SWP colleagues and HEIW. Meeting HEIW 1 May 2024 for discussion on panel set up. Meeting with regional colleagues separately to link in s part of regional work programmes.
	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:	Feb-22	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Aug-24
Strategic Objective:	5. Safe and sustainable and accessible and kind care	Lead Committee:	Strategic Development and Operational Delivery Committee	Date of Next Review:	Sep-24



Risk ID:	1350	Principal Risk Description:	There is a risk of the Health Board not being able to meet the 75% target by March 2025, and 80% by March 2026 for waiting times in the ministerial measures for the Single Cancer Pathway (SCP). This is caused by by reduced capacity to meet the expected demand for diagnostics and treatment delays at our tertiary centre, and the fragility within key tumour sites. This could lead to an impact/affect on 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, 797



Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	8
Trend:	↑

Rationale for CURRENT Risk Score:

The 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 and impact of industrial action 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, in particular within Urology pathway which constitutes 44% of overall backlog. Performance since April 2022 has been variable due to treating higher volumes of patients particularly in the Urology, LGI, and Skin pathways.

Performance was on internal trajectory of 60% in March 2024, highest compliance since 2021. Performance has decreased April 24 to 43% due to collective impact of IA and Easter resulting in reducing surgical treatments with volumes lower than previous month (125 March, 113 April) with higher numbers treated out of target. (96 in March and 130 in April).
May performance will improve. Performance will improve in May and will recover closer to predicted trajectory of 60%+ from June 24.

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. # Accelerated imaging from Endoscopy to CT within the GI pathway now in place across all sites, reduction time on patient pathway by 23 days # 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. # 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. # Robust Urology diagnostic recovery plan to eliminate patients waiting more than 28 days in place, with committed resource allocation from recovery money. Monitoring of Urology diagnostic improvement trajectory via Cancer watchtower. # Cancer Pathway Review to be discussed at the MDT Business meetings and plans put in place to address and improve any bottlenecks or issues. Pathway reviews will also be a standing agenda item on the Oncology Quality & Safety meeting to ensure governance and part of the relevant Directorate Quality & Safety meetings # Process in place to improve component wait times and reduce patients waiting more than 14 day for first Outpatient Appointments (OPA) and	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.	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	Completed	Process in place to implement demand capacity modelling tool in line with SBUHB. Radiology are reviewing referral pathway mapping, working with ARCH to build a new Radiology dashboard with support from the Strategic Workforce Team to review workforce elements. The aim is to more timely examinations and reports which will improve the patient pathway and reduce the risk of long waits for investigations and reporting of results, and reduced times on patient pathways. The Radiology dashboard was launched in January 2024 and in place. Work continues to assess workforce capacity within Radiology, and colleagues from Radiology Directorate at Hywel Dda continue to liaise with Swansea Bay. Further detail on the progress of this work can be found in corporate risk 797 - Risk to the ability to deliver ultrasound services due to workforce pressures.
		Each MDT to review and adopt recommended optimal tumour site specific pathways.	Humphrey, Lisa	Completed	The Macmillan Cancer Quality Improvement Manager continues to work with teams with regards to implementing the new pathways. One-to-one escalation meetings are held when intervention is required with Cancer Watchtower leads and Tumour site service managers. A new Endoscopy booking process is now in place.

28 days for Diagnostics.
One to one escalation meetings held with Cancer Watchtower leads and Tumour Site Service Managers for tumour sites that require intervention.
New Endoscopy booking process implemented in November 2023 which tracks all patients referred for an endoscopy on a USC priority. If capacity is identified as a trending breach reason, the Service Management team supports targeted intervention to address these concerns in order to reduce time on patient pathways.
One Stop Hysteroscopy within Gynaecology implemented in May 2024 at Bronglais General Hospital, with plan to implement across all sites during Q2 of 2024/25
Pathway changes in Head and Neck to include Laryngeal Biopsy at first OPA, reducing reliance on pan-endoscopy
Health Board wide internal escalation framework now in place to support the monitoring of performance targets, with a TI de-escalation target of 60% for three months (as at May 2024)

To establish the Urology Improvement Group to identify further opportunities for improvement, implement changes and monitor outcomes along the Urology / Prostate pathway	Humphrey, Lisa	Completed	Initial meeting scheduled for 20th June 2024, where TORs will be ratified.
Map NOP as per WHC 124 for vague symptoms (RDC)	Bennett, Debra	30/09/2024	In progress
Map NOP Teenage and Young adults as per WHC 124	Bennett, Debra	30/09/2024	In progress
Map MUO/CUP NOP as per WHC 124	Bennett, Debra	30/09/2024	In progress
Undertake full FIT process review to assess impact and inform future planning to meet the NOP	Hire, Stephanie	30/09/2024	Planning in progress
Work with multidisciplinary team to reallocate FIT pathway to primary care in line with NOP and rest of Wales	Humphrey, Lisa	31/03/2025	Planning in progress
Radiology to utilise agreed funding to remove the backlog of patients that require CT reporting (350 patients)	Roberts-Davies, Gail	30/09/2024	To commence 24th August 2024
Establish weekly escalation meetings for radiology and pathology to include the NHSE and monitor impact on SCP component waits	Humphrey, Lisa	Completed	Completed
Radiology to work with NHSE to refine demand and capacity planning	Roberts-Davies, Gail	31/12/2024	in progress
Radiology to work with cancer services and the NHSE to improve productivity and efficiency processes	Roberts-Davies, Gail	31/12/2024	In progress
Recovery plan for skin treatment to reduce overall waiting list volume back to sustainable level of 100patients	Wisdom, Ceri	30/09/2024	in progress
Roll out gynaecology one stop hysteroscopy to reduce diagnostic pathway across all sites	Freeman, Lyndon	31/12/2024	One stop in place for BGH and GGH - planning for WGH by end of December
Establish accelerated Neck lump pathway to reduce diagnostic pathway	Lewis, Caroline	31/12/2024	engagement required with Radiology and SBUHB
Implement radial EBUS within the lung pathway to reduce time on diagnostic pathway and demand on CTGBX.	Thomas, Anna	31/12/2024	Procurement happening August - live running expected before Dec24.

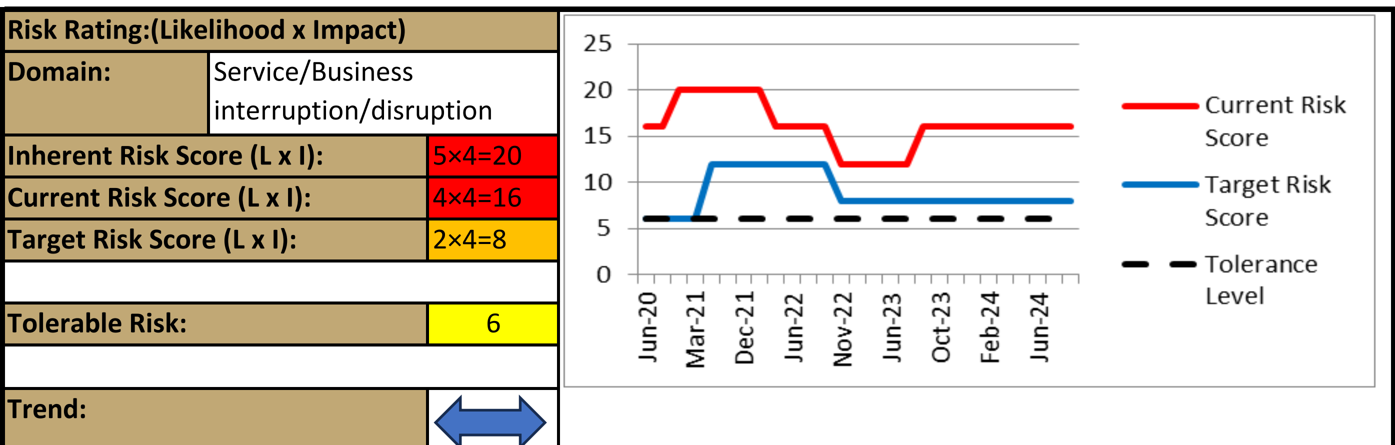
Action	By Who	By When	Progress
Work with NHSE to review referral rates and patterns within primary care to reduce and refine demand to secondary care	Humphrey, Lisa	31/03/2025	Mapping in progress
radiology to reduce patients waiting in excess of 28 days for a diagnostic in the urology pathway	Roberts-Davies, Gail	30/09/2024	commencing 24th august
update TOR as per internal audit recommendation	Bennett, Debra	30/09/2024	In progress
Assess the impact of OPA Laryngeal biopsy on overall performance for Head and Neck	Lewis, Caroline	30/10/2024	In progress

ASSURANCE MAP					Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance	Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
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:	Jan-19	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Aug-24
Strategic Objective:	N/A - Operational Risk	Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Sep-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, 1785

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 aged 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. There is a continuous process locally by which equipment is prioritised for replacement.

For 23/24 funding was obtained to replace two X-ray rooms and due to the RISP risks of non-DR compliant equipment, it was decided to replace the x-ray equipment at Tenby Cottage Hospital and the A&E x-ray room at Bronglais.

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 July 2024.

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, and confirmation of funding received for the 24-25 financial year, there is uncertainty as at August 2024 with regards to continued equipment replacements beyond the 2024/25 financial year 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.

As of August 2024, the x-ray unit at Tenby has been replaced and work underway planning the replacement of equipment in A&E Bronglais which is due to commence in August 2024. Additional WGH EOY funding was secured (23-24 financial year) and replaced aged US units and upgraded the software on MRI scanners at BGH and WGH providing latest technology.

WG funding has been secured to replace a fluoroscopy unit and a CR x-ray unit at WGH along with a much needed MRI upgrade at PPH during the 24-25 financial year.

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.

Due to the nature of the release of funding which is usually in Q3/Q4 of the financial year it is difficult to plan large installations due to the speed at which the replacement need to be completed. This means that sometimes equipment of lesser priority is replaced before the bigger installations which have a greater need.

The number 1 replacement priority in the Health Board is to replace the Nuclear Medicine SPECT scanner. This is a service risk as it is the only scanner in the HB (Risk 1706, score 20) and has suffered frequent breakdowns since June 2023. A specific task and finish group has been convened to forward plan the replacement in anticipation of WG funding.

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. # All equipment at main sites are now DR and so will be compliant with the RISP project	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, and the requirement to replace two pieces of equipment (South Pembs & Llandovery) which will be non-compliant after August 2025. These departments are currently being included in discussions concerned with the Clinical Services Plan. No dedicated diagnostic equipment	To confirm the capital funding to replace existing aged equipment for FY 2023/24	Roberts-Davies, Gail	Completed	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. Additional EOY funding has been secured to replace US units across the HB and 2 image intensifiers (BGH & WGH). Tenby equipment has been replaced and work is underway to replace an x-ray set at BGH. US and Image intensifiers recieved.

	replacement funding for the 2023-24 financial year meant that DCP bids had to be developed for all equipment replacement. National Imaging and Capital Priorities Group held its first meeting in September 2023 and has met three times. There is 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 funding arrangements for the remaining equipment that needs to be replaced, supported by individual DCP bids or dedicated replacement funds for 2024/25.	Roberts-Davies, Gail	Completed	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 provided in late May 2024. 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. NIECP meeting was held in April 2024 where the prioritised list of equipment replacements was be presented for consideration along with those of all HB's. Priorities were reiterated and a list ranked for WG. The outcome of this for Hywel Dda is that the final CR piece of equipment at a main site (WGH) will be replaced with DR equipment, along with the fluoroscopy room at WGH and an upgrade of the aged MRI scanner at PPH will also be undertaken.

Installation of replacement Gamma Camera, WGH	Roberts-Davies, Gail	~~31/07/2024~~ 30/06/2025	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. No funding allocated as of 09/02/2024 This will not be replaced in the 24/25 financial year. A specific T&F group is due to be set up as of June 24 to plan the necessary accommodation improvements required. July 2024 update- the T&F group has been set up and meets weekly
Replacement of CT Scanner at GGH	Procter, Sarah	~~31/03/2024~~ ~~31/07/2024~~ 30/06/2025	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. Will not be replaced in 23/24 this financial year Will not be replaced in the 24/25 financial year
Replacement of digital x-ray rooms at Tenby Cottage Hospital and South Pembrokeshire Hospital	Roberts-Davies, Gail	Completed	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. Tenby equipment has been replaced. SPH will not be replaced in the 23/24 financial year.

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	Completed	Ageing equipment with replacements required for obstetric scanning, and resilience of services provided to Theatres. BGH and GGH Image intensifiers replaced. VAB equipment not to be replaced at this time. 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	Whitecross, Faith	~~31/03/2024~~ ~~31/07/2024~~ 31/03/2025	Equipment is 17 years old with significant downtime experienced. Routine testing by Medical Physics department in January 2024 has found that image quality has deteriorated and the equipment is delivering increased doses to account for this. Awaiting confirmation of funding as at April 2024. Confirmation that this piece of equipment will be replaced in the 24/25 financial year was received late May '24- action will be closed when this piece of equipment is operational.
Replacement of CR A&E DR room and OPT (Dental) units, BGH	Edwards, David	~~31/03/2024~~ 31/10/2024	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. Equipment in process of being replaced as at April 2024, delayed due to funding requirement for building works required and will be due to go live in Oct 2024. This action will be closed when the equipment is online.

Replacement of CR X-ray Room 1, WGH	Roberts-Davies, Gail	~~31/03/2024~~ ~~31/07/2024~~ 31/03/2025	Ageing equipment. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. This will not be replaced in the 2023/24 financial year Confirmation that this piece of equipment will be replaced in the 24/25 financial year was received late May '24- action will be closed when this piece of equipment is operational.
Replacement of CR X-Ray room, Llandovery Hospital	Osell, Fiona	~~31/03/2024~~ ~~31/07/2024~~ 30/06/2025	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 April 2024. This will not be replaced in the 2024/2025 financial year
Replacement of Mammography Units, BGH and WGH	Roberts-Davies, Gail	~~31/03/2024~~ ~~31/07/2024~~ 30/06/2025	Ageing equipment, exacerbated by the failure of Securview. These will not be replaced in the 23/24 financial year These will not be replaced in the 2024/2025 financial year
Upgrade or replacement of MRI scanner, PPH	Osell, Fiona	~~31/03/2024~~ ~~31/07/2024~~ 31/03/2025	Ageing equipment with increasing failures, with new technologies now available. Awaiting confirmation of funding as at April 2024. Confirmation that this piece of equipment will be upgraded in the 24/25 financial year was received late May '24- action will be closed when this new piece of equipment is operational.

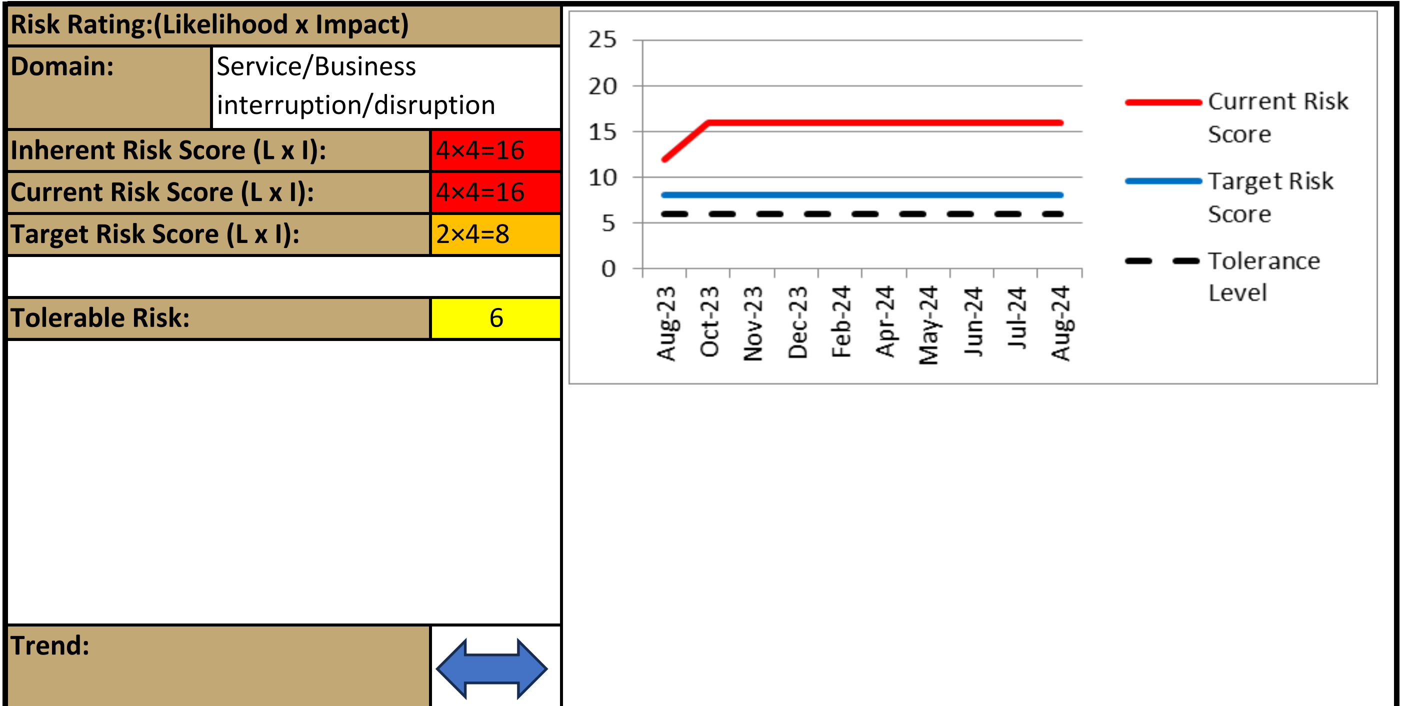
Action	By Who	By When	Progress
Upgrade or replacement of MRI scanner, GGH	Procter, Sarah	~~31/03/2024~~ 30/06/2025	Ageing equipment with increasing failures, with new technologies now available. Awaiting confirmation of funding as at April 2024. This will not be replaced in the 24/25 financial year.
Replacement of Room 3 (Digital x-ray room), BGH	Edwards, David	~~31/03/2024~~ ~~31/10/2024~~ 30/06/2025	Mobile unit currently being used. Awaiting confirmation of funding as at April 2024. This will not be replaced in the 24/25 financial year
To consider alternative funding options for the DEXA unit, BGH	Edwards, David	~~31/03/2024~~ 30/09/2024	Unit is 17 years old, and previously funded via charitable funds To write business case for charitable funding

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 8 weeks.	Monthly reports on equipment downtime and overtime costs	1st			Radiology Equipment SBAR - Executive Team - Mar19 Further updates CEIMT Feb20 Further updates CEIMT Sep20 Radiology Diagnostic Imaging update to Capital Sub-Committee July 2022, July 2023, with the next update due to be presented September 2024	Lack of process of formal post breakdown review.				
	IPAR report overseen by PPPAC and Board bi-monthly	2nd								
	Internal Review of Radiology Service Report	3rd								
	WAO Review of Radiology - Apr17	3rd								
	External Review of Radiology - Jul18	3rd								

Date Risk Identified:	Jul-23	Executive Director Owner:	Paterson, Jill	Date of Review:	Sep-24
Strategic Objective:		Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Oct-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:

8 dental contracts have been returned to the Health Board in the last 12 months, of which four contracts (totalling £958,500) confirmed as being awarded by NWSSP Procurement Services in May 2024. 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. 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. There has been increased demand in urgent dental appointments resulting in appointments for the week being booked up early within the same week. The Dental Access Portal (DAP) pilot commenced in Powys in June 2024, with roll out due to the next Health Board cohorts in Autumn 2024.

2 GMS contracts has been returned to the Health Board in the last 12 months. However from previous contract terminations, 2 out of the 3 GMS contracts have become Health Board managed practices, resulting in additional financial pressures as the workforce is salaried. The third practice has been awarded as of 1st April 2024 after a successful procurement process. The outcome of the contract which was returned in April 2024 was presented and agreed by Board in July 2024, with decision made to manage list dispersal. It is recognised that any further managed practices would likely have a negative impact on the GMS budget.

Implementation plans are in place with Ophthalmology to support the transition of patients into Welsh General Optometric Service (WGOS4) (clinical pathways for Glaucoma, HQC and Medical Retina) as part of the new Optometry contract implementation which is due to commence in September 2024.

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)
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 Requests sent to contractors to assess potential risk of RAAC, with outcomes reported to WG 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. Strategic Programme for Primary Care (SPCC) bids approved for 2024/25 and 2025/26 to support workforce initiatives

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 series of patient facing videos have been developed with Pocket Medic to support patient education in accessing Primary Care Services, and due to launch during Q1 2024/25. 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 not a contractual requirement as at June 2023). Insufficient resources to support the estates development across all Primary Care services, particularly with independent contractors. Due to national review of Premises	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~~ 31/03/2025	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. This information now needs to inform and align to the Primary Care Workforce Strategy. Support is being provided to the Directorate with this work from colleagues in Workforce, and is also discussed via the Primary Care Academy.
	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~~ 31/03/2025	Paper submitted to Board in September 2023 setting out the scope of the Primary Care Strategy, with a further paper presented at Board in January 2024. The issues paper was presented at Board in March 2024, with feedback being addressed, with a further paper to be presented to Board in May 2024.

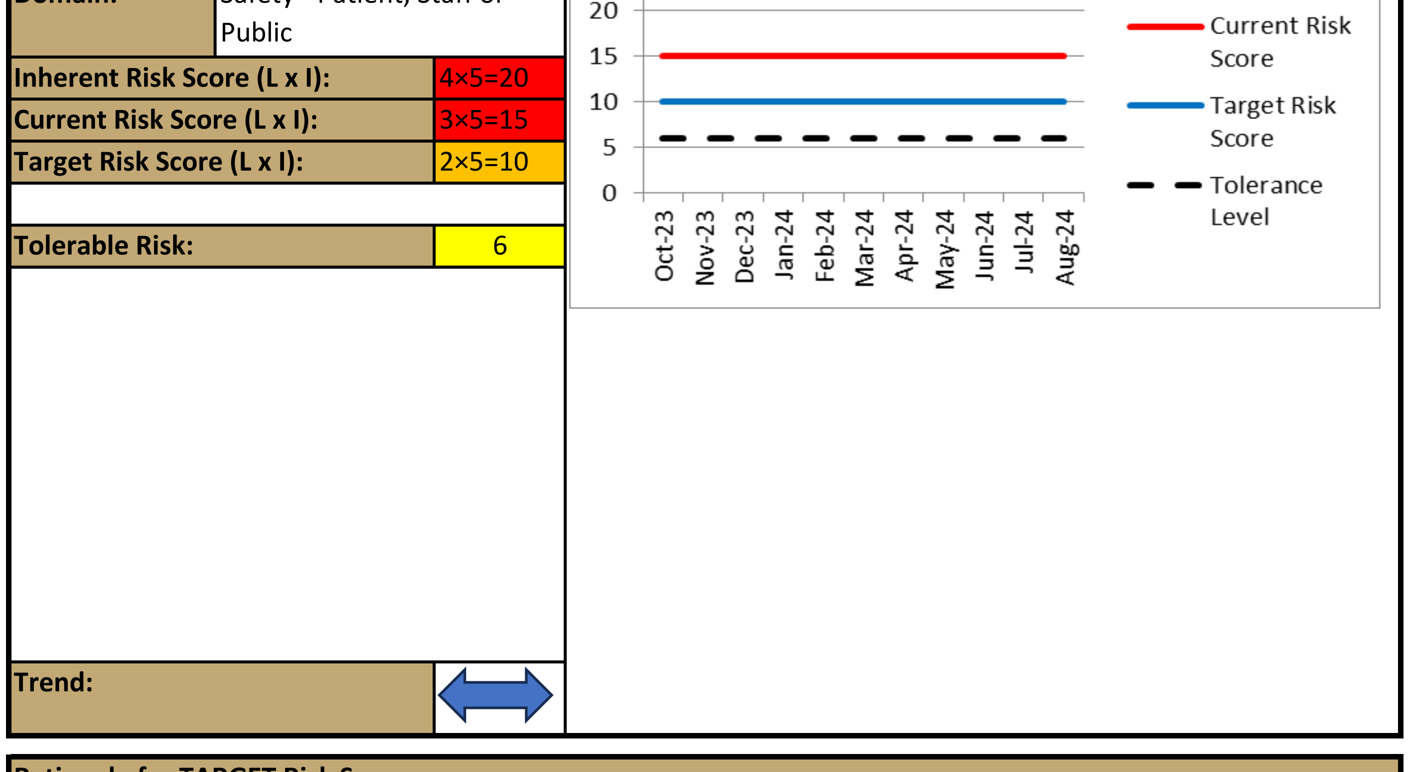
	national review of Premises Directions, there is no improvement grant funding for 2024/25. Whilst Community Pharmacy Breach Management process in place, 2 notices are currently under the appeals process - the Health Board is awaiting confirmation on the outcomes of these by Welsh Government, which to date has taken over a year. Outcomes of these appeals will directly influence the approach taken going forward, and may result in the nationally agreed process unable to be fully implemented. Whilst RAAC declarations were requested, these were not mandatory for contractors to respond.	Consider the potential to deliver a wider range of salaried NHS Dental Services through the Community Dental Service.	Owens, Mary	~~30/04/2024~~ ~~30/06/2024~~ 31/10/2024	Negotiations are continuing as at August 2024, and guidance still awaited from Welsh Government.
		Implement the Managed Practice Strategy plan will give greater system resilience.	Swinfield, Anna	~~30/04/2024~~ ~~30/10/2024~~ 31/01/2025	The tender process for Neyland and Johnston concluded without a contract award, however taking lessons learnt there is a plan to re-procure for the contract with an estimated contract award date in January 2025.

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	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:	Aug-23	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Aug-24
Strategic Objective:		Lead Committee:	Health and Safety Committee	Date of Next Review:	Sep-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?	1795		

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.

NWSSP Shared Services has supported a 3 year investment programme for Major Infrastructure.
WG are in support of this plan (With a £5m CapX per year limit) however they have not yet supported the fees to deliver the 3 year programme.
Note reductions of plans from earlier proposals costing several hundreds of millions, which WG were unable to support.
Current funding status is WG support for year 1 of a 3 year plan in 2024-25 together with a small number of priority schemes. Negotiations are ongoing with WG to secure funding for the 3 year plan but unable to give a date as yet.

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)
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) WG additional funding in 24/25 for priority items. Risks are identified by Estates and services and these inform prioritisation of DCP funding Skilled and trained Estates workforce in place.

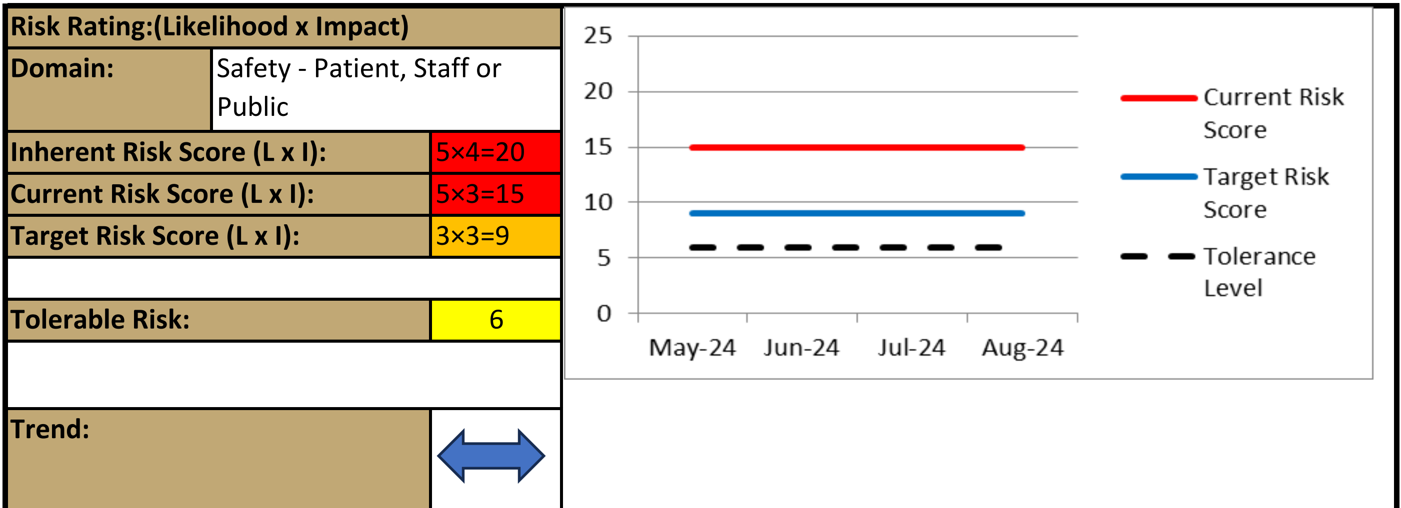
Gaps in CONTROLS				
Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
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	~~31/03/2024~~ 31/12/2024	NWSSP Shared Services has supported a 3 year investment programme for Major Infrastructure. WG are in support of this plan (With a £5m CapX per year limit) however they have not yet supported the fees to deliver the 3 year programme. Note reductions of plans from earlier proposals costing several hundred millions, which WG were unable to support. Current funding status is WG support for year 1 of a 3 year plan in 2024-25 together with a small number of priority schemes. Negotiations are ongoing with WG to secure funding for the 3 year plan but unable to give a date. A revised date for this action has been included and will be reviewed if the situation changes.
	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	Completed	Completed
	AHMWW PBC submitted to WG in February 2022 remains not endorsed. Agreement required with Welsh Government on next steps and broader strategic direction.	Davies, Lee	31/10/2024	Nuffield Trust report on clinical strategy received and presented to Board. Management response to be agreed through SDODC. Meeting arranged with Deputy Chief Executive, NHS Wales and Director of Finance, NHS 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	3rd								

Date Risk Identified:	Apr-24	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Aug-24
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	Sep-24

Risk ID:	**1842**	**Principal Risk Description:**	There is a risk of non-delivery of planned care ministerial targets by March 2025. This is caused by a mismatch between demand and current/forecast capacity in key specialties, workforce limitations, and the impact of the Health Boards' financial forecast for 2024/25, which limits the amount of recovery funding agreed by the Board to ensure full achievement of the respective ministerial delivery targets. 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):	5×3=15
Target Risk Score (L x I):	3×3=9
Tolerable Risk:	6
Trend:	↔



Rationale for CURRENT Risk Score:

The combined impact of a mismatch between demand and current/forecast capacity in key specialties, workforce limitations and limitations on the amount of recovery funding agreed by the Board all pose a risk to full achievement of ministerial planned care recovery targets. The Annual Plan, approved by the Board in March 2024 highlighted delivery risks in Orthopaedics and Ophthalmology, and the additional recovery resource agreed by the Board is below the level required to ensure full delivery of the ministerial milestones.

Whilst delivery plans for 2024/25 reflect positive progress in increasing outpatient activity & treatment capacity, underpinned by planned improvements in workforce availability and operational productivity and efficiency, the Annual Plan signalled expected delivery gaps in both specialties. Furthermore, revised delivery expectations advised by Welsh Government since submission of the Health Board's Annual Plan have brought forward the expected target dates for achievement of the 104 week Total Pathway maximum wait from March 2025 to December 2024. Health Board performance in respect of planned care delivery milestones is also a key feature of its escalation to Targeted Intervention status.

Both specialties have been prioritised for active exploration of regional solutions, in partnership with Swansea Bay University Health Board (SBUHB), to expand available capacity and address forecast shortfalls against anticipated demand.

Following further deep dive reviews of all specialty delivery plans, delivery risks in Ophthalmology have now been mitigated enabling an improved forecast trajectory in respect of the maximum 104 week Total Pathway wait by March 2024. However, delivery risks in respect of the December 2024 milestone remain in both Ophthalmology and Orthopaedic specialties. Whilst monthly breach volumes against both targets increased during Q1 in line with expectations (due to lead in times associated with implementation of recovery plans and operational challenges in specific specialties), breach volumes in respect of the Stage 1 52 week target improved significantly in July 2024 and breach volumes in respect of the Total Pathway 104 week target also showed a small improvement.

Taking the above into account, the current risk score is assessed to be lower than the inherent risk score due to the significant progress achieved in the past 12 months in improving waiting times, and current performance compares positively with other Health Boards. However the current risk score will remain unchanged until forecast monthly breach volumes further reduce in line with expectations during Quarter 2.

Rationale for TARGET Risk Score:

The target score of 9 reflects the continuing delivery ambitions which remain, despite the workforce and resource limitations reflected in the Annual Plan. At the end of March 2024, 98.5% of all patients waiting experienced a wait of less than 2 years (104 weeks). Of note, positive progress achieved both in respect of effective demand management and transformation of outpatient pathways has ensured that overall waiting list demand has not grown with waiting list volumes at their lowest level for 2 years. This offers positive indicatons for future improvements in waiting times in 2025/26 onwards.

Opportunities to make further progress towards the Ministerial targets in 2024/25 in Orthopaedics will continue to be explored, including exploration of the regional opportunities referred to.

The tolerable risk (6) 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. # Quarterly deep dive reviews of all specialty delivery plans and delivery assumptions to ensure full account of OP transformation and theatre productivity and efficiency opportunities # 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. # Elective care delivery plan developed for inclusion within Annual Delivery Plan. # Additional Planned Care Recovery proposals developed to utilise the additional recovery funding committed by the Board # Elective optimisation improvement programme in place to improve theatre activity productivity and efficiency, including improvements to waiting list scheduling and pre-operative assessment processes # Productive & Effective Elective Care Improvement Plan produced to drive productivity and efficiency improvements # Planned Care Delivery Workstream established, reporting to Integrated Quality, Financial Performance Delivery (IQFPD), as part of revised Targeted Intervention governance arrangements.	# Workforce staffing availability to support further expansion of theatre capacity # Sufficiency of Anaesthetic medical staffing capacity to support further expansion of required operating lists. # Sustainability challenges remain in a number of specialty areas which have been targeted for in-depth review via regional planning programmes for key specialties and the Clinical Services Plan review. # Widespread adoption of national best practice guidance to improve elective optimisation and utilisation of available operating capacity # Deficiencies within pre-operative assessment process and overall capacity to support required volume of Pre-Operative Assessment Clinic (POAC) assessments	Recruitment of additional orthopaedic surgeons to increase operating capacity within specialty to maximise utilisation of remaining sessions	Hire, Stephanie	30/09/2024	2 surgeons appointed, expected start date September 2024. 2 further surgeons to be recruited (awaiting approval to advertise), planned start date January 2025.
		Ongoing recruitment an job planning efforts to improve Anaesthetic workforce availability	Hire, Stephanie	~~30/06/2024~~ 30/09/2024	All staffed GA IP theatre sessions now covered in Anaesthetic job plans. Partial deficits remains in cover of DSU theatre sessions in Carmarthenshire although not critical to delivery of targets at present. 3 General Anaesthetic consultant vacancies in Carmarthenshire with partial locum cover in place. 61% of consultant job plans complete with 27% awaiting clinical sign off. This action will remain under quarterly review to assess the impact on overall capacity for elective care.
		South West Wales Regional Orthopaedic Delivery Programme established, led by Hywel Dda's Director of Operations as Senior Reporting Officer. Opportunities being explored to maximise capacity across Hywel Dda University Health Board and Swansea Bay University Health Board to support further recovery of waiting times	Jones, Keith	~~30/06/2024~~ 30/09/2024	Opportunities to further improve forecast breach volumes will be dependent on availability of additional financial resource to support additional activity solutions. This remains subject to monthly review.
		South West Wales Regional Ophthalmology Programme to be established, led by Swansea Bay University Health Board Director of Operations as Senior Reporting Officer.	Jones, Keith	~~30/06/2024~~ 30/09/2024	Formal launch of programme awaited, now expected September 2024. Service scoping document produced to inform programme priorities.

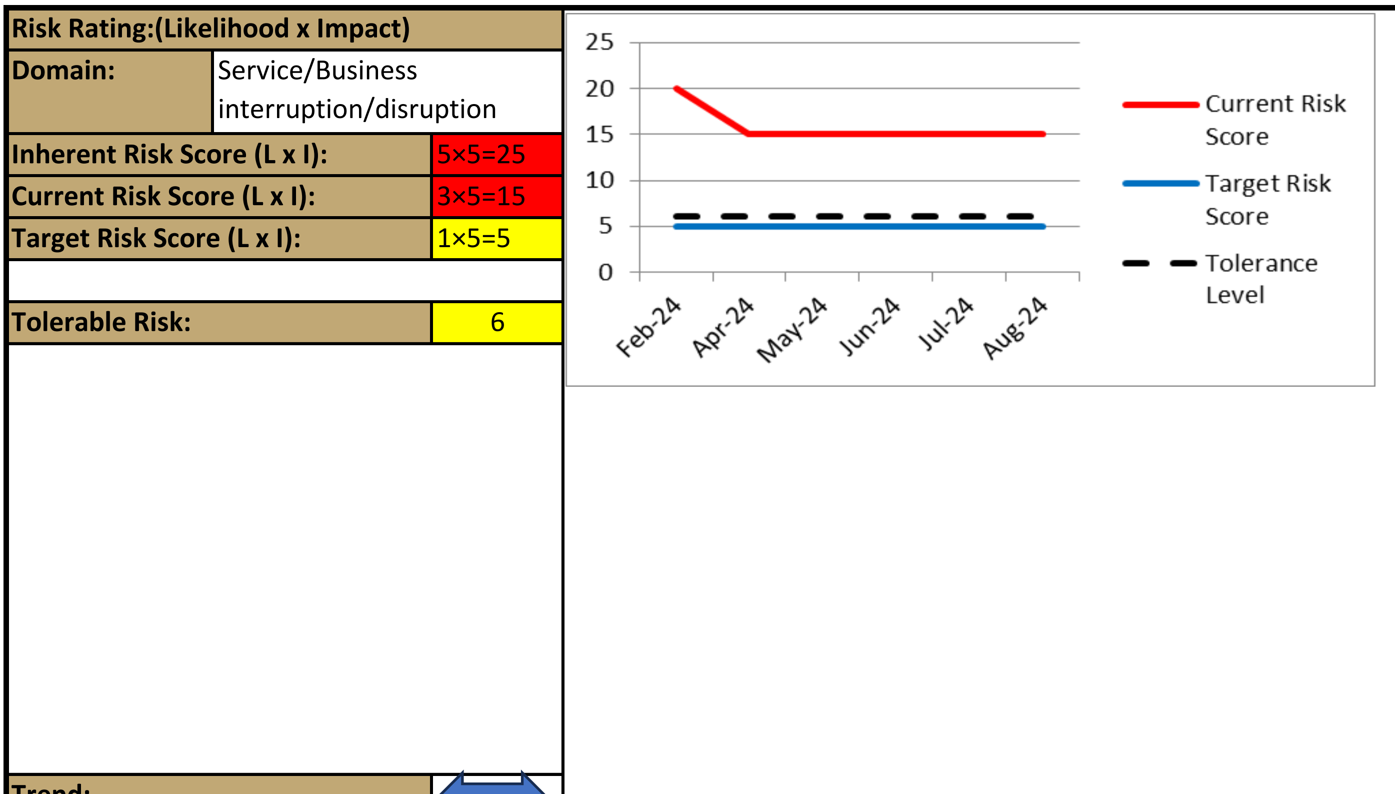
	Monitor progress with implementation of revised pre-operative assessment protocols to ensure alignment with best practice (Getting It Right First Time - GIRFT)	Hire, Stephanie	30/09/2024	Pre-Operative Assessment Clinic (POAC) pathway improvement plan agreed. Capacity pressures within POAC sevice remain due to limitations on Anaesthetic capacity to undertake patient reviews. Mitigating actions include planned implementation during Q2 of revised POAC pathways for Day Surgical patients and commencement of some aspects of POAC assessments during OPD appointments for specialties with shorter waiting times.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
A suite of planned care metrics have been developed to measure the system performance.	Activity volumes are reported daily on situation reports	1st			Annual Plan 2024/25	None				
	Daily performance data overseen by service management	1st								
	Delivery Plans overseen by Acute Services Triumvirate	1st								
	Bi-monthly reports to SDODC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	IPAR Performance Report to SDODC & Board	2nd								
	Welsh Government IQFPD & Enhanced Monitoring Meetings	3rd								

Date Risk Identified:	Feb-24	Executive Director Owner:	Paterson, Jill	Date of Review:	Aug-24
Strategic Objective:		Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Sep-24

Risk ID:	1810	Principal Risk Description:	There is a risk that the Health Board will be unable to continue manufacturing cancer treatments for our patients. This is caused by the facilities of the Pharmacy Aseptic Unit being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS) standards 5th edition (published 2016) and therefore at risk of closure. This could lead to an impact/affect on the Health Board's ability to provide all the cancer treatments currently offered. The Health Board would be entirely reliant on outsourcing cancer therapy from commercial suppliers. A fully outsourced service would cost an additional £1.3m each year. Some therapies cannot be outsourced, meaning Hywel Dda could not offer over 500 cancer treatments each year. This would have a significant negative impact on patient care as patients would either be required to travel further from home to neighbouring Health Boards to receive their treatment (dependant on their capacity to absorb the additional demand) or would be offered less clinically appropriate treatments at Hywel Dda, negatively affecting clinical outcomes. The closure of the Aseptic unit would directly impact the ability of the Health Board to achieve ministerial priorities and targets such as the Single Cancer Pathway, A Healthier Wales, etc.
Does this risk link to any Directorate (operational) risks?			374, 1350, 716

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):	3×5=15
Target Risk Score (L x I):	1×5=5
Tolerable Risk:	6
Trend:	⇔



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
The facilities of Withybush Aseptic unit are currently non-compliant with regulatory standards. The unit is subject to external audit by the National Pharmacy Quality Assurance Lead and the facilities were identified as being a high risk to patient safety in 2019. An audit performed in February 2023 confirmed the facilities were a high risk, and the unit at risk of forced closure. A pharmacy Aseptic unit based at Glangwili General Hospital was forced to close in December 2018 as the facilities were deemed a risk to patient safety. Withybush Aseptic unit is the only functional unit that can manufcature cancer treatments remaining in the Health Board. Short term control measures have been implemented by the Health Board to reduce the risk of immediate forced closure (see control measures). The controls are currently successfully minimising the amount of microbial contamination present within the unit. This is demonstrated by ongoing environmental monitoring results undertaken by the aseptic unit staff (combination of daily/weekly/monthly monitoring). However, as the unit and equipment are beyond their useful expected life, there will come a time where the control measures will no longer be sufficient to allow the safe running of the unit. If the stringent controls fail at limiting the amount of microbial contamination, the unit may be forced to close. This is because continued manufacture of cancer treatments within non-compliant facilities with unacceptable levels of microbial contamination would be a high risk to patient safety. Due to the age of the equipment and facilities, and the fact that the facilities were not designed against current regulatory standards, it is not possible to predict if or when the current controls will fail. If the unit was forced to close, the Health Board would be entirely reliant on outsourcing cancer therapy from commercial suppliers. Some cancer treatments cannot be outsourced due to their short shelf life. There were 345 reported service and quality-related incidents (e.g. delayed or failed deliveries) linked to outsourcing from commercial suppliers between September 2022 and August 2023 at Hywel Dda (an average of 29 incidents each month). The number of service and quality-related incidents between September 2023 and February 2024 remained high at an average of 25 incidents each month. Without a functioning Aseptic unit, the Health Board could not offer over 500 cancer treatments each year, and further treatments would be delayed/cancelled due to supplier service failures. Demand for aseptically prepared cancer therapy increased by an average of 14% each year between 2021 and 2023 (12,718 cancer treatments requiring aseptic preparation in 2021 compared with 16,648 treatments requiring aseptic preparation in 2023). Therefore the negative impact of not having a functioning aseptic unit is likely to grow each year. The most recent audit, conducted on the 20th and 23rd February 2024 with the final report received on 7th March, confirmed that the control measures employed are mitigating the risk and that all reasonable controls have been implemented. Therefore the current risk score has been adjusted from 20 to 15 to reflect the reduction in the likelihood of the risk of forced closure materialising, provided that these control measures remain effective. A business case for the demountable unit at Withybush General Hospital was submitted to Welsh Government in February 2023. The business case also requested funding to convert the current Aseptic unit into drug storage facilities. Based on budget cost estimates of £2.89m the submission was for review and scrutiny by Welsh Government to provide assurance to the Health Board before resourcing, and underwriting the financial risk, of progressing a detailed design for tendering. In September 2023, Welsh Government requested submission of a fully tendered business justification case, which is currently being worked up by the Health Board. As part of the Transforming Access to Medicines (TrAMS) project programme, a regional manufacturing hub will be built in South West Wales that will prepare cancer therapy for Hywel Dda patients. The hub was originally estimated to open during 2028, however there have been delays to the project plan and the opening date is currently unknown. There is therefore a high risk that the current Aseptic unit at Withybush will be forced to close before the South West TrAMS manufacturing hub is operational. In this case, there would be no means of obtaining certain cancer therapy for Hywel Dda patients to be administered within the Health Board locality.	The target risk score is based on the premise that funding for a new aseptic unit is approved by Welsh Government. The unit would be compliant with regulatory standards and once operational, it would be extremely unlikely for the unit to be forced to close. A new unit would allow the Health Board to continue to safely prepare cancer therapy until the TrAMS South West manufacturing hub is operational.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)
Transfer of the radiopharmacy service to Singleton Hospital in October 2022; this means less overall activity through the Withybush Aseptic unit reducing the risk of contamination and errors. More time and resource provided to the Quality System (i.e. internal audits, investigation of near misses and microbial growths, maintaining SOPs). Increased training of aseptic staff to develop their skills and knowledge. Increase outsourcing from commercial suppliers; this limits the volume of products prepared within the unit, allowing products that must be made in-house to be prepared safely. New pharmaceutical isolators have been procured to replace the existing isolators that are beyond their working life of 10 years. The new isolators will be stored with the intention of installing into the demountable unit (if funding is secured) or will be installed into the existing unit if the current isolators fail mitigating the risk of equipment failure causing prolonged service disruption. Removal of outsourced dispensing from the Aseptic unit; this minimises the risk of contamination and potential for error. Preparation of products near to the time of use; this limits the pre-administration storage time. More stringent gowning process; this minimises contamination risk. More stringent cleaning and monitoring programmes; this minimises contamination risk and allows early detection of microbial growth. Oversight and steer from Capital Sub-Committee.

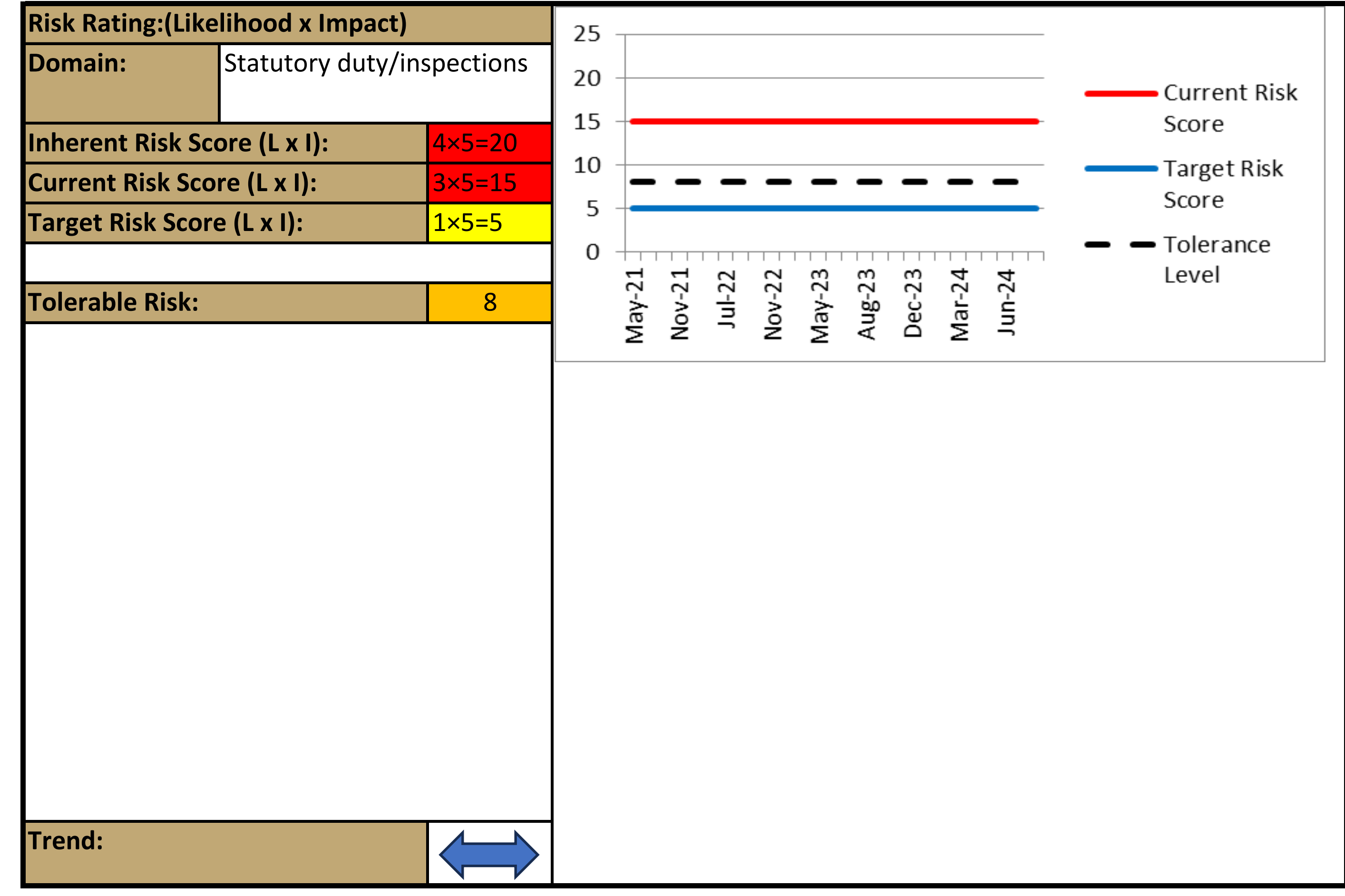
Gaps in CONTROLS				
Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Controls are reliant on a key group of skilled staff (i.e to maintain Quality System, to follow cleaning and monitoring procedures) therefore subject to key person dependencies. Limited accommodation to employ additional staff to expand workforce within the existing unit at WGH. Limited accommodation to store starting materials and finished products or to perform the associated tasks that are required to safely supply cancer treatments. Between 2021 and 2023, the number of cancer treatments requiring aseptic preparation at Hywel Dda increased from 12,718 to 16,648 (average of 14% increase each year). There is limited space within the Pharmacy at WGH to manage this increase in demand. Lack of funding to build a new unit at WGH.	To commence tender process for building a demountable aseptic unit on site at Withybush General Hospital.	Morgan, Cerith	Completed	The Mechanical and Electrical Engineering Professional Services evaluation was undertaken on 28.02.2024. A preferred provider was selected. The project timelines are currently running to schedule. Based on current schedule, the demountable aseptic unit will be operational by November 2025 if business case approved by WG.
	To submit revised business case for demountable unit to Welsh Government (estimated £2.89m).	Morgan, Cerith	31/01/2025	The project timelines are currently running to schedule. Based on current schedule, the revised business case will be submitted to WG during January 2025.
	To work with estates and capital planning team to source temporary accommodation at Withybush to increase the storage capacity for outsourced cancer therapy. This will help the aseptics service to meet the increasing demand for cancer therapy and will allow cost efficiencies related to outsourcing to be achieved whilst the business case for a demountable aseptic unit is being developed.	Morgan, Cerith	30/09/2024	Capital bids proforma submitted to Health Board capital planning team 11 June 2024. Ratification paper signed off by Huw Thomas and contract awarded to Portakabin on 02/08/2024. Continue to work with estates around delivery of Portakabin to site.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Audit Reports from annual audits detailing areas of non-compliance KPI Dashboard in place to provide continuous oversight of unit performance, updated monthly.	Annual Audits by Lead Quality Assurance Pharmacist (NWSSP) .	3rd			Capital Sub Committee (22nd January 2024). MMOG report to QSEC for Feb 2024.		To partake in annual audit (WHC 2024-004) by the Lead Quality Assurance Pharmacist.	Morgan, Cerith	Completed	Audit by Lead Quality Assurance Pharmacist was undertaken during February 2024. The audit confirmed that the facilities remain a high risk to patient safety but the control measures in place are appropriate.
							To commence "self-inspection" process where the Health Board pharmacy aseptics team will internally assess compliance of the service against QAAPS standards. Results of self-inspection to be discussed with Lead Quality Assurance Pharmacist or deputy to provide ongoing assurance that the aseptic unit complies with all other standards despite the facilities not meeting the standards.	Morgan, Cerith	~~31/07/2024~~ 31/10/2024	Initial meeting held between Cerith Morgan and Lead Quality Assurance Pharmacist. "Self-inspection" will commence July 2024 and results reviewed with Lead Quality Assurance Pharmacist or deputy during October 2024.

Date Risk Identified:	Oct-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Aug-24
Strategic Objective:	3. Striving to deliver and develop excellent services	**Lead Committee:**	Health and Safety Committee	**Date of Next Review:**	Sep-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 GGH Phase 1 (Nov 24) and GGH Phase 2 (30th June 2025) have been fully agreed by MWWFRS. WBH phase 2 date TBA.

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.

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)
Pre Planned Maintenance (PPM) checks are carried out across the UHB on fire safety components. A detailed physical estates backlog system is in place that identifies the scale (£) and risk of backlog for UHB. Data used to manage backlog maintenance & statutory decision making also regularly reported to WG. Extensive fire safety improvement works are being undertaken at WBH, GGH and at BGH from WG agreed funding (EFAB bids for BGH and funding and From submitted business cases), with phased timelines fully agreed with MWWFRS. Regular communications and dialogue is taking place between HB and MWWFRS. Individual Fire Risk Assessments (FRA's) in place for all sites across the UHB identifying fire related risks. Training Needs Analysis (TNA) for fire safety training in place, as defined in Fire Policy. UHB has implemented a governance structure for fire safety reporting. Estate plans with fire zones, fire doors, fire compartmentation, fire infrastructure items (alarm and detection system). UHB assesses its performance in respect of operational maintenance work carried out on fire safety components and presents this information as a formal paper at all UHB wide fire safety meetings. Annual prioritisation of investment against high risk backlog. Internal governance review (2019/20) initiated by the CEO and all action implemented from review. The HB has now embedded a fully resourced fire safety management team, with appropriate reporting arrangements for fire safety and addressing the backlog of out of date fire risk assessments across the UHB. The UHB has improved fire safety management culture and management ownership for fire safety. 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.

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

as a reminder for staff on when and how to book a session.

Works already completed following issue of Enforcement Notices and LoFSM at various sites. For EN sites (WBH and GGH) - Advanced Works to vertical escape routes now completed. Also further improvements under LoFSM at Tregaron, Bronglais, Glangwili and Withybush Hospitals.

Level 1 & 2 Fire Safety training is delivered via Teams. Level 3 Fire Safety training is provided face to face. Level 4 training (Fire Safety Warden training) is also a face to face session, with an external trainer. Level 5 training is provided on Teams as part of the H&S Managers induction training. 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.

Now the new Boris fire safety system is being implemented across the HB (training planned for June 22 for staff), fire risk assessment actions from this need to be monitored by those responsible. These actions need to be communicated at all fire safety sub groups and fed to the HB wide FSG for complete transparency.	Evans, Paul	Completed	System now live in the HB and staff training programme in place. From this point all fire risk assessment actions will be closely monitored using this system.
Introduce a system to manage fire risk assessment recommendations more effectively. System to have the ability to assign risks to risk owners, to track/manage risk and to demonstrate progress on the actions.	Evans, Paul	Completed	The fire team are utilising the current system as best as possible. An Excel system is being introduced (completion Jun20) however a more robust automated system is needed by the HB to track the significant number of actions. Progressing this has been delayed due to COVID-19, however quotes have now been obtained and are under discussion with the Director of Facilities. Approval has now been provided to purchase a system. Completion date for system trial on site by July 2021. System now being tested on site on a few Fire Risk Assessments, we plan to go fully live in Nov/Dec 2021.
Establish a teams training platform to deliver the level 3 and level 4 fire safety training programmes. Although this will also be supported by face to face sessions.	Evans, Paul	Completed	Following a review of level 3 & 4 fire safety training programmes it has been established that these cannot be delivered via Teams. These are now delivered as follows: Level 3 training has been reviewed and requires a face to face practical delivery. Level 4 training (Fire Safety Warden training) is also a face to face session, with an external trainer.
WBH - Completion of Phase 1 works - For all remaining horizontal escape routes.	Elliott, Rob	Completed	Completed on Dec 15th 2023

			WBH - Completion of Phase 2 works - For all departments, ward areas and risk rooms.	Elliott, Rob	~~30/04/2025~~ 30/04/2025	Full agreement has now been reached with Welsh Government (WG)/NHS Wales Shared Services Partnership - Special Estates Services (NWSSP- SES) to change the procurement approach for Phase 2. This following a wide-ranging lessons learned exercise undertaken jointly with NWSSP-SES. Noting the change in procurement and the new appointments the HB will be making we need to consider now formally the future programme for Phase 2. This is currently being reviewed by the full team and will be reported to the next Phase 2 Fire Project Team.
			GGH - Completion of Phase 1 works - For all remaining horizontal escape routes.	Elliott, Rob	~~28/04/2023~~ ~~22/01/2024~~ ~~31/10/2024~~ ~~31/07/2024~~ ~~31/12/2024~~ 30/11/2024	Completion by the end of November 2024. This programme is being maintained but there is potential for a small amount of slippage taking the completion date into December 2024.
			GGH - Completion of Phase 2 works - For all departments, ward areas and risk rooms.	Elliott, Rob	~~30/04/2024~~ ~~30/08/2024~~ 30/06/2025	The MWWFRS have now formally extended the FEN to 30 June 2025. Further extensions will be necessary, and we will work closely with MWWFRS to manage this process as the works proceed. We have already briefed the MWWFRS on GGH Phase 2 programme uncertainty given the revised approach which will be necessary. We agreed to keep in close contact on this as the project develops to keep MWWFRS fully informed.

	Develop a Fire Training information pack for distributing to agency staff across all 4 sites.	Elliott, Rob	Completed	Completed - We have supported the HoN on this recommendation and issued our current training material to all agency companies. We will continue to support the HoN with any new welcome packs they introduce.
	To ensure all fire risk assessments are transferred from NWSSP-SES system to Boris	Evans, Paul	Completed	Boris system transfer now completed, review of data now being undertaken

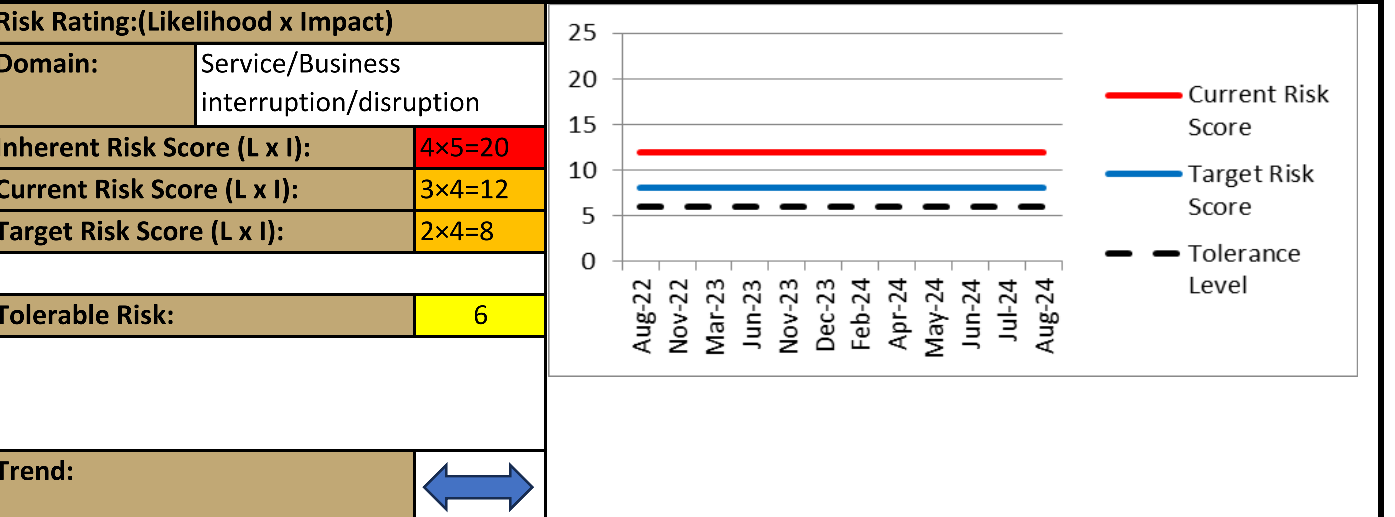
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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. Monitor the number of risks now held in the new Boris Fire Safety System.	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. Boris Fire Safety System (UPDATE) and Fire Training Performance SBAR's submitted to Sept 24 HSAC.	General site management checks/walkarounds on all sites				
	Site Fire wardens reporting fire safety issues	1st								
	Annual Online Fire Audit Self-Assessment submitted to NWSSP	1st								
	Review of compliance through fire safety groups	2nd								
	4 Fire Safety Sub Groups (one at each site) which report into the UHB wide Fire Safety Group (reporting into the HSC)	2nd								
	Fire Safety SBAR reports regularly issued to HSC	2nd								
	Fire inspections by Fire Service & Fire Improvement Notices	3rd								

	NWSSP fire advisor inspections	3rd									
	NWSSP IA Fire Precautions Follow Up May-18 - Reasonable Assurance	3rd									
	IA Fire Governance follow up in July 2022 - Substantial assurance.	3rd									
	IA WGH Fire Precautions Works: Phase 1 in Aug 22 - Reasonable rating.	3rd									
	High level action plan meeting with MWWFRS (Dec 8th 22) - with very positive comments received from then on our commitment to improve fire safety performance.	2nd									

Date Risk Identified:	May-22	Executive Director Owner:	Gjini, Ardiana	Date of Review:	Aug-24
Strategic Objective:	4. The best health and wellbeing for our individuals and families and our communities	Lead Committee:	Health and Safety Committee	Date of Next Review:	Oct-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. The Government Respiratory Pandemic Guidance is now due late Summer 2024. 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)
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 2025 # 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 also awaiting the Gov Respiratory Pandemic Guidance) # 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

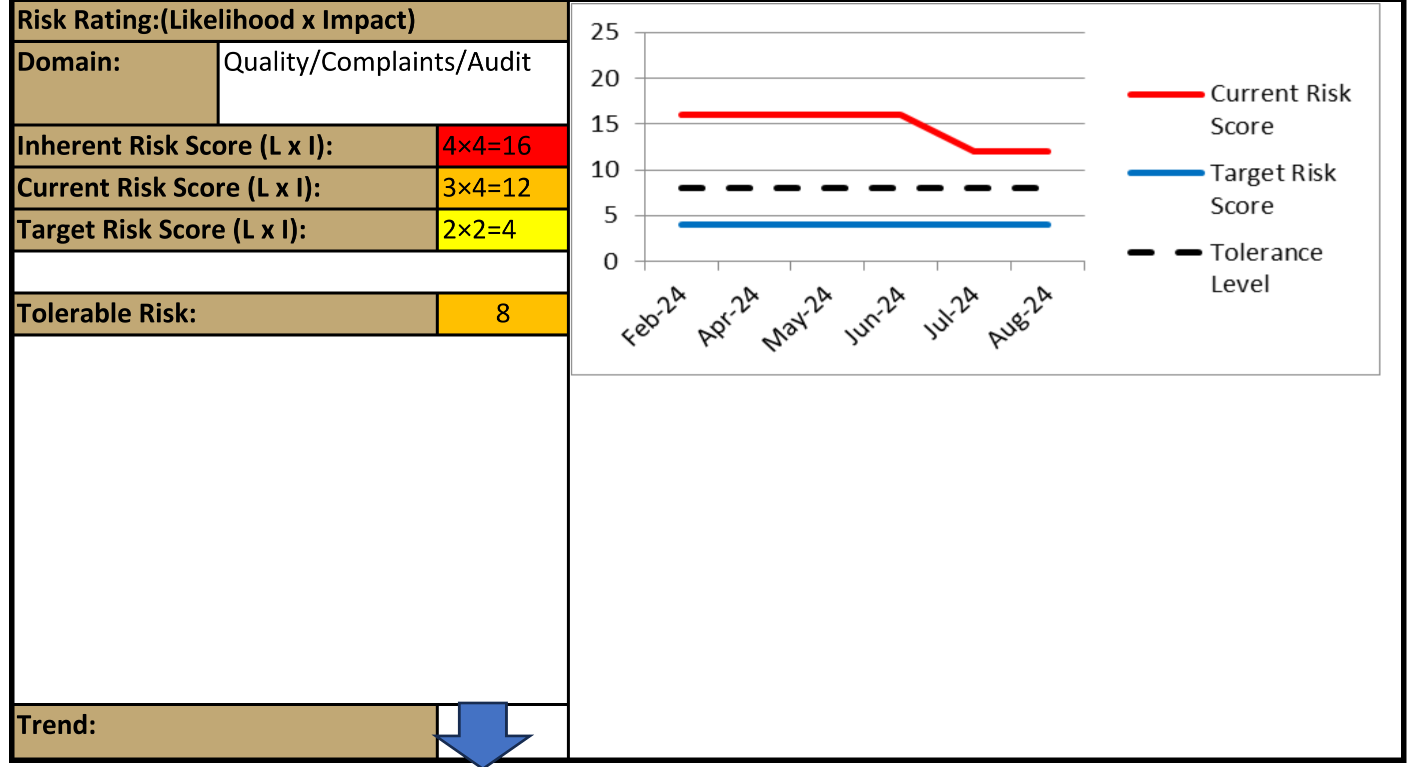
Gaps in CONTROLS				
Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
	Pandemic Response Framework reviewed which broadens remit from Influenza focus to generic pandemic events.	Hussell, Sam	~~31/01/2024~~ ~~31/05/2024~~ ~~31/08/2024~~ 31/10/2024	Awaiting publication of UK Gov Respiratory Pandemic Planning Guidance prior to progressing to ratification process.

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			Vaccine Equity Strategy - Board 30 May 2024 Vaccination Delivery Programme Update - Board via SDODC (Sep 23) Major Incident Plan - Board via HSC (Jul 23 and scheduled for July 2024)	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:	Nov-21	Executive Director Owner:	Henwood, Mr Mark	Date of Review:	Jul-24
Strategic Objective:	4. The best health and wellbeing for our individuals and families and our communities	Lead Committee:	Quality, Safety and Experience Committee	Date of Next Review:	Sep-24

Risk ID:	1812	Principal Risk Description:	There is a risk of the Health Board failing to comply with Medical Examiners (Wales) regulations and Death Certification Reforms coming into force on 9th September 2024. This is caused by the failure to fully resource internal processes that enable the Medical Examiner Service to scrutinise all deaths from all acute sites. This includes in particular the provision of human and hardware resource to enable the scanning of notes on Glangwili and Prince Philip Hospital sites. This could lead to an impact/affect on the experience of the bereaved following the death of a patient and the inability to register a death in a timely manner and within required timescales. This is likely to increase the number of complaints received from bereaved families. There is also a potential impact on the Health Board's reputation through non-compliance with statutory regulations and legislation. There are missed opportunities to reduce avoidable deaths and improve clinical outcomes through the learning gleaned from Mortality Review, and a failure to consistently reviewing mortality across the Health Board in alignment with the All Wales Learning from Mortality Review Framework.
Does this risk link to any Directorate (operational) risks?			1152, 1335, 1672

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



Rationale for CURRENT Risk Score:

New processes are in place for mortality review, in line with the All Wales Learning from Mortality Framework, supported by the Clinical Lead for Mortality and Mortality Review and Improvement Facilitator. As at July 2024, 2 wards remain outstanding at GGH who require training, with this envisaged to be completed by mid-August 2024, therefore increasing scanning capacity.

As of July 2024, the risk score has been reviewed and revised to 12, with the likelihood score reduced reflecting the increased capacity to scan, along with a review of existing processes and procedures to ensure compliance with Medical Examiner requirements. The capacity for clinical scanning remains below the required level, however it has increased recently due to the appointment of a Clinical Effectiveness Co-ordinator, and the Directorate will continue to review ongoing capacity requirements.

GGH scanning staff are currently scanning some of Prince Philip Hospital (PPH) casenotes and all GGH wards.

In line with the above screening resources, the Directorate will monitor the current backlog and develop contingency plans where required.

Rationale for TARGET Risk Score:

The ability to scan and send notes to the Medical Examiner Service across all sites will enable the Health Board to meet the statutory responsibilities, by providing the information required by the Medical Examiner Service in a timely manner. Full roll-out of this service across all Health Board sites will allow for global communications to be issued, with information about the processes and responsibilities of Doctors. This will also allow for reminders to be sent when there are issues with the process, e.g. support for timely completion of the Medical Certificate of Cause of Death. The Internal Scanning Bureau being developed may provide a potential sustainable, long-term solution however won't be operational prior to 9th September 2024. As an interim measure the Health Board are looking to recruit scanning personnel on a fixed term basis, but this depends on the successful recruitment of staff in to those positions.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Processes have been developed and implemented in line with the All Wales Learning from Mortality Review Framework to manage cases received from the Medical Examiner Service, covering Bronglais, Prince Philip, Withybush and parts of Glangwili Hospitals. The Medical Examiner Service has delivered some sessions at Grand Rounds previously and there are further sessions planned (to outline the basic principles of the Medical Examiner Service and how to complete a Medical Certificate of Cause of Death), through 2024 to introduce the legislative changes once the system becomes statutory on 9th September 2024. Fortnightly Multidisciplinary Review Panel in place, which is Chaired by the Clinical Lead for Mortality and has membership including Deputy Associate Medical Director - Primary Care; Hospital Director; Head of Quality and Governance; Head of Nursing; Assistant Director of Nursing and Quality Improvement; Head of Legal Services; Clinical Pharmacy Lead for Patient Services; Clinical Effectiveness Co-ordinator; Senior Nurse Infection Prevention and Patient Safety Officer. The Mortality Review and Improvement Facilitator is responsible for co-ordinating the Panel. Datix module now being used to record all cases received from the Medical Examiner Service. Community Hospital Roll-out complete and primary care roll-out ongoing (which is required to be in place by 9 September 2024), managed by the Medical Examiner Service, with the Health Board assisting with supporting communications. A Care After Death Steering Group has been established and is scheduled to meet bi-monthly. The Group is Chaired by the Assistant Director of Nursing, Legal Services and Patient Experience and is attended by: Head of Bereavement Services, Senior Care After Death Project Manager, Clinical Lead for Mortality, Assistant Director of Nursing and Quality Improvement, Head of Effective Clinical Practice and Quality Improvement, Assistant Director, Medical Directorate, County Director representative, General	Different processes are in place across acute sites currently to enable the scanning of casenotes to the Medical Examiner Service, with fragility remaining across sites and Glangwili Hospital being only partially rolled out. An interim solution to transfer casenotes from Prince Philip to Glangwili Hospital to be scanned also needs to be addressed. An SBAR has been developed with resource requirements to resolve this and enable the processes to be fully rolled out. The SBAR has been shared at Executive level. The potential solution of the Internal Scanning Bureau will be explored as a long term, sustainable solution, however this may not be operational by 9th September 2024. Full roll-out in Glangwili still to be achieved due to scanning resources. This is having an impact on global communications and training programmes as there is an inability to inform all staff of the new processes whilst there are different processes in operation in Glangwili. Processes for primary and community deaths in progress. This is being led by the Medical Examiner Service. While a Care After Death Steering Group has been established, due to operational pressures, meetings have been postponed. However, there are plans to re-establish the meeting in July 2024.	Acceleration of local plans to support the full implementation in Glangwili General Hospital, and provide a sustainable solution for Prince Philip Hospital (as outlined in the SBAR).	Perry, Sarah	~~30/04/2024~~ 30/09/2024	National date amended to 9th September 2024. Local plans being accelerated to support implementation in Glangwili General Hospital however awaiting agreement of SBAR for additional scanning resources before roll out can be completed. Medical Examiner Service is almost fully operational in Hywel Dda UHB for acute and community hospital sites. Bronglais, Prince Philip and Withybush all fully operational, however there are delays being experienced with implementation in Glangwili Hospital, due to scanning capacity. Interim arrangements to scan Prince Philip case notes in Glangwili need to be addressed - the SBAR includes this. There is also some service fragility in Withybush. Detailed conversations are ongoing with regards to clinical engagement, scanning capacity and mortuary provision. Community Hospitals are fully operational. Discussions with Primary Care ongoing. As at July 2024, implementation plan has been agreed for the outstanding areas in GGH (noting no issues at PPH), anticipated to be completed by 15th August 2024.

Manager (Community & Primary Care (Ceredigion), Head of Pathology, Lead Biomedical Scientist for Histology and Mortuary Services, Cellular Pathology Services Manager, Regional Mortuary Manager, Regional Mortuary Manager, Assistant Director Acute Services Nurse Representative, Head of Patient Experience, Clinical Nurse representative Women and Children, Clinical Nurse representative Mental Health and Learning Disabilities, Clinical Nurse representative Primary, Community and Intermediate Care, Specialist Bereavement Counselling Service, Chaplaincy Representative, Transplant Co-Ordinator representative, Learning and Development representative, General Practitioner representative, Psychological Services representative.		Ensure engagement on and communication of new processes to all Doctors across sites, using information, training sessions (e.g. Grand Rounds) and promotion of SharePoint information.	Hill, Carly	~~31/03/2024~~ ~~30/06/2024~~ 30/08/2024	Engagement and communication is ongoing. Discussions with Hospital and Directorate Triumvirates and other Quality and Governance groups. Regular global communications have commenced, and will continue until September 2024. SharePoint pages developed not live until processes are fully in place by 15 August 2024. Training plan developed, with training remaining to be given for the two remaining wards. Wider communications need to be issued when process is fully operational. Discussion has taken place with Medical Education on programme of training for completion of MCCD. Grand Rounds session undertaken in February 2023. Communication to all Doctors has taken place in relation to responsibilities for completion of MCCD.
		Identify additional clinical staff across disciplines to screen letters received from the Medical Examiner Service.	Hill, Carly	Completed	Inclusion of request within the Autumn 2023 and Spring 2024 Medical Directorate newsletter for anyone interested in screening cases to come forward. Attempt to secure an additional Medical screener has failed over negotiations around service release. Clinical Effectiveness Coordinator has commenced in post, who is a registrant and has increased screening resources screening. Quality Improvement team are also supporting the screening effort when possible. Medical Directorate will continue to request additional screening support from operational teams.

		Explore the solution of the Internal Scanning Bureau, once operational.	Hill, Carly	30/09/2024	The tender for the scanners is due out by week ending 19/01/2024 and there is a lead in time of around 8 weeks, once a contract is awarded. Estimated time for service to be fully operational not anticipated until Summer 2024. As at July 2024, contract has been awarded for a 5 year period. 3 scanners to be installed in Dafen. Assistant Director of Medical Directorate to liaise with Head of Health Records to discuss further progress and ownership of this action.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Number of deaths not scrutinised. Number of Delayed MCCD's completed. Number of deaths not registered due to lack of Medical Examiner involvement.	Number of deaths and number of case notes shared with Medical Examiner Service	1st			Effective Clinical Practice Advisory Panel (05/12/2023) Effective Clinical Practice Advisory Panel (19/03/2024) Quality, Safety and Experience Committee (13/02/2024) Operational Quality, Safety and Experience Sub-Committee (14/05/2024)	The process from death to registration is not captured on one system therefore gaps in completion and delays are dependent on information sharing across organisations including Health Board, Medical Examiner Service and Registrar Offices in Carmarthenshire, Ceredigion and Pembrokeshire.	Discuss with stakeholders improved information sharing arrangements.	Hill, Carly	Completed	Continued discussions with Health Records service to identify one system, however, scanning bureau not yet operational to support this function. Once a central scanning team has been established this will support the assurance on this risk. As at July 2024, systems are in place across the four sites bespoke to their arrangements that are appropriate for the current situation, whilst awaiting the implementation of a centralised scanning bureau. No concerns have been raised by the Medical Examiners Service.
	Mortality Scrutiny Group Medical Examiner Service	1st								
	Monitored by Medical Examiner Service	1st								

Date Risk Identified:	Oct-23	Executive Director Owner:	Gostling, Lisa	Date of Review:	May-24
Strategic Objective:	1. Putting people at the heart of everything we do and 2. Working together to be the best we can be and 3. Striving to deliver and develop excellent services	Lead Committee:	People, Organisational Development and Culture Committee	Date of Next Review:	Jul-24

Risk ID:	1821	Principal Risk Description:	There is a risk that staff will have a poor experience while at work. This is caused by the inability of leaders to lead compassionately due the current climate within which the Health Board is operating within and competing demands. This could lead to an impact/affect on the work life balance, morale and satisfaction of staff at work, and negatively impact the culture which staff experience at work. This could cause detriment to staff wellbeing and create a negative cycle which could lead to increased employee relations issues, team dysfunction, increased sickness absence and a higher number of staff choosing to leave the organisation with a negative effect on staff engagement, productivity and performance.
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):	3×3=9
Target Risk Score (L x I):	3×2=6
Tolerable Risk:	8
Trend:	⟺

25
20
15
10
5
0
May-24 Jun-24 Jul-24 Aug-24
Current Risk Score
Target Risk Score
Tolerance Level

Rationale for CURRENT Risk Score:

We are alert to the potential consequences of the Staff Welfare Risk; and are monitoring a number of areas/metrics to assess if the risk may be increasing e.g. turnover, absence etc. Careful consideration is being taken at different organisational levels to mitigate through organisational planning approaches to manage workload at management level and then the consequences upon staff wellbeing.

Rationale for TARGET Risk Score:

The target risk score is based on assessment of the work ongoing across the Health Board within the management and executive tiers to ensure clarity and focus of work programmes. Reviewing and streamlining where appropriate. The actions below are across all staff groups and focus on specific actions that are within the gift of the Workforce and OD function to drive and support with managers.

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**
Policies and procedures, which are readily available to staff via the Health Board intranet and the Wellbeing Single Portal. This provides guidance and resources for managers and staff. Forums in place with Executive oversight to review performance against objectives - Core Delivery Group, Directorate Improving Together Sessions, Clinical Services Plan Formal governance arrangements via Board and its sub-committees by Executives and Independent Members - People, Organisational Development and Culture Committee, Strategic Development and Operational Delivery Committee. Performance dashboards to monitor sickness, vacancies, grievances Structure of Workforce and Organisational Development Directorate encompasses a number of pillars with a focus on supporting staff, promoting healthy working cultures, and providing support and resources.	Review of the WHC for the Non Pay Deal has identified specific gaps to be addressed and strengthened as identified under actions opposite.	Review of WHC for Non-Pay Deal and Action Plan developed for implementation.	Gostling, Lisa	31/07/2024	In progress
		Review the Staff Retention Discovery Work and ensure high level actions are delivered.	Gostling, Lisa	31/12/2024	In progress
		Ensure promotion of compassionate leadership principles through a) PADR quantity and quality b) compassionate management and leadership programmes c) localised cultural progression plans	Gostling, Lisa	31/12/2024	In progress
		Review of Best Practice Guidance on Health & Wellbeing Launched for All Wales by HEIW.	Davies, Christine	30/09/2024	In progress
		Develop Action Plan for the Best Practice Guide on Health & Wellbeing	Davies, Christine	30/11/2024	To be planned

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 Dashboards	Wales Audit - Workforce Planning - External Audit	3rd			No specific papers. Recent papers to PODCC highlighted the deep dive on Workforce Themed Risks in October 2023.
	Core Delivery Group	1st			
	Directorate Improving Together Sessions	1st			
	Staff Wellbeing Internal Audit	2nd			
	Workforce & OD Leadership Team Meetings (Risk led)	2nd			
	PODCC	3rd			
	Executive Team meetings (Risk led)	1st			

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**
Monitoring of actions aligned to wider PO and alignment to Wellbeing for Management and Staff	Evaluation of Action Plans to be fed back to PODCC	Walmsley, Tracy	30/09/2024	Paper shared with WOD Leadership Team for PODCC in review of risk.