Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	30 May 2019
TEITL YR ADRODDIAD: TITLE OF REPORT:	Corporate Risk Register
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Steve Moore, Chief Executive
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Wilson, Board Secretary Charlotte Beare, Head of Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

Cefndir / Background

Risk management is a key component of the governance framework, and should underpin organisational strategy, decision-making and the allocation of resources, and 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 them to exercise good oversight.

The Board agreed the approach, format and content of the CRR and BAF at its meeting on 27th September 2018, and that it should receive the CRR and the BAF twice a year, however moving forward both will be received twice a year. The in-depth scrutiny and monitoring of corporate risks was delegated to its Board Committees in order that they would provide assurance to the Board, through its Committee Update Report, on the management of its principal risks.

The CRR contains risks that have been identified by individual Executive Directors, and are:

- Associated with the delivery of the objectives set out in Annual Plan 2019/20; or
- Significant operational risks escalated by individual Directors and agreed by the Executive Team as they are of significant concern and need corporate oversight and management.

The BAF should set out strategic objectives, the risks in relation to each strategic objective, along with controls in place and assurance on their operation, and should support the Board in assessing progress against its strategic objectives and strategic risks to inform operational planning and delivery and shape future Board agendas. The attached BAF only includes the risks associated with the achievement of the UHB objectives as set out in the Annual Plan 2019/20 as the UHB refreshes its strategic objectives this year.

The Executive Team is responsible for reviewing and discussing the CRR at its monthly formal Executive Team, and agree the any new risks and the escalation/de-escalation of operational risks that are on directorate risk registers. It is the role of Executive Team 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.

Asesiad / Assessment

There are 29 principal risks on the CRR/BAF at present which have been aligned to the UHB objectives listed below.

1. Deliver the Annual Plan 2019/20 by the end of March 2020
2. Deliver the agreed financial control total for 2019/20 by the end of March 2020
3. Achieve the agreed savings requirement for 2019/20 by the end of March 2020
4. Maintain performance and delivery of RTT by the end of March 2020
5. Deliver year 1 of the Health and Care Strategy by the end of March 2020
6. Deliver year 1 of Board approved strategies (Health and Well-Being, Continuous Engagement and Quality Improvement) by the end of March 2020
7. Development of the three year plan for 2020 – 2023 (IMTP)

Since the CRR was presented to the Board in January 2019, the corporate risks have been reviewed and discussed in detail at its Board Committees, and has been reported to the Board via the Committee Update Reports.

Attached to this report to provide the Board with assurance on the management of its principal and risks are:

Appendix 1 - CRR Summary
Appendix 2 - BAF Summary
Appendix 3 - Each risk detailing the strategic objective, controls, assurances, performance indicators and action plans to address any gaps in controls and assurances.

The following changes have taken place since the CRR was previously presented to the Board in January 2019. Whilst many of the scores remain unchanged, there is evidence that actions are being taken forward, although some dates in delivery have changed.

Total Number of Risks	29	
New risks	4	*See note 1*
Increase in risk score ↑	0	
No change in risk score →	23	
Reduction in risk score ↓	3	*See note 2*
De-escalated/Closed	4	*See note 3*

Note 1 – New Corporate Level Risks
The Executive Team have approved the following 3 risks for adding/escalating to the CRR:

Risk Ref	Risk Description	New Risk/ Escalated?	Date	Reason
684	Lack of agreed replacement programme for radiology equipment	Escalated from Unscheduled Care Directorate	10/04/19	This was escalated due to the wide scale disruption to all sites caused by breakdown of key imaging equipment which has a

		Risk Register		significant impact on the UHB's ability to meet its RTT target and the impact to patients which can include delays in diagnosis and treatment. The Executive Team recently received a paper detailing the current state and patient facing impacts of the UHB's diagnostic imaging equipment which identified the immediate level of investment required to replace items of equipment considered to pose the greatest risk to clinical services and are also considered long overdue for replacement.
718	Health and Safety Capacity	New	10/04/19	High level gap analysis undertaken on current operational staffing levels identifies significant lack of capacity which means that key aspects of health and safety management are not being undertaken, such as audits, inspections and case reviews, timely learning and follow up after health and safety incidents.
730	Failure to realise all the efficiencies and opportunities for the Turnaround Programme in 2019/20	New	08/05/19	This risk will replace the previous corporate risk (626) on delivery of the Turnaround Programme. This new risk reflects the risk to deliver the new savings target for delivery in 2019/20.
735	Ability to deliver the Financial Plan for 2019/20	New	22/05/19	This risk will replaces the previous corporate risk (630) relating to the delivery of the Financial Plan 2018/19. This new risk reflects the risk to deliver the new financial plan in 2019/20.

Note 2 – Reduction in Risk Score

Risk Ref	Risk Description	Previous risk Score	Risk Score Jan-19	Date	Reason
117	Delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery	4x5=20	2x5=10	21/03/19	The risk has been reduced on account of recent success of the Regional 'Treat & Repat' arrangement.
635	No deal Brexit affecting continuity of	3x4=12	3x3=9	19/03/19	The risk has been reduced to reflect the work that on-going

	patient care				to clearly identify the risks and impacts to the UHB in conjunction with Wales and UK Governments.
648	Ability to implement its Quality Improvement Strategic Framework within current financial and workforce resources	4x3=12	2x4=8	21/03/19	This risk has reduced as funding has been made available to fund the first collaborative cohort from June 2019.

Note 3 – De-escalated/Closed Risks

The Executive Team has agreed the de-escalation of the removal of the following 3 risks from the CRR:

Risk Ref	Risk Description	De-escalated /Closed?	Date	Reason
43	Ability to fully comply with the statutory Welsh Language Standards (WLS) by Mar19	De-escalate risk from CRR to Directorate Risk Register (Partnerships & Corporate Services)	08/05/19	Funding has been agreed to implement the Welsh Language Standards and therefore this risk can be de-escalated and managed at Directorate level.
626	Failure to realise all the efficiencies and opportunities for the Turnaround Programme	Closed	08/05/19	The Executive Team agreed to close risk 626 following delivery of £30.7m savings by the agreed date of 31st March 2019. This was achieved through operational savings of £26.4m with the gap mitigated through a range of recovery savings actions to the value of £6m. A new risk (above – risk 730) has been approved by Executive Team to reflect the UHB's new savings target for delivery in 2019/20.
630	Ability to deliver the Financial Plan for 2019/20	Closed	22/05/19	This risk is no longer relevant as the 2018/19 financial year has ended. A new risk (above – Risk 735) has been approved in respect of the risk to deliver the financial plan for 2019/20.
636	Ability to deliver zero breaches for RTT with 36 weeks, diagnostic within 8 weeks and therapy services within 14 weeks	Closed	08/05/19	The UHB delivered against its objective to deliver 0 breaches for Referral to Treatment Time (RTT) within 36 weeks in 2018/19 therefore this risk did not materialise and is no longer relevant.

				The Planned Care Directorate are currently reviewing the risk associated with delivery of RTT in 2019/20', and dependent on the level and nature of the risk, the Executive Team may be asked to consider the new risk for inclusion on the CRR.

'Acceptance' of Risk

At its Board meeting on 27th September 2019, the Board agreed its risk appetite and tolerance levels. These have been embedded within the risk management framework and those with responsibility for managing risk are aware of the agreed risk tolerance levels for risks within different impact domains. Risk tolerance provides guidance to risk owners within the organisation on the level of risk the Board will accept. If the risk is higher than the tolerance level, risk owners must take appropriate action to reduce the risk to within the 'acceptable' level', i.e. bring within risk tolerance levels set by the Board. Where it is not possible to reduce the level of risk to within risk tolerance, the Board must be asked whether it will 'accept' the risk.

It is the role of the Board and Committees, and performance management reviews, to challenge where current and target risk scores, set by those managing risks, do not meet the agreed tolerance levels. Where risk actions do not enable a risk to be reduced to the agreed tolerance level, a discussion needs to take place at the Board Committee aligned to the risk as to whether the target risk score is 'acceptable' based on the planned actions and resources available to manage the risk. It the Committee concludes that everything possible has been or is planning to be done (within available resources), then it should make recommendation to the Board to 'accept' that the risk will not be brought within its agreed tolerance level.

At the Business Planning and Performance Assurance Committee on 30th April 2019, the Committee discussed the risks aligned to the Committee, and considered in detail the risks where the target risk score was above the UHB agreed tolerance level. The Committee agreed to request that the Board 'accept' that that these risks will not be reduced to the UHB agreed tolerance level during the 2019/20 financial year unless there are significant changes in resources or circumstances. Risk owners will continue implement the planned actions to enable the risk to be reduced to the stated target risk score.

The Board is therefore asked to agree and 'accept' that the following risks can only be reduced to the stated target risk score and will remain above the UHB agreed tolerance level.

Risk	Risk Title	Current Risk Score	Target Risk Score	Agreed Tolerance level (Impact Domain)	Discussion
451	Cyber Security Breach	5x4=20	3x4=12	6 (Service/ Business Interruption/ Disruption)	The Committee agreed that cyber security was an inherent risk for all organisations and without infinite funds, it would be challenging to reduce the risk lower than 12.
624	Ability to maintain and address backlog maintenance and develop infrastructure to support long term strategic objectives	4x4=16	4x4=16	6 (Business Objectives/ Projects)	The Committee agreed that given the significant challenge to address the backlog with limited capital resources, no further improvements are achievable and therefore the risk score will be

					unable to be reduced further.
629	Ability to deliver against Annual Plan targets against rising demand in unscheduled care	4x4=16	3x4=12	8 (Quality/ Complaints/ Audits)	Whilst improvement work continues, there is an unprecedented level of risk within unscheduled care given the complexity of the system, and the Committee accepted that a lower risk score is currently not attainable, due to multiple factors.
632	Ability to fully implement WG Eye Care Measures (ECM)	4x4=16	2x4=8	6 (Safety - patients, Staff or Public)	Whilst the UHB has received some funding from the Welsh Government to implement Eye Care Measures, patients are still unable to access treatments in a timely manner, and therefore it would not be possible for the UHB to reduce the target likelihood and impact any lower than 2 x 4 = 8 at this point in time.
295	Inability to maintain routine & emergency services in the event of a severe pandemic influenza event	3x4=12	3x3=9	6 (Service/ Business Interruption/ Disruption)	The Committee accepted that due to the focus on Brexit, the UHB is currently awaiting the publication of the Cabinet Office review therefore it will not be possible to reduce this risk further.

Argymhelliad / Recommendation

The Board is asked to

- Consider if they have sufficient assurance that principal risks are being assessed, managed and reviewed appropriately/effectively through the risk management arrangements in place, noting that these have been fully reviewed by its Board level Committees.
- Approve BPPAC's recommendation that the aforementioned risks will be unable to be reduced to within the UHB agreed tolerance level during the 2019/20 financial year, unless there are significant changes in resources or circumstances, and 'accept' that that the risks will not be reduced lower than the target risk score.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	Governance, Leadership and Accountability
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	Not Applicable

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	Current risk score – Existing level of risk taking into account controls in place. Target risk score - The ultimate level of risk that is desired by the organisation when planned controls (or actions) have been implemented. Risk appetite can be defined as '*the amount of risk that an organisation is willing to pursue or retain*' (ISO Guide 73, 2009). ISO (2009) define risk tolerance as '*the organisation's readiness to bear a risk after risk treatment in order to achieve its objectives*', however it can be simpler to see it as a series of limits such as lines in the sand beyond which the organisation does not wish to proceed.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts
Gweithlu: Workforce:	No direct impacts
Risg: Risk:	Poor risk management systems will affect the UHB's ability to achieve its objectives, maintain safe and effective services, and compliance with legislation and regulations, as well as result poor regulatory feedback from auditors.
Cyfreithiol: Legal:	No direct impacts
Enw Da: Reputational:	No direct impacts
Gyfrinachedd: Privacy:	No direct impacts
Cydraddoldeb: Equality:	• Has EqIA screening been undertaken? No • Has a full EqIA been undertaken? No

Risk Ref	Risk (for more detail see individual risk entries)	Included on BAF	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score May-19	Trend	Target Risk Score	Risk on page no...
451	Cyber Security Breach	1	Miles, Karen	Service/Business interruption/disruption	6	5×4=20	5×4=20	→	4×3=12	19
730	Failure to realise all the efficiencies and opportunities from the Turnaround Programme in 2019/20	3	Carruthers, Andrew	Statutory duty/inspections	8	N/A	4×5=20	New risk	2×4=8	22
627	Ability to implement the UHB Digital Strategy within current resources to support the UHB's long term strategy	5	Miles, Karen	Business objectives/projects	6	4×5=20	4×5=20	→	2×3=6	24
245	Inadequate facilities to store patient records and investment in electronic solution for sustainable solution	1	Teape, Joe	Service/Business interruption/disruption	6	5×4=20	5×4=20	→	1×4=4	27
624	Ability to maintain and address backlog maintenance and develop infrastructure to support long term strategic objectives	5	Miles, Karen	Business objectives/projects	6	4×4=16	4×4=16	→	4×4=16	30
628	Fragility of therapy provision across acute and community services.	1, 5	Shakeshaft, Alison	Quality/Complaints/Audit	8	4×4=16	4×4=16	→	3×4=12	33
629	Ability to deliver against Annual Plan targets against rising demand in unscheduled care.	1, 5	Teape, Joe	Quality/Complaints/Audit	8	4×4=16	4×4=16	→	3×4=12	36
735	Ability to deliver the Financial Plan for 2019/20	2	Thomas, Huw	Finance inc. claims	6	N/A	4×4=16	New risk	2×4=8	40
625	Ability to recruit, retain and engage clinical staff to meet rising demand and deliver the long term clinical services strategy	1, 5	Gostling, Lisa	Quality/Complaints/Audit	8	4×4=16	4×4=16	→	2×4=8	42
632	Ability to fully implement WG Eye Care Measures (ECM)	1	Teape, Joe	Safety - Patient, Staff or Public	6	4×4=16	4×4=16	→	2×4=8	45
291	Thrombectomy services being withdrawn by Cardiff and Vale Health Board	1	Teape, Joe	Quality/Complaints/Audit	8	4×4=16	4×4=16	→	2×4=8	48
686	Delivering the Transforming Mental Health Programme by 2023.	1, 5	Teape, Joe	Service/Business interruption/disruption	6	4×4=16	4×4=16	→	2×4=8	50
684	Lack of agreed replacement programme for radiology equipment across UHB	1	Teape, Joe	Service/Business interruption/disruption	6	N/A	4×4=16	New risk	2×3=6	52
634	Overnight theatre provision in Bronglais General Hospital	1	Teape, Joe	Safety - Patient, Staff or Public	6	3×5=15	3×5=15	→	1×5=5	54
508	Insufficient resources in fire safety management to undertake appropriate PPMs, risk assessments and audits	1	Teape, Joe	Safety - Patient, Staff or Public	6	3×5=15	3×5=15	→	1×5=5	56
295	Inability to maintain routine & emergency services in the event of a severe pandemic influenza event	1	Jervis, Ros	Service/Business interruption/disruption	6	3×4=12	3×4=12	→	3×3=9	60
384	Ability to fully comply with statutory and manufacturer guidelines for medical devices and equipment	1	Teape, Joe	Statutory duty/inspections	8	3×4=12	3×4=12	→	3×3=9	62
44	Ability to manage patients awaiting follow up appointments	1	Teape, Joe	Safety - Patient, Staff or Public	6	3×4=12	3×4=12	→	2×4=8	65
631	Failure to recognise increasing mortality rates	1	Kloer, Dr Philip	Safety - Patient, Staff or Public	6	3×4=12	3×4=12	→	2×4=8	68
633	Ability to meet the new waiting time target of 95% in the new Single Cancer Pathway by August 2019	1	Teape, Joe	Quality/Complaints/Audit	8	4×3=12	4×3=12	→	3×2=6	70
646	Ability to achieve financial sustainability over medium term	2, 3	Thomas, Huw	Finance inc. claims	6	3×4=12	3×4=12	→	2×3=6	72
647	Failure to have robust systems in place to support the reporting requirements of the Nurse Staffing Levels (Wales) Act 2016	1	Rayani, Mandy	Statutory duty/inspections	8	3×4=12	3×4=12	→	2×3=6	75
129	Ability to deliver a GP Out of Hours Service for Hywel Dda patients	1	Teape, Joe	Service/Business interruption/disruption	6	4×3=12	4×3=12	→	2×3=6	77
652	Security on acute hospital sites	1	Teape, Joe	Safety - Patient, Staff or Public	6	3×4=12	3×4=12	→	1×4=4	80
117	Delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery	1	Teape, Joe	Safety - Patient, Staff or Public	6	4×5=20	2×5=10	↓	2×5=10	82
635	No deal Brexit affecting continuity of patient care	1	Jervis, Ros	Service/Business interruption/disruption	6	3×4=12	3×3=9	↓	2×3=6	85
718	Lack of Capacity within Health, Safety and Security Team	1	Teape, Joe	Statutory duty/inspections	8	N/A	3×3=9	New risk	2×3=6	87

650	Quality and safety governance arrangements	1, 6	Rayani, Mandy	Quality/Complaints/Audit	8	3×3=9	3×3=9	→	1×2=2	89
648	Ability to implement its Quality Improvement Strategic Framework within current financial and workforce resources	1, 6	Rayani, Mandy	Business objectives/projects	6	4×3=12	2×4=8	↓	2×2=4	91

Risk Ref	Strategic Objectives	Risk Title (for more detail see individual risk entries)	Risk Owner	Controls	Domain	Current Risk Score (L x I)	Target Risk Score (L x I)	Performance Indicators	Assurance from What? (sources/providers of assurance) L1, L2 & L3 (see below key)	Latest paper	Assurance Sufficient? (Y/N)	Control RAG rating (see below key)	Risk on page no...
451	1	Cyber Security Breach	Miles, Karen	* Controls have been identified as part of the national Cyber Security Task & Finish Group. * Continued rollout of the patches supplied by third party companies, such as Microsoft, Citrix, etc. * £1.4m national investment in national software to improve robustness of NWIS. * Further Task and Finish Group established to review the future patching arrangements within NHS Wales - this will lead future work locally to implement recommendations. * Capital funding has been made available by WG in 2018/19 to improve cyber security - this will be used to purchase required software/equipment for penetration testing.	Service/Business interruption/disruption	5×4=20	4×3=12	No of cyber incidents. Current patching levels in UHB. No of maintenance windows agreed with system owners. Removal of legacy equipment.	* Department monitoring of KPIs (L1) * IGSC monitoring of cyber security workplan addressing recent internal and external audits/assessments (L2) * IGSC monitoring of National External Security Assessment (L2) * Follow-up Information Backup, Disaster Recovery & Business Continuity and Data Quality: Update on Progress (L3) * WAO IT risk assessment (part of Structured Assessment 2018 (report awaited) (L3) * Internal Audit IM&T Security Policy & Procedures Follow-Up - Reasonable Assurance (L3)	External Security Assessment - IGSC - Jul 18	N		19

245	1	Inadequate facilities to store patient records and investment in electronic solution for sustainable solution.	Teape, Joe	* Annual weeding and destruction programme agreed and facilitated accordingly across the Health Board up to 2018/19. * Electronic clinic systems including: PACS (radiology), LIMS (Pathology), WAP e-referrals, CANIS (Cancer), Diabetes 3, Selma, Myrddin & Secretarial systems/shared drives (Clinic Letters). * Alteration to current racking and purchase of additional racking at GGH. Resourcing of additional racking for the offsite facility. * Agreed and approved Health Records strategies, policies and procedures (approved Aug15). * Electronic Records Project Group undertaking scoping work for Turnaround Project for long term solution (Sep18).	Service/Business interruption/disruption	5×4=20	1×4=4	Service KPIs in place.	* Weekly management audit to assess current capacity against demand (L1) * Deputy Health Records Managers Meetings to review storage & weeding (L1) * Health Records Audits (L1) * Electronic Records Group (L2) * Oversight by IGSC (L2) * IA Records Management Report - Feb19 (Limited Assurance) (L3)	* Destruction of records report - Exec Team - Dec17. * Records Management Brief report - Exec Team Nov 2018. * Records Management Brief update report - Exec Team Dec 2018. * Records Management Brief report - BPPAC April 2019.	N		27
624	1, 5	Ability to maintain and address backlog maintenance and develop infrastructure to support long term strategic objectives.	Miles, Karen	* There is an annual programme of replacement in place for equipment, IT and Estates which follows a prioritisation process. * The Business Planning & Performance Committee (BPPAC) and Capital Estates & IM&T Sub Committee (CEIM&T) (with IM membership and wide stakeholder engagement in prioritisation process), receive reports and recommendations on the prioritisation and allocation of available capital. * When possible, aligning replacement equipment to large All Wales Capital schemes to minimise the impact on discretionary capital within the UHB. * Completion of the medical devices inventory by the operational management team which helps in the prioritisation of available funds. * Retention of a medical equipment capital contingency to manage urgent issues of repair or replacement. *Review of regulatory reports which have a capital component ie. HIW, WAO, CHC. * Investigating the potential for 'Charitable' funding rather than Discretionary Capital Programme as appropriate. * Communication with Welsh Government via Planning Framework and IMTP (Infrastructure & Investment Enabling Plans) and regular dialogue through Capital Review meetings. * Preparation of priority lists for equipment, Estates and IM&T in the event of notification of additional capital funds from Welsh Government i.e. in year slippage and to enable where possible, the preparation of forward plans. This is also addressed through the identification of high priority issues through the annual planning cycle.	Business objectives/projects	4×4=16	4×4=16	Performance against plan & budget.	* Reports of delivery against capital plan & budget (L1) * Capital Audit Tracker in place to track implementation of audit recommendations (L1) * Monitoring returns to WG include Capital Resource Limit (L1) * Datix & risk reporting at an operational management level (L1) * BPPAC & CEIM&T Sub-Committee reporting (supported by sub-groups) (L2) * Bi-monthly Capital Review Meetings with WG to discuss/monitor Capital Programme (L2) * NWSSP Capital & PFI Reports on capital audit (L3) * WAO Structured Assessment 2017 (L3)	* DCP and Capital Governance Report - BPPAC Apr19	N		30

628	1, 5	Fragility of therapy provision across acute and community services.	Shakeshaft, Alison	* Agency staff utilised where appropriate, funded from within core budget (2 vacancies fund 1 agency staff). * Prioritisation of patients is undertaken through triage and risk assessment by therapy services. * Introduction of the Malcomess Care Aims Framework for Paediatric Therapy Services. * Local solutions include review of each vacant post to make them attractive, including skill mix review, early advertisements for new graduates. * Priority areas agreed for development, plans being progressed to increase capacity in these areas during 19/20.	Quality/Complaints/Audit	4×4=16	3×4=12	Maintenance of 14 week waiting times for therapy services. Clearance of backlog for pulmonary rehabilitation, with 100% achievement of 14 week maximum wait by Dec20. Improved compliance with minimum standards for stroke therapy care by Q3 2020/21. Improved staffing ratios for priority areas by Mar20	* Management monitoring of breaches of 14 week waiting times (L1) * Exceptions to achieving 14 week waiting times reported via IPAR to BPPAC (L2) * Monitored nationally via SSNAP and monitored via Stroke Steering Group & RCP Annual Report with recommendations produced (L2) * External Peer Reviews, Delivery Unit Reviews & national audits, eg Diabetes paediatric audit - action plans developed (L3)		N		33
629	1, 5	Ability to deliver against Annual Plan targets against rising demand in unscheduled care.	Teape, Joe	* Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. * Comprehensive daily management systems in place to manage unscheduled care risks on daily basis including multiple daily multi-site calls in times of escalation. * Escalation plans for acute and community hospitals. * Unscheduled Care Board includes system-wide representation (Local Authority, Out of Hours, 111). * Annualised delivery plans aligned to Transforming Clinical Services. * Annual winter plans developed to manage increased activity.	Quality/Complaints/Audit	4×4=16	3×4=12	Performance indicators for Tier 1 targets.	* Daily performance data overseen by service management (L1) * Delivery Plans overseen by Unscheduled Care Board (L2) * Executive Performance Reviews (L2) * IPAR Performance Report to BPPAC & Board (L2) * WAST IA Report Handover of Care (L3) * 11 x Delivery Unit Reviews into Unscheduled Care (L3) * Delivery Unit Report on Complex Discharge (L3)	IPAR Paper - Board 26/07/18. A&E Waits & Evaluation of winter preparedness - QSEAC - Apr19	N		36

632	1, 4	Ability to fully implement WG Eye Care Measures (ECM).	Teape, Joe	* Eye Care Action Plan in place. * Ophthalmology RTT delivery plan in place. * Identification of delivery opportunities to reduce costs of RTT delivery (identified in RTT paper to Board 26/07/18). * Commissioning arrangements for outsourcing ophthalmology activity secured via an extension to 2017/18 contractual arrangements. * Eye Care Collaborative Group established and meet quarterly to oversee performance against eye care standards. * ECM Coordinators recruited. * WG Monitoring information from W-PAS 18.1.standards is now functional and information is being submitted	Safety - Patient, Staff or Public	4×4=16	2×4=8	Reduction in number of follow-ups	* Monitoring arrangements by management (L1) * Executive Performance Reviews (L2) * IPAR Performance Report to BPPAC & Board (L2) * Monthly oversight by WG (L3)	* IPAR Mth 11 - Board Mar19 * IPAR Mth 12 - BPPAC - Apr19 * EC Collaborative Group Meeting Feb19	Y		45
686	1, 5	Delivering the Transforming Mental Health Programme by 2023.	Teape, Joe	* Open commitment and mandate from the Board on the implementation of the TMH Programme. Board approved implementation plan (Jan18). * Mental Health Implementation Group established to oversee delivery of the TMH Implementation Programme. * Established work streams in place for Pathway and Access Design, Workforce and Cultural Change, Transport, and Estates and infrastructure, IT, Partnerships & Commissioning and Data & Evaluation.	Service/Business interruption/disruption	4×4=16	2×4=8	N/A	* Work streams report progress, key risks and issues to MHIG (L1) * TMH Plan is monitored by TMH Implementation Group and Planning Sub-Committee, and to Board every 6 months (L2)	* TMH Progress Report - Board - Sep18&Nov18 * HOS reports - MHQSESC - Sep18 * MHLAC Update - Board - Jul18 * TMH update - Planning Subcommittee - Nov18	Y		50

625	1, 5	Ability to recruit, retain and engage clinical staff to meet rising demand and deliver the long term clinical services strategy.	Gostling, Lisa	* Continuous national recruitment programmes are ongoing in addition to bespoke recruitment campaigns. * Medical rotas sustained where possible by use of locum/agency staff through agreed frameworks such as Medacs when deemed essential. * Service workforce plans in challenged areas developed to look ahead and control risk including nursing plans produced by Heads of Nursing and plans to recruit to core trainee numbers. * Weekly workforce control panel under leadership of Director of Workforce & OD responsible for overseeing a series of workforce issues including vacancies. * Revised authorisation process for high cost temporary staff. * Bank & agency usage for all nursing areas authorisation process linked to nurse rosters * Leadership development programmes in place across organisation. * OD support & development in place	Quality/Complaints/Audit	4×4=16	2×4=8	Retention, recruitment, leavers data. Workforce KPIs.	* WOD Sub Committee review of workforce information (L2) * Review of workforce KPIs, recruitment/retention data and WOD workplan by WOD Sub-Committee (L2) * Review of workforce tier 1 performance by BPPAC and Board (L2) * Workforce Control Panel reviews series of workforce related issues eg corporate vacancies, bank & agency usage, secondments, etc (L2) * IA Mandatory Training Compliance May-16 (Reasonable) (L3). * IA Workforce Planning May-18 (Reasonable) (L3). * WAO Temporary Staffing Jun-17 (L3).	*Paper for Mar19 Workforce & OD Sub Committee include updates relating to: - Organisational Development - Workforce Annual Plan - HWCs & Audits - Employee Relations Activity & trends - Workforce Intelligence Report - Absence Management - Recruitment Update - Risk Register - Mandatory Training - Medical Education - Staff Experience - Workforce Policies	Y		42
291	1	Thrombectomy services being withdrawn by Cardiff and Vale Health Board.	Teape, Joe	* Re-commencement of thrombectomy services in Cardiff and Vale Health Board, dependent upon capacity * WHSSC currently putting in place a service in North Bristol which is planned to be in place by May 2019 and will support the Cardiff and Vale service	Quality/Complaints/Audit	4×4=16	2×4=8	Datix incident reports.	* Daily/weekly/monthly/ monitoring arrangements by management (L1) * Executive Performance Reviews (L2) * IPAR Performance Report to BPPAC & Board (L2) * Stroke Delivery Group review of patient cases (L2).	Thrombectomy Report - ET - Sep17.	N		48

684	1	Lack of agreed replacement programme for radiology equipment across UHB	Teape, Joe	* 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. * CT Scanner including fluoroscopy room and WGH MRI included on all Wales Capital Programme (AWCP)(not yet agreed)and AWCP secured for replacing the BGH MRI. * Replacement programme has been re-profiled by risk, usage and is influenced by service reports.	Service/Business interruption/disruption	4×4=16	2×3=6	Reduction of waiting times to under 6 weeks by Mar22. Reduction in overtime costs to nil by Mar22.	* Monthly reports on equipment downtime and overtime costs (L1) * IPAR report overseen by BPPAC and Board bi-monthly (L2) * Internal Review of Radiology Service Report (Reasonable Rating (L3) * External Review of Radiology - Jul18 (L3) * WAO Review of Radiology - Apr17 (L3)	Radiology Equipment SBAR - Executive Team - Mar19	N		52

508	1	Insufficient resources in fire safety management to undertake appropriate PPMs, risk assessments and audits.	Teape, Joe	* Fire Safety Policy approved Mar18 - implemented through fire training. * Fire Management Structure in place (Head of Fire Safety plus 3.8wte fire advisors). * 400+ valid fire risk assessments undertaken across UHB. * Staff training programme in place with level 1 compliance at 67.41% and level 2 at 44.27% as at Jan19. Also the introduction of Managers training to ensure that managers are made fully aware of their responsibilities (These are being delivered throughout 2019). A further change is also being made to fire safety training where the merger of L1 and L2 training content will take place. * Estate and statutory maintenance programme in place with focus on high risk in-patient facilities. * 7 x local fire safety groups which report to the HB wide Fire Safety Group, which feeds into the Health and Safety & Emergency Planning Sub Committee (HSEPSC). * Prioritised plan for fire safety investment in place which tackles highest risks coming out of the risk assessments as first calling.	Safety - Patient, Staff or Public	3×5=15	1×5=5	Improve mandatory fire safety training compliance for level 1 & 2 ideally above the 75% target by Nov19. Increasing no of valid in date risk assessments to >95% by April 2019. Reduce the no of unwanted fire signals (UwFS) to Fire Brigade by 40% by end of 2018 (from 119 UwFS for 2017 period). Planned and Preventative Maintenance programme in place for high risk business critical areas with a target of >95% completion(defined by the operational maintenance policy).	* Review of compliance through fire safety groups (L2) * Compliance reports regularly issued to HSEPSC (L2) * Fire inspections by Fire Service (L3) * NWSSP fire advisor inspections (L3) * NWSSP IA Fire Precautions Follow Up May-18 - Reasonable Assurance (L3)	IA Fire Precautions Report - ARAC 19/06/18. Quarterly reports to H&S EM SC.	Y		56
634	1	Overnight theatre provision in Bronglais General Hospital	Teape, Joe	* Resident Operating Department Practitioners (OPD) Team * 24/7 anaesthetic cover on site (obstetrician and consultant anaesthetist). * All families are informed by the Maternity Service at Bronglais Hospital of the services available at the hospital and that they will be a Continual Risk Assessment throughout pregnancy for the suitability of the Mother to deliver at BGH. Maternity staff are trained to deal with emergencies, with protocols in place for transfer out to appropriate centre is issues are identified. * Principle of removal of on-call compensatory rest approved by Executive Team.	Safety - Patient, Staff or Public	3×5=15	1×5=5	No of incidents reported where 30 minute response target is missed.	* Maternity Services governance systems review of incident reports (L1) * Management audit of cases presented to QSEAC (L2) * Discussions with WG Chief Nursing Officer & UHB Medical & Nursing Director (L3)	Executive Team - Jul18 Executive Team - Dec18	N		54

295	1	Inability to maintain routine & emergency services in the event of a severe pandemic influenza event	Jervis, Ros	* Local Resilience Forum (LRF) multi-agency plans for managing pandemic influenza (updated in accordance with current data and approved by Strategic LRF 14/11/18). * LRF Excess Deaths Plan (which supports the LRF multi-agency pandemic influenza management arrangements) developed as a recommendation from Exercise Cygnus. Plan was ratified by the LRF Strategic Group on 11/07/2018. * Health Board Pandemic Influenza Response Framework and associated plans (currently outdated awaiting review). * Quality assurance process via national & local exercise programmes. * Access to national counter measures stockpile. * Welsh Government Pandemic Influenza Guidance and National Pandemic Flu Service. * Hywel Dda participation in Welsh Government Pandemic Influenza Group. * Reinstated Hywel Dda Pandemic Influenza Group.	Service/Business interruption/disruption	3×4=12	3×3=9		* Reports to Health & Safety and Emergency Planning Sub-Committee (L2) * Emergency Planning Action Group (EPAG) Wales meetings re Pandemic Flu (L2) * NHS Wales wide workshops (L3) * LRF Cygnus Test of plans (L3) * Reviewed LRF Pandemic Flu Plan (L3)	No recent reports.			60
384	1	Ability to fully comply with statutory and manufacturer guidelines for medical devices and equipment.	Teape, Joe	* Medical and Non-Medical Devices Control Group reviewing performance. * HSE Action Plan is nearing completion. * Management information including regular reports provided for scrutiny. * Identification of devices and categorisation and inventory refresh complete and new database procured and commissioned. * System review processes operating to ensure missed inspections are not allowed to go unchecked. * 5 tier risk stratification system developed for Health Board device holding which facilitates high risk devices targeted for first attention. * Increased capital allocation has been realised. * Strategic replacement plan for the Health Board's medical device holding now in place and servicing capital decision making. * Improved ultrasound governance in place. * Training Needs Analysis has been undertaken in conjunction with L&D Team. * Servicing and inspection capacity restored to 2015 levels in clinical engineering. * Broader control over all aspects of all aspects of medical device management to include pathology, radiology and estates now in place.	Statutory duty/inspections	3×4=12	3×3=9	Maintain accuracy level at >95% items on Medical Devices inventory. Performance data from Planned Preventative Maintenance set out in IPAR. Performance data reported to control Medical Device Group. Incident reports relating to medical devices.	* Internal Management Review 2018 (L1) * Medical and Non-Medical Devices Control Group reviewing performance data (L2) * Oversight of incidents by Health & Safety & Emergency Planning Sub-Committee (L2) * PPM Performance reviewed by Medical Devices Assurance Group (which reports to Operational QSE Sub-Committee(L2) * PPM Performance on medical devices reported in IPAR to BPPAC and Board (L2) * HSE Improvement notices (L3)	* Update on Medical Devices Management - QSEAC - Aug18 * Medical Devices Assurance Group Update - Operational QSE Sub Committee- Nov18 *IPAR Month12 - BPPAC - Apr19	N		62

44	1	Ability to manage patients awaiting follow up appointments	Teape, Joe	* The programme of work underway within the Health Board is focussing on a number of key stages, urology and cancer. * Admin validation, cleaning up the waiting lists and removing obvious duplicate entries or patients that have been seen and the pathway not closed. * Engaging Clinical Leads for each specialty in the prioritisation of their patients and the identification of those most at risk of harm. * Specialty Service Delivery Manager (SDM) and clinical lead have identified patients on their follow up list who might be at risk. * Lessons learned from SUI / adverse events / complaints relating to delayed care shared through Directorate QSE meetings.	Safety - Patient, Staff or Public	3×4=12	2×4=8		* Watchtower meetings are held weekly to review all patient waits (L1) * Ophthalmology ECM specifically report compliance with the follow up intervals (L1) * Outpatients Turnaround Group reviewing levels of follow-up (L2) * Planned Care Programme Board (WG) reviewing HB implementation of PCP (L3) * Scrutiny of FUNB forms part of the Delivery Unit remit for scrutiny (L3)	* IPAR Report Month 9 - Board - Jan19 * IPAR Report Month 10 - BPPAC - Jan19 * Delayed Follow Up Improvement Plan 19/20 - BPPAC - Feb19	Y		65
631	1	HB wide risk: Failure to recognise increasing mortality rates.	Kloer, Dr Philip	* Stage 1 reviews are a standardised process across all sites in the Health Board * Learning from mortality review learning shared at Whole Hospital audit Meetings. * Stage 2 mortality reviews are in place on all sites however is being reviewed and standardised.	Safety - Patient, Staff or Public	3×4=12	2×4=8	No. of stage 1 mortality reviews undertaken in 28 days. No. of stage 2 mortality reviews undertaken. No of Datix incident reports.	* Mortality reviews (L1) * IPAR reviewed by BPPAC/PMAF Reviews (L2) * Each specialty to have established a quality and safety forum with mortality reviews as a standing agenda item (L2) * Quality improvement meetings with WG (L3)		N		68
633	1	Ability to meet the new waiting time target of 95% in the new Single Cancer Pathway by August 2019	Teape, Joe	* Working with all Wales Cancer Network to gain full understanding of implications of new pathway. * Implementation Group established, reporting to Cancer Board with awareness / engagement sessions held on each hospital site. * Shadow monitoring in place. * Demand & Capacity planning in progress to assess anticipated impact on diagnostic services.	Quality/Complaints/Audit	4×3=12	3×2=6	Performance indicators for Tier 1 targets. Shadow performance data.	* Daily/weekly/monthly/ monitoring arrangements by management (L1) * Executive Performance Reviews (L2) * IPAR Performance Report to BPPAC & Board (L2) * Monthly oversight by WG (L3)	* IPAR Report Mth11- Board - Mar19 * Implementation of Single Cancer Pathway Report - BPPAC - Feb19	Y		70

647	1	Failure to have robust systems in place to support the reporting requirements of the Nurse Staffing Levels (Wales) Act 2016	Rayani, Mandy	* Temporary staffing arrangements in place. * Risk based escalation arrangements and process in place in services. * Emergency Pressure & Escalation Policy ((Approved Sept 2018). * Nurse Staffing Levels (Wales) Act Steering Group. * (Inconsistent) reporting arrangements in place.	Statutory duty/inspections	3×4=12	2×3=6		* E-rostering system reviewed by Head of Nurses in Operation Teams (L1) * Datix Reports reviewed by Corporate Nursing Team to identify reportable breaches (L1) * Director of Nursing review of significant reported breaches (L2) * Workforce & OD Sub-Committee review of workforce challenges (L2) * Annual Report to Board (L2) * WG Review HB Papers in 18/19 (L3) * 3 yearly compliance report to Welsh Government (L2)	* Briefing on NSLA - QSEAC Aug18 and Feb19 * NSLA Update - Board May18, Jul18 and Nov18 * NSLA Annual Report - QSEAC Jun19 and Board May19	N		75
129	1	Ability to deliver a GP Out of Hours Service for Hywel Dda patients.	Teape, Joe	* GP's rotas are constantly reviewed and updated by the OOH staffing team with a view to improve resilience. * 111 programme board with 111 now live across the HB area. * The clinical advice hub as part of the '111' service is assisting with OOH demand * Dedicated Advice GP rota in place at times of high demand (weekends). * Health Professional feedback form in use between clinicians, service management and 111 leads. * Patients directed to alternate OOH care where capacity allows. ED and MIU direction is made for most urgent cases * GP Advisory Group established to improve communication/relationships with local GPs. * WAST APP support in place and provides significant mitigation to risk when other staff unavailable. * Health care support workers augmenting GP workloads by undertaking basic observations. * Pharmacist deployed locally into GGH but working as extended arm of support hub.	Service/Business interruption/disruption	4×3=12	2×3=6	Performance against Wales Quality and Monitoring for Delivery of OOH standards. Filled rotas.	* Daily sitreps/Weekend briefings for OOH (L1) * Monitoring of performance against OOH standards (L1) * Executive Performance Reviews (L2) * BPPAC monitoring (last month) (L2) * WAO Review of OOH in Wales (L3) * WG Peer Review completed Sep-18 (L3)	Internal Review of 111 - BPPAC Jun-18.	N		77

652	1	Security on acute hospital sites	Teape, Joe	* Doors are in place. * Porters locking each door in person at specific times. * Staff wearing ID badges at all times across sites. * Survey of access points on acute hospital sites identified gaps in access controls - Access controls in large number of areas.	Safety - Patient, Staff or Public	3×4=12	1×4=4	Reduction in no of incidents unauthorised access.	* Management investigation of unauthorised access and issues / H&S & Security Team identify trends across sites (L1) * Site inspections by night staff (L1) * Security compliance reports to H&S/ EM Planning Sub-Committee (L2) * Security issues discussed at Site Staff Partnership forums (L2) * Counter Terrorism Advisor Report on Security Controls in UHB (L3) * IA Physical Security Follow up - May 2015 - Limited Rating (L3)	* Lockdown policy - H&S SC - Jan19 * Access Control, CCTV, Lockdown Report - H&S/EP SC - May18	Y		80
117	1	Delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery	Teape, Joe	* Medical and nursing staff review patients daily and update the referral database as appropriate. * Bi-monthly operational meeting with Abertawe Bro Morgannwg (ABMU) to improve flow. * Daily telephone call Coronary Care Unit (CCU) to review all patients awaiting transfer with review of patients waiting for transfer to ABMU. * Escalation process in place. * All patients are risk scored by cardiac team in ABMU. * Local evaluation of catheter laboratory project to identify more local solutions. * Additional cardiac capacity for Winter 2018/19 providing 6 ring-fenced beds at PPH to enable timelier transfer to ABMU. ABMU have agreed to 2 transfers per day for HDUHB patients form 7/1/19 - this has achieved an average reduction from 10 to 3 days in the wait from 'referrals for angio' to ' angio undertaken'.	Safety - Patient, Staff or Public	2×5=10	2×5=10	Performance indicators for Tier 1 targets.	* Daily/weekly/monthly/ monitoring arrangements by management (L1) * Audit of N-STEMI referral undertaken by Clinical Lead show average wait of 10.7 days (L1) * Executive Performance Reviews (L2) * IPAR Performance Report to BPPAC & Board (L2) * Monthly oversight by WG (L3)		N		82

718	1	Lack of capacity within Health, Safety and Security Team	Teape, Joe	* 1 x Head of H&S, 1 x H&S Manager and 1 x Security/Case Manager/Prevent Co-ordinator who currently take a reactive approach to health and safety issues, as opposed to a more beneficial proactive approach. * Datix Risk module in place. The Health Board has invested in the Datix module which enables services to identify, assess and manage risks associated with health and safety. * Standard operating procedures in laboratory, radiology, theatre environments which reflect some of the hazards/ risks (Policy approved, most departments have material safety data sheets but very few COSHH risk assessments, pathology have undertaken monitoring for Xylene and Formaldehyde) * Incident/concerns investigations are undertaken however depth of investigations could be improved to ensure there is appropriate follow up, support for those affected and lessons are learnt across the organisation. * H&S policies and procedures are in place and are published on staff intranet. * Incident/concerns investigations are undertaken however depth of investigations could be improved to ensure there is appropriate follow up, support for those affected and lessons are learnt across the organisation. * H&S policies and procedures are in place and are published on staff intranet.	Statutory duty/inspections	3×3=9	2×3=6		* Incident and RIDDOR and progress against workplan reports to H&S/EP Sub-Committee (L2) * Progress against workplan reports to H&S/EP Sub-Committee (L2) * IA report on Health and Safety Sep16(Reasonable Rating) (L3)	SBAR Exec Team Oct-18 H&S/EP Sub-Committee	N		87
635	1	No deal Brexit affecting continuity of patient care	Jervis, Ros	* Regular meetings with CEO, DPH & Head of Emergency Planning plus verbal updates/discussions and papers at Executive Team and Board. * Brexit Steering Group has been established to manage the consequences of Brexit and its interface with partners. * Wider governance infrastructure in place - of note the Dyfed Powys LRF Brexit Group and Welsh Government led groups. * Risk assessments and business continuity plans feed into a dynamic risk summary document which continues to track on-going risks and controls assurance with business continuity. * Scoping exercise undertaken within Workforce to identify EU nationals and resolve data gaps in ESR. Workforce Brexit Plan developed. * Information flows are being co-ordinated to ensure that any discussions with respective Health Board services and national services and/or professional leads are captured within our planning. * The Health Board is represented at the WG SRO's, Comms and Brexit Health & Social Care Civil Contingencies Group and also within the DP LRF Brexit Group. * Staff Brexit Intranet page developed as single point of information plus a closed Facebook Group for EU staff. * Exercise Brexit Challenge undertaken resulting in recommendations and an action plan that will be progressed via the Brexit Steering Group. * Sitrep process in place at local, regional and national level for reporting and escalating impacts of consequences of Brexit. * Systems in place to review and respond to new consequences of Brexit at local, regional and national level.	Service/Business interruption/disruption	3×3=9	2×3=6	To be identified when risk is fully understood.	* Response submitted on 19Nov18 to Andrew Goodall letter of 05 October stating approach to be taken by Health Boards confirming progress (L1) * Response submitted to Wales Audit Office letter notifying of intention to undertake an initial baseline of arrangements by 30Nov19 (L1) * Emergency Planning Team to review UHB no deal Brexit arrangements and associated BCPs (L1) * Executive oversight of Brexit arrangements and BCPs (L2) * Review of Exercise planned for Jan19 (L3) * WAO Review of Brexit Preparedness (L3)	None to date.			85

650	1, 6	Quality and safety governance arrangements	Rayani, Mandy	* Review of QSEAC Sub-Committee Structure undertaken. * Nurse staffing levels reports. * Quality metrics in place including Fundamentals of Care, Incident reporting, and concerns, etc. * Quality & Safety Dashboard reviewed by QSEAC and assurance reports provided at each QSEAC.	Quality/Complaints/Audit	3×3=9	1×2=2	Incident reports Q&S Dashboard	* Q&S metrics reported through IPAR to BPPAC (L2) * Monthly meetings with WG Q&S Unit (L2) * Q&S Dashboard and Sub-committee reports to QSEAC (QSEAC report to Board) (L2) * HIW Reports indicate areas of improvement of Q&S (L3) * WAO Structured Assessment 2018 - focus on Q&S governance (L3)		N		89
648	1, 6	Ability to implement its Quality Improvement Strategic Framework within current financial and workforce resources	Rayani, Mandy	* Small scale quality improvement activity taking place across the organisation. * Quality Improvement Strategic Framework (QISF) & implementation plan developed. * Launch of QISF in Mar19. * Funding for first collaborative cohort has been agreed. * Network of coaches identified from within and outside of organisation. * Full support from 1000 Lives and the Director of Quality and Safety NHS Wales. * Collaborative Steering Group established and meets monthly to monitor delivery of implementation plan.	Business objectives/projects	2×4=8	2×2=4		* Collaborative Steering Group established to monitor delivery of QISF Implementation Plan (L2)	N/A			91

735	2	Ability to deliver the Financial Plan for 2018/19. (under review)	Thomas, Huw	* Financial reports provided to directorates in a timely way, focused on trends; cost drivers; projected expenditure; risks and actions. * Turnaround Director Holding to Account meetings. * CEO Holding to Account meetings. * Executive Performance meetings. * Commissioning arrangements with key partners (Local Authorities; Care home sector; Other NHS providers; Primary Care; Third Sector). * Process of reveiw of recovery plans process in place for Month 3 and approaching of system-wide issues.	Finance inc. claims	4×4=16	2×4=8	Identification and delivery of savings schemes. Financial performance and projections reported on a monthly basis. Breakeven recovery plans where deficits are projected. Financial process assurances. Internal Audit and Wales Audit Office reports.	* Finance dashboards (L1). * Finance report to Finance Committee and Board (L2). * CEO Holding to Account meetings (L1). * Financial assurance report to Audit Committee (L2). * Year-end reporting to Audit Committee (L3).	Month 1 Finance Report 2019/20 reports - Finance Committee - May 2019	Y		40
646	2, 3	Ability to achieve financial sustainability over medium term.	Thomas, Huw	* Understanding the underlying deficit. An initial assessment has been completed. * Very high level base-case long term financial model. * Assessing the full financial implications of Transforming Clinical Services.	Finance inc. claims	3×4=12	2×3=6	Operational agreement to underlying deficit assessment. Plan in place to develop a long term financial plan. High level financial assessment of TCS in place.	* Reporting to Finance Committee (L1).	N/A	N		72

730	3	Failure to realise all the efficiencies and opportunities from the Turnaround Programme in 2019/20	Carruthers, Andrew	* Turnaround Programme Director in post. * Fortnightly 'Holding to Account' (HTA) meetings including a monthly Chief Executive HTA session for the highest risk directorates. * Each Directorate has signed up to a savings plan and recovery plan - costed and RAG rated. * Identified Exec lead for red schemes and for key Turnaround Improvement Programmes. * Specific aspect of Performance Review focus on finance and link to HTA session. * Escalation process to HTA monthly meeting. * Executive Team Turnaround Meetings.	Statutory duty/inspections	4×5=20	2×4=8	Performance against agreed savings plan In-month financial monitoring	* Performance against plan monitored through HTA meeting with Services (L1) * Executive Performance Reviews (L2) * Finance Committee oversight of current performance (L2) * Turnaround & Financial Report to Board & BPPAC (L2) * WG scrutiny through Targeted Intervention (TI)(L3) * WG scrutiny through Joint Executive Team (JET) (L3) * WAO Structured Assessment 2018 (L3)	* Mth 12 Finance Report & Turnaround Report - Board Apr19 * Finance Report & Turnaround Report - Mar19 Finance Committee	Y		22
627	5	Ability to implement the UHB Digital Strategy within current resources to support the UHB's long term strategy	Miles, Karen	* Board approved the 5 year Digital Strategy - Jan17. * Board Approved the updated 2018 Digital Plan, and Operational Delivery Plan. * Development of a Digital Futures Programme.	Business objectives/projects	4×5=20	2×3=6		* Signed off project plans by the relevant committees (L1) * Delivery of digital plans are overseen by Digital Steering Group (reports to Planning Sub Committee) (L2)	Digital strategy/plans included in annual plan document-action to Board.	Y		24

Assurance Key:

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

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

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

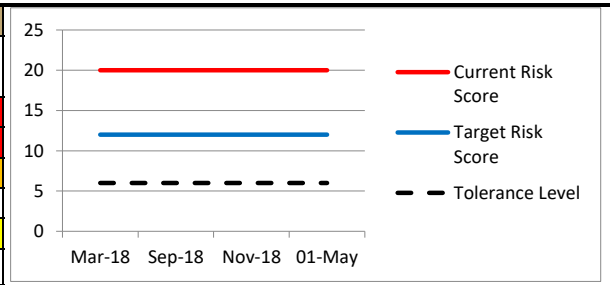
Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective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

Strategic Objective:	*1 -Deliver the Annual Plan 2019/20 by the end of March 2020*

Executive Director Owner:	Miles, Karen	**Date of Review:**	09/05/2019
Lead Committee:	Business Planning and Performance Assurance Committee	**Date of Next Review:**	09/06/2019

Risk ID:	**451**	**Principal Risk Description:**	There is a risk of the Health Board experiencing a cyber security breach. This is caused by a lack of defined patch management policy, lack of management on non-ICT managed equipment on network, end of life equipment no longer receiving security patching from the software vendor, lack of software tools to identify software vulnerabilities and staff awareness of cyber threats/entry points. This could lead to an impact/affect on a disruption in service to our users cause by the flooding of our networks of virus traffic, loss of access to data caused by virus activity and damage to server operating systems.
Does this risk link to any Directorate (operational) risks?	451, 356		

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



Rationale for CURRENT Risk Score:
There are daily threats to systems which are managed by NWIS and UHB. Current patching levels within the UHB of is 60% for Desktop / Laptops and 25% for the server infrastructure and there is lack of capacity to undertake this continuous work at the pace required. Severity score is 5 as a cyber attack has the potential to severely disrupt service provision across all sites for a significant amount of time.

Rationale for TARGET Risk Score:
Increased patching levels will help to reduce to impact of disruption from a cyber threat. However this work is continuous and is dependent on obtaining the appropriate level of resources to undertake the patching anti-virus work at pace. A paper was prepared for the Formal Executive Team in Sep18 which identified the revenue resources required. The target risk score of 12 reflects the wider risk to other applications not Microsoft.

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**
Controls have been identified as part of the national Cyber Security Task & Finish Group. Continued rollout of the patches supplied by third party companies, such as Microsoft, Citrix, etc. £1.4m national investment in national software to improve robustness of NWIS. Further Task and Finish Group established to review the future patching arrangements within NHS Wales - this will lead future work locally to implement recommendations. Capital funding has been made available by WG in 2018/19 to improve cyber security - this will be used to purchase required software/equipment for penetration testing	Lack of comprehensive patching across all systems used in UHB. Lack of staffing capacity to undertake continuous patching at pace. Lack of dedicated maintenance windows for updating critical clinical systems.	Continue to focus on critical and security updates to clinical critical systems.	Solloway, Paul	Ongoing	These are implemented when received however this work does take time with current staffing resource level.
		Review of cyber security measures underway following wannacry virus incident.	Solloway, Paul	Completed	Additional resources were received from Welsh Government to implement the necessary software to monitor cyber incidents. A further all Wales bid was submitted for 2 staff to undertake the remedial work. Presently awaiting formal funding letter for these posts.
		Implement local UHB workplan developed in response to the National External Security Assessment.	Tracey, Anthony	Ongoing	Progress is reported to IGSC at every meeting.

software/equipment for penetration testing.		A paper has been prepared to request additional revenue resources from the Executive Team.	Tracey, Anthony	Completed	The Executive Team considered the paper and acknowledged that the steps outlined should be incorporated within Emergency Planning procedures as recommended. The Executive Team also requested that money saving opportunities elsewhere will need to be considered, and a risk assessment exploring all options needs to be undertaken and presented to the Board for considerations. The Executive Team acknowledge the importance of Cyber Security and requested a Dashboard on compliance to be developed.
		Work with system owners to arrange suitable system down-time or disruption.	Solloway, Paul	Ongoing	Patching policies have been created however little progress has been made due to lack of resources. Service catalogue creation is progressing well and this will be amalgamated with Information Asset Owners group to agree down-time for the key local systems. However patching KPI's will not be met until sufficient technical resources are in place.
		Purchase Vulnerability Scanning to adopt a proactive approach to identifying cyber threats.	Tracey, Anthony	Completed	The required software was purchased with year end capital released from Welsh Government. It has been implemented and is operational within the Health Board.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
No of cyber incidents.	Department monitoring of KPIs	1st			External Security Assessment -	Lack of committee oversight.	Update IGSC TORs to include responsibility to monitor cyber security.	Tracey, Anthony	Completed	Regular reports on progress on External assessment.

Current patching levels in UHB. No of maintenance windows agreed with system owners. Removal of legacy equipment.	IGSC monitoring of cyber security workplan addressing recent internal and external audits/assessments	2nd			IGSC - Jul 18		Internal Audit (IA) of GDPR (Dec 18) and cyber security (Sep 18).	Tracey, Anthony	Completed	The IA GDPR final report in Apr19 reported 'Substantial Assurance' whilst the Internal Audit deferred Cyber Security to the 2019/20 Internal Audit Plan.
	IGSC monitoring of National External Security Assessment	2nd								
	Follow-up Information Backup, Disaster Recovery & Business Continuity and Data Quality: Update on Progress	3rd								
	WAO IT risk assessment (part of Structured Assessment 2018 (report awaited)	3rd								
	Internal Audit IM&T Security Policy & Procedures Follow-Up - Reasonable Assurance	3rd								

Strategic Objective:	3 - Achieve the agreed savings requirement for 2019/20 by the end of March 2020

Executive Director Owner:	Carruthers, Andrew	**Date of Review:**	08/05/2019
Lead Committee:	Finance Committee	**Date of Next Review:**	08/06/2019

Risk ID:	**730**	**Principal Risk Description:**	There is a risk of the UHB not delivering the planned recurrent savings of £24m by end of March 2020. This is caused by a failure to realise the opportunities identified in the Turnaround programme. This could lead to an impact/affect on a failure to meet its financial statutory duty to breakeven, attain an approvable IMTP, loss of stakeholder confidence in the organisation's ability to deliver its objectives and increased scrutiny by WG.
Does this risk link to any Directorate (operational) risks?	yes		

Risk Rating:(Likelihood x Impact)	***No trend information available***
Domain:	Statutory duty/inspections
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	8
Trend:	*New risk*

Rationale for CURRENT Risk Score:

At this point in time there is a possibility that the UHB will fail to deliver the full £24m savings in 2019/20. Currently as at the end of Mar19, the Health Board has identified £20.5m against that target for 2019/20.

Rationale for TARGET Risk Score:

As the Turnaround programme is an intervention aimed at supporting delivery of the overall financial plan, and as such has had the in year recovery actions required to achieve breakeven, the target score has been set to align with the risk to delivery of the overall financial plan.

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**
Turnaround Programme Director in post. Fortnightly 'Holding to Account' (HTA) meetings including a monthly Chief Executive HTA session for the highest risk directorates. Each Directorate has signed up to a savings plan and recovery plan - costed and RAG rated. Identified Exec lead for red schemes and for key Turnaround Improvement Programmes. Specific aspect of Performance Review focus on finance and link to HTA session. Escalation process to HTA monthly meeting. Executive Team Turnaround Meetings.	Lack of sufficient capacity to support and facilitate the delivery of Turnaround programme. Ability to control operational priorities that adversely affect delivery of savings plans, eg, winter pressures, vacancy position. Lack of clarity in organisation about true priorities specially achieving balance quality performance, TCS and finance delivery.	Increase capacity of programme management office (PMO) and service improvement capability to support delivery of Turnaround Programme.	Ryan-Davies, Libby	30/06/2019	Capacity to support the Turnaround programme activity has been agreed by the Board in Mar19 however the recruitment process will mean that the additional capacity will be unlikely to be in place before Jun19.
		Work closely with the Director of Operations to ensure robust operational and contingency plans are in place that minimise additional cost, and align with turnaround savings actions.	Carruthers, Andrew	31/03/2020	Joint Chairs of Operational Effectiveness Group and Unscheduled Care Programme Board.
		Chief Executive setting out the organisations goals for 2019/20 to Executive Team.	Moore, Steve	31/05/2019	Executive Team away day set up to clarify goals and the contribution each portfolio needs to make to them.

ASSURANCE MAP	**Control RAG**	**Latest Papers**	**Gaps in ASSURANCES**

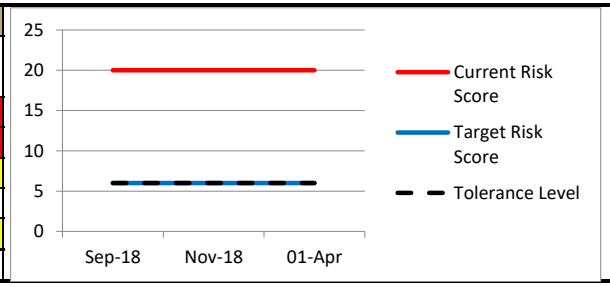
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level	Rating (what the assurance is telling you about your controls	(Committee & date)	Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance against agreed savings plan In-month financial monitoring	Performance against plan monitored through HTA meeting with Services	1st			* Mth 12 Finance Report & Turnaround Report - Board Apr19 * Finance Report & Turnaround Report - Mar19 Finance Committee	None				
	Executive Performance Reviews	2nd								
	Finance Committee oversight of current performance	2nd								
	Turnaround & Financial Report to Board & BPPAC	2nd								
	WG scrutiny through Targeted Intervention (TI)	3rd								
	WG scrutiny through Joint Executive Team (JET)	3rd								
	WAO Structured Assessment 2018	3rd								

Strategic Objective:	5 - Deliver year 1 of the Health and Care Strategy by the end of March 2020

Executive Director Owner:	Miles, Karen	**Date of Review:**	09/05/2018
Lead Committee:	Business Planning and Performance Assurance Committee	**Date of Next Review:**	09/06/2019

Risk ID:	**627**	**Principal Risk Description:**	There is a risk of the digital capability of the organisation not supporting the delivery of the outputs from the Transforming Clinical Services Programme (A Healthier Mid and West Wales: Health and Care Strategy). This is caused by a lack of resources to support the implementation of the UHB digital strategy. This could lead to an impact/affect on delays in implementing the Health Board's long term strategy and improvements to support the delivery of safe and effective patient care.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Business objectives/projects
Inherent Risk Score (L x I):	4×5=20
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:

The current Informatics Teams are not resourced to take forward the current strategic options. Around 95% of staff time is dedicated to "keeping the lights on" which comprises of ensuring that the infrastructure is robust and operational. The teams are not resourced to take forward any innovation or new builds at this time. Anything that is currently progressed, in terms of new builds is undertaken at the expense of guaranteeing robust ICT systems.

Rationale for TARGET Risk Score:

An assessment of the resources required has been supplied to the TCS programme. Further work is underway with the newly appointed management consultants, however the work to implement the recommendations is still not funded.

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**
Board approved the 5 year Digital Strategy - Jan17. Board Approved the updated 2018 Digital Plan, and Operational Delivery Plan. Development of a Digital Futures Programme.	Resourcing of digital strategy. Resourcing of digital programme to deliver the Health and Care Strategy.	Where resources are required then Business Cases will be developed, in line with the digital plan.	Tracey, Anthony	~~31/03/2018~~ 30/09/2019	Progress is being monitored via the Planning Sub-Committee and the CE&IM&T Committee. Formal Business Case is in the process of being developed and will be finalised by Sep19.
		A paper has been prepared to request additional revenue resources from the Executive Team.	Tracey, Anthony	31/12/2019	Progress is being monitored via the Planning Sub-Committee and the CE&IM&T Committee. The Planning Sub Committee has approved the establishment of a digital steering group to take forward the digital agenda. A number of sub-groups will also be established to ensure that a robust resource plan is identified, and to also improve the project management of large projects.

		Work with the 'A Healthier Mid and West Wales' Team to ensure that there is synergy and cross mapping of requirements.	Tracey, Anthony	Completed	An initial meeting has taken place between the Project Team and the ADI and CCIO, to ensure that the Digital Plan is linked to the strategy. Following the meeting a revised Digital Plan will be developed and presented as part of the updated enabling plans.
		Develop a clear vision/scope for the digital workstream following the formal feedback from the consultation.	Tracey, Anthony	~~31/03/2019~~ 31/05/2019	An initial meeting has taken place between the newly appointed management consultants and the Director of Planning, Performance, Informatics and Commissioning along with the ADI to provide an update specification of the work required to enable digital transformation

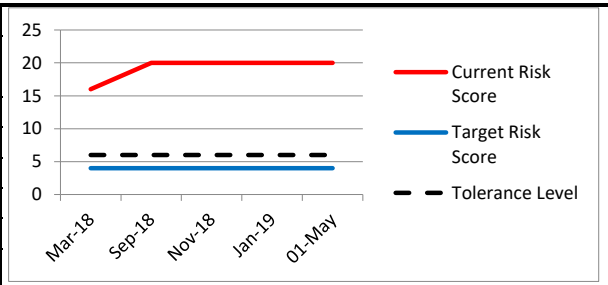
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Signed off project plans by the relevant committees	1st			Digital strategy/plans included in annual plan document- action to Board.	Lack of committee oversight	Information to be supplied to Planning Sub-Committee and CE&IM&T.	Tracey, Anthony	Completed	A newly established Digital Steering Group under the auspices of the Planning Sub Committee to ensure the appropriate governance is in place for the digital plan.
	Delivery of digital plans are overseen by Digital Steering Group (reports to Planning Sub Committee)	2nd								

Strategic Objective:	*1 - Deliver the Annual Plan 2019/20 by the end of March 2020*

Executive Director Owner:	Teape, Joe	**Date of Review:**	02/05/2019
Lead Committee:	Business Planning and Performance Assurance Committee	**Date of Next Review:**	03/06/2019

Risk ID:	**245**	**Principal Risk Description:**	There is a risk of avoidable interruption to business continuity affecting all clinical teams. This is caused by poor and inadequate facilities within the Health Records Service with insufficient storage capacity for patient records and a lack of investment in electronic systems to deliver a sustainable model. This could lead to an impact/affect on patient record service with it unable to store records securely, potential loss, damage or inappropriate disclosure of patient records leading to breach of confidentiality, review and fine by the ICO, significant service disruption with several localities compromised, indirect adverse impact to patient safety arising from inappropriate clinical decisions, leading to poor patient care, complaints and litigation.
Does this risk link to any Directorate (operational) risks?	Yes		

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):	5×4=20
Target Risk Score (L x I):	1×4=4
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
Acute and mental health services are no longer able to transfer records for storage to the UHB's offsite facility. As a result of historical abuse and blood transfusion inquiries, further weeding and destruction programmes have been curtailed exacerbating the current situation. The relocation of deceased and non active records has also ceased from all main hospital localities.

Rationale for TARGET Risk Score:
This risk needs significant resources and planning to identify, fund and implement a long term sustainable solution that will provide more effective patient care, more appropriate working conditions for staff and financial sustainability. Without this, the risk will not be reduced in the near or long term future.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Annual weeding and destruction programme agreed and facilitated accordingly across the Health Board up to 2018/19. Electronic clinic systems including: PACS (radiology), LIMS (Pathology), WAP e-referrals, CANIS (Cancer), Diabetes 3, Selma, Myrddin & Secretarial systems/shared drives (Clinic Letters). Alteration to current racking and purchase of additional racking at GGH. Resourcing of additional racking for the offsite facility. Agreed and approved Health Records strategies, policies and procedures	Lack of sustainable long term solution for records management and storage. Lack of capital funding to support sustainable solution (estimated to be in excess of £8m). Lack of capacity within current storage facilities resulting in more records being stored on wards/service areas.	Implementation of the weeding and destruction plan 2017/2018.	Bennett, Mr Steven	Completed	The weeding plan for 2017/2018 was agreed and the plan was implemented in priority order. The plan has now been completed for all hospital localities removing and relocating all non-current records from 2015. The weeding programme for 2018/19 was unable to be undertaken due to the public inquiry into infected blood products during 1970s and 1980s.

(approved Aug15). Electronic Records Project Group undertaking scoping work for Turnaround Project for long term solution (Sep18).	Inability to store all records safely within current storage facility. Difficulties in accessing records to comply with legal access timeframes and enable the UHB to deliver timely and clinical appropriate treatments, affecting RTT and unscheduled care targets.	Full implementation of Welsh Admin Portal (WAP) electronic referral system.	Tracey, Anthony	~~31/12/2018~~ 31/10/2019	The e-referral has now been fully implemented across 9 specialties within the health board. Testing has commenced in 4 other specialties and mapping has commenced in 4 specialties. Initial completion date of Mar19 will not be achieved due to staff resource initially allocated to the project being removed by NWIS.
		Develop a business case for the implementation of a scanning solution to deal with long term issue.	Rees, Gareth	~~31/03/2019~~ 30/09/2020	The first meeting of the Health Records Project Group took place on the 23rd April 2019. Discussions confirmed there was a requirement for other key individuals to be added to the group membership and essentially there was a need for programme management support. The chair will shortly present a paper to the Executive Team identifying these requirements. The estimated delivery of a Business Case remain at approximately 18 months.
		Re-establish Health Records Group.	Bennett, Mr Steven	Completed	First meeting of the Health Records Group took place on the 19th October 2018.
		Development of an implementation plan to improve management of storage arrangements for current records by information asset owners across the UHB.	Bennett, Mr Steven	Completed	Implementation plan has been endorsed by the Executive Team in Dec18 however funding resources will need to be appropriately supported to deliver the outcomes.

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**		
Service KPIs in place.	Weekly management audit to assess current capacity against demand	1st			* Destruction of records report - Exec Team - Dec17. * Records Management Brief report - Exec Team Nov 2018
	Deputy Health Records Managers Meetings to review storage & weeding	1st			
	Health Records Audits	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**
Lack of recent independent review of Records Management.	Include on Internal Audit Plan.	Wilson, Joanne	Completed	Already included on IA Plan 2018/19 - planned for Q3.

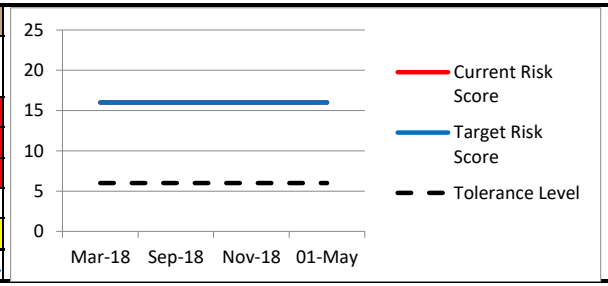
Electronic Records Group	2nd			2018. * Records Management Brief update report - Exec Team Dec 2018. * Records Management Brief report - BPPAC April				
Oversight by IGSC	2nd							
IA Records Management Report - Feb19 (Limited Assurance)	3rd							

Strategic Objective:	1 - Deliver the Annual Plan 2019/20 by the end of March 2020 5 - Deliver year 1 of the Health and Care Strategy by the end of March 2020

Executive Director Owner:	Miles, Karen	**Date of Review:**	03/05/2019
Lead Committee:	Business Planning and Performance Assurance Committee	**Date of Next Review:**	03/06/2019

Risk ID:	**624**	**Principal Risk Description:**	There is a risk of the UHB will not be able to maintain and address either the backlog maintenance or development of its estate, medical equipment and IM&T infrastructure, that it is safe and fit for purpose. This is caused by insufficient capital, both from the All Wales Capital Programme and Discretionary Capital allocation. This could lead to an impact/affect on delivery of strategic objectives, service improvement/development and delivery of day to day patient care.
Does this risk link to any Directorate (operational) risks?	Yes		

Risk Rating:(Likelihood x Impact)	
Domain:	Business objectives/projects
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	4×4=16
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
Although there are a number of controls in place, the risk score cannot be reduced significantly within the current capital allocation.

Rationale for TARGET Risk Score:
The target risk score of 16 reflects the actions and processes planned and controls in place to help mitigate the risk.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
There is an annual programme of replacement in place for equipment, IT and Estates which follows a prioritisation process. The Business Planning & Performance Committee (BPPAC) and Capital Estates & IM&T Sub Committee (CEIM&T) (with IM membership and wide stakeholder engagement in prioritisation process), receive reports and recommendations on the prioritisation and allocation of available capital. When possible, aligning replacement equipment to large All Wales Capital schemes to minimise the impact on discretionary capital within	Capital funding is significantly short of the level required to deal with backlog maintenance programme for estates, IM&T & equipment. An Estates Strategy aligned to the Board approved Health and Care Strategy.	Undertake backlog maintenance through the All Wales Capital programme for new equipment, IM&T and estates infrastructure. The Strategy is to apply discretionary capital in a prioritised way within the UHB however to take advantage of all Wales capital schemes where possible and any additional in-year (2019/20) capital allocations.	Miles, Karen	~~31/03/2019~~ 31/03/2020	At all Wales level, the development of the Specialist and Critical Care Centre at Aneurin Bevan University Health Board has affected the amount of available capital funding across Wales and therefore all Wales capital funding has been significantly constrained in 2018/19 and remains so for 2019/20 and will continue to impact into 2020/21.

the UHB. Completion of the medical devices inventory by the operational management team which helps in the prioritisation of available funds. Retention of a medical equipment capital contingency to manage urgent issues of repair or replacement. Review of regulatory reports which have a capital component ie. HIW, WAO, CHC. Investigating the potential for 'Charitable' funding rather than Discretionary Capital Programme as appropriate. Communication with Welsh Government via Planning Framework and IMTP (Infrastructure & Investment Enabling Plans) and regular dialogue through Capital Review meetings. Preparation of priority lists for equipment, Estates and IM&T in the event of notification of additional capital funds from Welsh Government i.e. in year slippage and to enable where possible, the preparation of forward plans. This is also addressed through the identification of high		Development of a medical devices inventory.	Rees, Gareth	Completed	A Medical Devices Coordinator is now in place and maintains the UHB medical devices inventory. The Inventory Report was submitted to the CEIM&T Sub Committee at its meeting Sep18 and formed part of the capital prioritisation process for DCP which was reported to BPPAC at its meeting in Oct18 and Feb19. This is now being utilised to inform the prioritisation of equipment process.
		The annual planning cycle identifies key capital enabling plans and priorities. The 2019/20 planning cycle will also include the start of the development of an Estates Strategy in support of the clinical strategy which will establish the timing and scope of key estate developments which will help address backlog issues across the UHB.	Miles, Karen	31/03/2020	To be evidenced in work in support of implementation of 'A Healthier Mid & West Wales' and inclusion in the Infrastructure and Investment Enabling Plan to be produced as part of the 2019/20 Planning Cycle.

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 plan & budget.	Reports of delivery against capital plan & budget	1st			* DCP and Capital Governance Report - BPPAC Apr19					
	Capital Audit Tracker in place to track implementation of audit recommendations	1st								
	Monitoring returns to WG include Capital Resource Limit	1st								
	Datix & risk reporting at an operational management level	1st								
	BPPAC & CEIM&T Sub-Committee reporting (supported by sub-groups)	2nd								

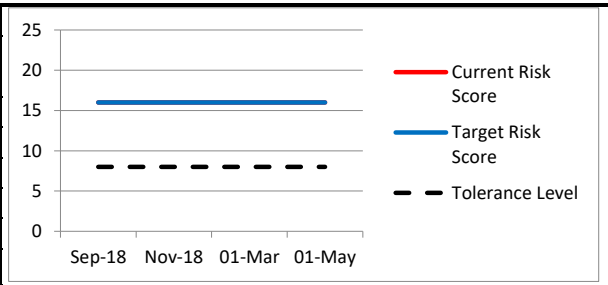
Bi-monthly Capital Review Meetings with WG to discuss/monitor Capital Programme	2nd								
NWSSP Capital & PFI Reports on capital audit	3rd								
WAO Structured Assessment 2017	3rd								

Strategic Objective:	1 - Deliver the Annual Plan 2019/20 by the end of March 2020 5 - Deliver year 1 of the Health and Care Strategy by the end of March 2020

Executive Director Owner:	Shakeshaft, Alison	**Date of Review:**	07/05/2019
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	07/06/2019

Risk ID:	**628**	**Principal Risk Description:**	There is a risk of patients in need of therapy services having poorer patient outcomes. This is caused by gaps in the therapy service provision across acute, community and primary settings from historical under-resourcing, exacerbated by vacancies and recruitment/retention issues due to national shortages. This could lead to an impact/affect on a detrimental impact on patient outcomes, longer recovery times, increased length of stay, a reduction in performance against 14 week waiting time and non-compliance with clinical guidance, with a potential adverse impact on patient safety/harm.
Does this risk link to any Directorate (operational) risks?	yes		

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):	3×4=12
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:

There are significant gaps in the therapy service provision across acute, community and primary care settings from historical under-resourcing, exacerbated by vacancies and recruitment/retention issues due to national shortages. Across all therapy services, current demand does not align to current capacity and whilst this is being managed as far as possible by the controls in place, it is not sustainable and a long term solution needs to be developed and resourced.

Rationale for TARGET Risk Score:

The target risk score has been assessed as 12 as although priority areas have been agreed and progressed, the risk will not be completely addressed in the coming year. A sustainable therapy workforce solution aligned to the Health and Care Strategy has been agreed. The following 3 high impact/workforce priority areas have been identified within the Annual Plan for focus during 2019/20: older people (incorporating frailty, dementia and stroke); improving self-management (including pulmonary rehabilitation and diabetes); therapists as first point of contact in primary care (including musculoskeletal, older people and irritable bowel syndrome). An additional area requiring development is the Major Trauma Network and a sustainable solution is also required to maintain the 14 week waiting time target. These areas of development will require practical, prudent and incremental workforce solutions to improve patient care, outcomes and experience, and sustainable funding models will be required through whole-system review and shifting of resource from elsewhere in the health and care system.

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**
Agency staff utilised where appropriate, funded from within core budget (2 vacancies fund 1 agency staff). Prioritisation of patients is undertaken through triage and risk assessment by therapy services. Introduction of the Malcomess Care Aims Framework for Paediatric Therapy Services. Local solutions include review of each vacant post to make them attractive, including skill mix review, early advertisements for new	Inability to secure funding for all developments identified in 19/20 plan. Shortage of qualified staff nationally limits applications to some posts.	Developing robust plans to evidence improved patient outcomes and experience through reprovision of resource from elsewhere in the health and care system aligned with strategic direction of the HB. This is a significant, long term piece of work, which will need to run alongside strategic development through the Health and Care Strategy. This will include skill mix review such as new HCSW and Advanced Practice roles	Shakeshaft, Alison	31/03/2020	Plans under development. Funding already secured for developments in pulmonary rehabilitation and dementia.

attractive, including skill mix review, early advertisements for new graduates. Priority areas agreed for development, plans being progressed to increase capacity in these areas during 19/20.		Robust workforce planning to inform to inform HEIW in respect to future graduate numbers required by the UHB/Region, which are aligned to the Health and Care Strategy workforce plan.	Shakeshaft, Alison	31/03/2024	Long-term piece of work that needs to be informed by action above.

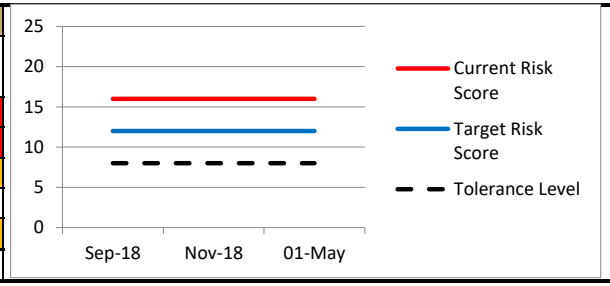
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Maintenance of 14 week waiting times for therapy services. Clearance of backlog for pulmonary rehabilitation, with 100% achievement of 14 week maximum wait by Dec20. Improved compliance with minimum standards for stroke therapy care by Q3 2020/21. Improved staffing ratios for priority areas by Mar20	Management monitoring of breaches of 14 week waiting times	1st				Reporting improved compliance with the Dementia Action Plan, including increased diagnostic rates.				
	Exceptions to achieving 14 week waiting times reported via IPAR to BPPAC	2nd								
	Monitored nationally via SSNAP and monitored via Stroke Steering Group & RCP Annual Report with recommendations produced	2nd								
	External Peer Reviews, Delivery Unit Reviews & national audits, eg Diabetes paediatric audit - action plans developed	3rd								

Strategic Objective:	1 - Deliver the Annual Plan 2019/20 by the end of March 2020 5 - Deliver year 1 of the Health and Care Strategy by the end of March 2020

Executive Director Owner:	Teape, Joe	**Date of Review:**	02/05/2019
Lead Committee:	Business Planning and Performance Assurance Committee	**Date of Next Review:**	02/06/2019

Risk ID:	**629**	**Principal Risk Description:**	There is a risk of the UHB not being able to deliver against annual plan targets to improve to health and well-being of citizens in Wales. This is caused by the inability to manage rising demand and acuity of patients within the unscheduled care pathway. This could lead to an impact/affect on delays in the treatment and care of patients, adverse publicity/reduction in stakeholder confidence and increased scrutiny/escalation from WG.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:

Whilst current performance shows a improving trend since December 2017 across Unscheduled Care for 4 hour waits in A&E and ambulance delays, the number of 12 hour waits in A&E continues to increase. In addition, the recent Delivery Unit report on complex discharge advised that although the UHB is taking the right actions, they are not being consistently implemented across the system due to workforce and capacity pressures.

Rationale for TARGET Risk Score:

It is unlikely that the current workforce and service models will support the UHB to meet current standards and improve unscheduled care performance. The UHB's current financial position makes it unrealistic reduce the target risk score of 12 at this point in time.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. Comprehensive daily management systems in place to manage unscheduled care risks on daily basis including multiple daily multi-site calls in times of escalation. Escalation plans for acute and community hospitals. Unscheduled Care Board includes system-wide representation (Local Authority, Out of Hours, 111). Annualised delivery plans aligned to Transforming Clinical Services. Annual winter plans developed to manage increased activity.	Workforce issues create an ongoing demand/capacity imbalance. Inability to improve current unscheduled care system due to high reliance on temporary staff. Inability to manage within current unscheduled care capacity continues to cause problems for elective programmes of work.	Redesign of services in unscheduled care through Transforming Clinical Services Programme.	Kloer, Dr Philip	31/03/2028	A Healthier Mid and West Wales: Health and Care Strategy was approved by the Board in Nov18. Since approval, significant work has been undertaken to plan for the delivery phase.
		Development and delivery of community wide unscheduled care plans to reduce delays in acute hospitals of medically fit patients.	Bishop, Alison	~~31/01/2019~~ 31/03/2021	Work progressing and is on target. USC System plans have been developed on a county level, next steps are peer review and agreement of outcome measures.
		Development and delivery of 7 cluster plans to support unscheduled care.	Paterson, Jill	~~31/12/2018~~ 31/03/2021	Cluster plans are in place however further work is required to ensure these align to the unscheduled care strategic objectives. These are now being considered for 2019/20 to ensure they are in place by Apr19.

Development and delivery of Unscheduled Care Programme including frailty plan, older people plan, Red2Green, SAFER bundles, PJ paralysis, last 1000 days.	Bishop, Alison	~~31/01/2019~~ 31/03/2021	Work progressing and is on target. USC System plans have been developed on a county level, next steps are peer review and agreement of outcome measures.
Implementation of joint work plan with Welsh Ambulance Service NHS Trust.	Teape, Joe	Completed	Completed - Advanced paramedics were in post at end of Dec18.
Implementation of 111 project throughout Hywel Dda.	Teape, Joe	Completed	Completed - 111 was implemented in Ceredigion and Pembrokeshire on 31st October 2018.
Delivery of pilot Integrated Plan for Older People in Carmarthenshire and Pembrokeshire.	Dawson, Rhian	Completed	The pilot of IPOP has been undertaken in conjunction with WG and DSU colleagues. A series of meetings and actions have been undertaken and productivity and quality changes duly made. Each county has an integrated USC plan with actions across the complete pathway. These will be presented at the Apr19 USC Board (Mar19 meeting was cancelled) and will form the basis of the actions moving forward as part of operational effectiveness.
Develop winter plans for 2018/19.	Teape, Joe	Completed	Winter plans presented to HDUHB Exec team and Board in Nov19. Plan shared with 3 x LA for approval, regional partnership, and WAST. Evaluation of Winter Plan 18/19 will go to Board in May19.
Complete bids for transformational funding through Regional Partnership Board to support implementation of TCS over next 10 years.	Jennings, Sarah	Completed	Submission successful in securing £11.9m with further opportunity for £6.1m in coming months. This will be mapped across to the annual plan ambitions to establish the impact. Groups now working on implementing three approved programmes and extra evidence for further submission of four more programmes.
Implementation Plan to be developed and delivered by UHB following the review on 'Amber' ambulance 999 calls	Bishop, Alison	~~31/03/2019~~ 31/03/2021	The USC system plan will encompass any actions to be delivered in partnership with primary care and WAST colleagues.

		Implementation of integrated plans in each county.	Bishop, Alison	31/03/2020	Local progress on delivery of year 1 actions will be monitored as part of the operational effectiveness group, overseen by USC Board. Each county is presenting their plan to USC Board in Apr19. Responsibility for delivery of longer term actions (over 2-5 years) needs to be clarified (USC Board or transformation groups for hospital and community).

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 for Tier 1 targets.	Daily performance data overseen by service management	1st			IPAR Paper - Board 26/07/18. A&E Waits & Evaluation of winter preparedness - QSEAC - Apr19	Unscheduled Care Board (UCB) does not report progress against delivery plans into HB Committee structure	Bi-annual reports to BPPAC on progress on delivery plans and outcomes (and to Board via update report)	Bishop, Alison	~~31/03/2019~~ 31/05/2019	Papers on the evaluation of winter and the associated quality and safety risks are going to Jun19 meeting.
	Delivery Plans overseen by Unscheduled Care Board	2nd								
	Executive Performance Reviews	2nd								
	IPAR Performance Report to BPPAC & 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								

Strategic Objective:	2 - Deliver the financial control totoal for 2019/20 by the end of March 2020

Executive Director Owner:	Thomas, Huw	**Date of Review:**	10/05/2019
Lead Committee:	Finance Committee	**Date of Next Review:**	10/06/2019

Risk ID:	**735**	**Principal Risk Description:**	There is a risk of the Health Board not achieving its agreed financial plan for the 2019/20 financial year. This is caused by : 1. The savings plans for the year not being delivered; or 2. Operational cost pressures arising from the requirement to meet performance targets of quality measures. This will lead to an impact/affect the Health Board's reputation with Welsh Government and other stakeholders.
Does this risk link to any Directorate (operational) risks?		All directorates	

Risk Rating:(Likelihood x Impact)	***New Risk - no trend information***
Domain:	Finance inc. claims
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:	*New Risk*

Rationale for CURRENT Risk Score:
The Health Board has not yet fully identified the savings requirement for the year in full. There are risks which are foreseeable through the operational unscheduled care pressures in particular, especially as we enter the latter part of the year; alongside other risks such as the closure of the Aseptic Unit and the management of commissioned solutions which could lead to reduced cost pressures.

Rationale for TARGET Risk Score:
The Health Board needs to demonstrate that it is able to manage its financial position effectively, cognisant of the risks which are inherent in the delivery of safe and timely care. Given the challenge in delivering the financial position this year, it is unlikely that the Health Board will achieve a risk which is in line with the tolerable risk for the year. Consequently, the target risk score exceeds the tolerable risk at this point. This is not an acceptable position, and further work is ongoing to manage this risk.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Financial reports provided to directorates in a timely way, focused on trends; cost drivers; projected expenditure; risks and actions. Turnaround Director Holding to Account meetings. CEO Holding to Account meetings. Executive Performance meetings. Commissioning arrangements with key partners (Local Authorities; Care home sector; Other NHS providers; Primary Care; Third Sector).	Finance support is not currently sufficient. Responsiveness and accountabilities need to be reinforced. Process to become embedded and refined. Variable arrangements, to be harmonised to enable effective	Complete outstanding appointments to key finance roles through OCP to support in understanding and developing actions.	Thomas, Huw	30/06/2019	Assistant DoF and Senior Finance Business Partners appointed and in post. Finance Business Partners appointed, majority in post. Band 7 & 6 appointments made. Slotting of Band 5 completed, transitional arrangements in progress over Quarter 1.
		Directorates to sign accountability statements in relation to Budget 2019/20.	Thomas, Huw	31/05/2019	Meetings embedded in monthly business processes. Queries being resolved and will be concluded by end of May 2019.

Process of review of recovery plans process in place for Month 3 and approaching of system-wide issues.	commissioning.	Review of contracting arrangements.	Thomas, Huw	30/06/2019	Paper regarding proposed approach to healthcare contract management discussed at Finance Committee November 2018. Team being established as part of Finance OCP - Bands 8c, 8a, 7 and 6 now in post. Regular Papers providing updates on progress timetabled into Finance Committee Agendas.

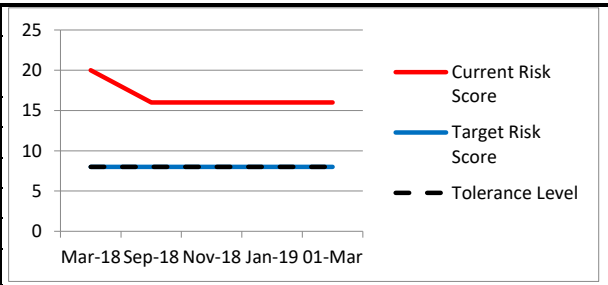
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Identification and delivery of savings schemes. Financial performance and projections reported on a monthly basis. Breakeven recovery plans where deficits are projected. Financial process assurances. Internal Audit and Wales Audit	Finance dashboards	1st			Month 1 Finance Report 2019/20 reports - Finance Committee - May 2019					
	Finance report to Finance Committee and Board	2nd								
	CEO Holding to Account meetings	2nd								
	Financial assurance report to Audit Committee	2nd								
	Year-end reporting to Audit Committee	3rd								

Strategic Objective:	1 - Deliver the Annual Plan 2019/20 by the end of March 2020 5 - Deliver year 1 of the Health and Care Strategy by the end of March 2020

Executive Director Owner:	Gostling, Lisa	**Date of Review:**	03/05/2019
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	03/06/2019

Risk ID:	**625**	**Principal Risk Description:**	There is a risk of the UHB being unable to deliver against (a) some Tier 1 targets set by WG and (b) to fully realise the outputs of the Transforming Clinical Services Programme. This is caused by the UHB's ability to recruit, retain and engage clinical staff (allied health professionals, nursing and medical) to meet increasing demand. This will lead to an impact/affect on patients having delays in treatment and care, increased fragility of services, adverse publicity/reduction in stakeholder confidence, increased scrutiny/escalation by Welsh Government, closer scrutiny by regulators and a reduction in the allocation of future training posts by the Deanery.
Does this risk link to any Directorate (operational) risks?	Yes		

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 score was developed in reference to the guidance for WOD areas. The UHB's current reliance on locum and agency staff use remains higher than it would wish it to be. The fill rates for agency and locum staff however remain good.

Rationale for TARGET Risk Score:
(1) Recognising the national shortages across a number of areas and our geographical area, it will take a number of years to know whether planned actions are successful in addressing the current recruitment issues. (2) There is renewed focus on retaining staff already employed by the UHB by reinforcing the values and behaviours framework and through targeted OD activities to reduce the need to recruit new staff.

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**
Continuous national recruitment programmes are ongoing in addition to bespoke recruitment campaigns. Medical rotas sustained where possible by use of locum/agency staff through agreed frameworks such as Medacs when deemed essential. Service workforce plans in challenged areas developed to look ahead and control risk including nursing plans produced by Heads of Nursing and plans to recruit to core trainee numbers. Weekly workforce control panel under leadership of Director of Workforce & OD responsible for overseeing a series of workforce issues including vacancies. Revised authorisation process for high cost temporary staff. Bank & agency usage for all nursing areas authorisation process linked to nurse rosters	Lack of consistent focused development of leadership capability and talent amongst medical staff. Reduced flexibility contributing to poor retention rates. Lack of clear clinical service configuration to effectively plan future workforce.	Implement a Medical leadership forum for senior medical leaders.	Gostling, Lisa	Completed	First Medical leadership Forum held on 11.11.18 and dates and programme in place for Mar and Jul19. Further Forum planned for Nov19 which will complete the commitment of 3 days PA.
		Develop and implement a leadership programme for aspiring medical leaders.	Gostling, Lisa	Completed	Cohort 1, including 20 Medical Leaders commenced on 11.1.19, programme completion by Dec19. Cohort 2 (another 20 combined leaders) commences in May19 with programme completion by Apr20.
		Implement a System Level Leadership Improvement Programme aimed at triumvirate medical & nurse leaders; General Managers and Heads of Therapies/ologies.	Gostling, Lisa	Completed	Part 1 of programme for cohort 1 completed Nov18, Part 2 coaching and action learning underway and runs until Jul19. Recruitment is now complete for cohort 2 which commences in Jun19 and runs until Mar20.

Leadership development programmes in place across organisation. OD support & development in place		Review UHB activities relating to Medical Workforce development as outlined in Together We Care and develop action plan for short (2019), medium (2022) and long term (2024) requirements.	Gostling, Lisa	31/03/2024	Gap analysis completed and action plan presented to Workforce & OD Sub Committee March 2019. Action plan to be implemented and progress monitored via Sub Committee
		Reinforce UHB Values and Behaviours Framework through PADR process, using role models at all levels and within training programmes, e.g. Manager's Passport.	Gostling, Lisa	Completed	PADR compliance Feb19 is 77% and is currently above the NHS Wales average (68.7%). Values and behaviours are embedded into the PADR process, induction and management development programmes. Bespoke programmes also developed.
		Development of action plan in response to NHS Staff Survey.	Gostling, Lisa	~~31/03/2019~~ 28/06/2019	Survey results received Q2 2018 and are currently being analysed from a range of lenses. Action plans will be developed at corporate, professional group and service level to address issues raised, and further improve on areas of good practice.
		Develop and implement 'grow your own' schemes within different professional groups.	Gostling, Lisa	30/12/2022	Phase 1 in place. Ongoing programme of work. Additional pathway in development but dependent on changes in the way HE&IW commission pre-registration nurse training. Board Seminar Presentation Oct18.
		Development of a robust workforce plan to deliver our defined Health and Care Strategy.	Gostling, Lisa	~~31/03/2019~~ 31/03/2020	Other than undertake baseline assessment of current workforce and skills, this action cannot be progressed until there is further clarity on the Health and Care Strategy. Therefore at this stage the revised date of completion is provisional and dependent on this further work 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
Retention, recruitment, leavers data.	WOD Sub Committee review of workforce information	2nd			*Paper for Mar19 Workforce &	None identified				

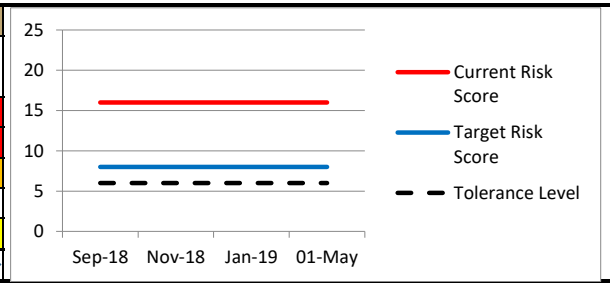
Workforce KPIs.	Review of workforce KPIs, recruitment/retention data and WOD workplan by WOD Sub-Committee	2nd			OD Sub Committee include updates relating to: - Organisational Development - Workforce Annual Plan - HWCs & Audits - Employee Relations Activity & trends - Workforce Intelligence Report - Absence Management - Recruitment Update - Risk Register - Mandatory Training - Medical Education - Staff Experience - Workforce					
	Review of workforce tier 1 performance by BPPAC and Board	2nd								
	Workforce Control Panel reviews series of workforce related issues eg corporate vacancies, bank & agency usage, secondments, etc	2nd								
	IA Mandatory Training Compliance May-16 (Reasonable) .	3rd								
	IA Workforce Planning May-18 (Reasonable) .	3rd								
	WAO Temporary Staffing Jun-17 .	3rd								

Strategic Objective:	1 - Deliver the Annual Plan 2019/20 by the end of March 2020

Executive Director Owner:	Teape, Joe	**Date of Review:**	02/05/2019
Lead Committee:	Business Planning and Performance Assurance Committee	**Date of Next Review:**	02/06/2019

Risk ID:	**632**	**Principal Risk Description:**	There is a risk of the UHB not being able to fully comply the WG Eye Care Measures (ECMs). This is caused by a lack of identified funding and capacity to support progress with the ECM Plan. This could lead to an impact/affect on delivery of the Ophthalmology RTT delivery plan, lead to delays in the treatment and care of patients, adverse publicity/reduction in stakeholder confidence and increased scrutiny/escalation from WG.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	⟺



Rationale for CURRENT Risk Score:
The known number of current delays in ophthalmology follow-ups would indicate that the UHB would not currently meet the new ECM standards.

Rationale for TARGET Risk Score:
The UHB aim to have a service where demand and capacity is aligned to meet the new ECM standards.

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**
Eye Care Action Plan in place. Ophthalmology RTT delivery plan in place. Identification of delivery opportunities to reduce costs of RTT delivery (identified in RTT paper to Board 26/07/18). Commissioning arrangements for outsourcing ophthalmology activity secured via an extension to 2017/18 contractual arrangements. Eye Care Collaborative Group established and meet quarterly to oversee performance against eye care standards. ECM Coordinators recruited. WG Monitoring information from W-PAS 18.1.standards is now functional and information is being submitted	Lack of 3 year balanced plan for ophthalmology. Lack of funding to utilise primary care to meet eye care standards. Delay in go-live of IT systems to support shared care / remote delivery of evaluations away form Acute Sites. Lack of investment / staffing funding to support required service developments across primary and secondary care.	Identify funding sources for ECM Coordinators and ophthalmology staff required to deliver Eye Care Plan.	Hire, Stephanie	Completed	RTT financial plan provides for partial progress with ECMs (recruitment of Ophthalmology co-ordinators) but not redirection of activity to Optometry service.
		Development of a 3 year eye care plan.	Hire, Stephanie	~~31/12/2018~~ 28/02/2019 31/05/2019	The service is undergoing a root and branch review to further develop workforce, financial, performance and quality models which are sustainable and fit for purpose. A workforce plan is being developed in discussion with both finance, planning, clinical and operational groups to include contribution to Mid Wales Plan. Two Locum Consultants have been recruited for Bronglais Hospital and are anticipated to commence by the end of Jul19

Identify funding sources to support primary care.	Hire, Stephanie	31/05/2019	Funding sources are under review to establish new processes with the optometric community. Welsh Government have provided project funding, however, there will be the requirement to identify sustainable funding to continue the use of this scheme beyond Mar20
Development bid of £1.42million made to WG Planned Care Program to support infrastructure, staffing and IT deficits identified by the Eye Care Collaborative Group as key to the implementation of a sustainable model of care.	Hire, Stephanie	Completed	UHB received £196,117 in capital revenue to support infrastructure deficits. The service have completed the capital purchases and taken delivery of those items to support infrastructure deficits.
Ability to use W-PAS 18.1 to identify, monitor and report on outcomes against ECM.	Beynon, Gareth	Completed	Analysis of errors underway to isolate where data errors are occurring. Ongoing with NWIS.
Recruitment of ECM Coordinator	Wragg, Gordon	Completed	Successful candidate commenced in Nov18.
Installation of MediSIGHT software to allow for joint management of VR, Cataract, Medical Retinal and AMD patient pathways.	Tracey, Anthony	Completed	All work within the secondary care setting has been completed. Infrastructure has been built, tested and implemented, and MediSIGHT has been rolled out to the areas indicated. In terms of the community elements, VPN tokens have been allocated to the community areas identified, however a more sustainable solution for community optometrists is part of a wider work programme around the implementation of a Eye System for NHS Wales (the delivery date for this is yet to be determined).

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 in number of follow-ups	Monitoring arrangements by management	1st			* IPAR Mth 11 - Board Mar19 * IPAR Mth 12 - BPPAC - Apr19 * EC	3 year operational plan requires confirmation	Develop new IT reporting measures.	Hire, Stephanie	Completed	Completed - Welsh (PAS) Patient Administration System went live on 13/08/18.
	Executive Performance Reviews	2nd					Identification of source of data errors.	Beynon, Gareth	Completed	Analysis of errors underway to isolate where data errors are occurring. Ongoing with NWIS.

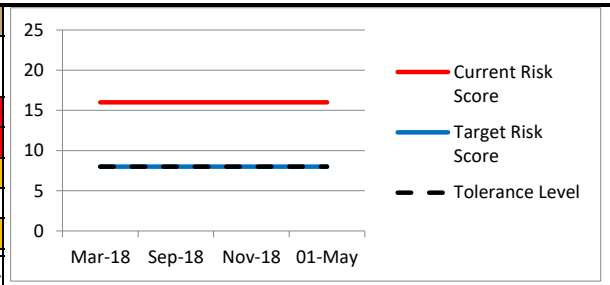
	IPAR Performance Report to BPPAC & Board	2nd			Collaborative Group Meeting - Feb19		Root and branch review of operational, workforce and financial plans and sustainability models.	Buckingham, Carly	31/05/2019	Recent change in management structure has prompted a review of systems and plans to support the delivery of service.
	Monthly oversight by WG	3rd					Review of management meetings and accountability structures within service.	Buckingham, Carly	31/05/2019	Recent change in management structure has prompted a review of systems and plans to support the delivery of service.

Strategic Objective:	*1 -Deliver the Annual Plan 2019/20 by the end of March 2020*

Executive Director Owner:	Teape, Joe	**Date of Review:**	30/04/2019
Lead Committee:	Business Planning and Performance Assurance Committee	**Date of Next Review:**	15/05/2018

Risk ID:	**291**	**Principal Risk Description:**	There is a risk of patients having poorer outcomes and increased mortality due to the lack of access to mechanical clot retrieval services (thrombectomy). This is caused by thrombectomy services being withdrawn by Cardiff and Vale Health Board due to a lack of interventional neuroradiologists. This will lead to an impact/affect on increased mortality rates, increased dependency of patients and an inability to access a National Institute for Health and Care Excellence (NICE) approved intervention within 5 hours of onset of stroke symptoms.
Does this risk link to any Directorate (operational) risks?			

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



Rationale for CURRENT Risk Score:

The Cardiff and Vale service has been restarted, although access for patients of other Health Boards remains on an ad hoc basis, dependent upon capacity. WHSSC are working to bring online a new service in Bristol in support of the Cardiff and Vale service. This is planned to be made available in May 2019 but is pending confirmation from WHSSC.

Despite discussions with the Royal Stoke Hospital, North Bristol Hospital, the Walton Centre and QE Birmingham, Hywel Dda have been unable to make alternative arrangements for directly commissioned thrombectomy services for its patients.

Although a theoretical 10% of ischaemic strokes are suitable for mechanical clot retrieval, the numbers of suitable patients presenting within Hywel Dda are far less than this. It is suggested that around 30 patients per year would be suitable, but would require very rapid transport and diagnostics to be considered as realistic candidates for thrombectomy at either Cardiff or Bristol.

Rationale for TARGET Risk Score:

The uncertainty surrounding the changes proposed in the Transforming Clinical Services programme have a significant impact upon the development of acute and hyper acute services within the UHB. Thrombectomy services continue to be sought and escalated with English Neuroscience units until the Cardiff and Vale service is reinstated and the instigation of a WHSSC commissioned service with North Bristol NHS Trust.

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**

Re-commencement of thrombectomy services in Cardiff and Vale Health Board, dependent upon capacity WHSSC currently putting in place a service in North Bristol which is planned to be in place by May 2019 and will support the Cardiff and Vale service	Timely investigations that are required to support transfers for thrombectomy not supported 24/7 on all sites. Work is ongoing to ensure that CT Angiography is available in all Hywel Dda units to provide the necessary diagnostic investigations prior to transfer to a specialist neuroscience centre.	Develop and review the Thrombectomy pathway, throughout the Health Board.	Mansfield, Simon	Completed	Review of thrombectomy pathway undertaken, no facility to procure ad hoc services from North Bristol or Stoke. National Stroke Implementation Group have worked with WHSSC to commission an all Wales Thrombectomy service with North Bristol NHS Trust for Welsh patients.
		Development of pathway and protocols for the referral of stroke patients within each of the Hywel Dda Acute Hospitals to suitable neuroscience in England.	Mansfield, Simon	Completed	Briefing paper and protocols developed for the direct commissioning of ad hoc thrombectomy services from English Neuroscience units.
		Negotiate short-term commissioning arrangements with neuroscience units.	Teape, Joe	Completed	Completed - however unable to secure new commissioning arrangements whilst WHSSC work to commission all Wales service
		Work with WHSSC to ensure all Wales thrombectomy service is commissioned	Teape, Joe	~~31/12/2018~~ 31/05/2019	WHSCC are in the process of negotiating provision of all Wales service with North Bristol NHS Trust

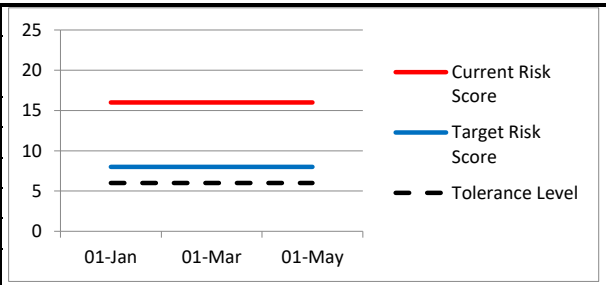
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Datix incident reports.	Daily/weekly/monthly/ monitoring arrangements by management	1st			Thrombectomy Report - ET - Sep17.					
	Executive Performance Reviews	2nd								
	IPAR Performance Report to BPPAC & Board	2nd								
	Stroke Delivery Group review of patient cases .	2nd								

Strategic Objective:	1 - Deliver the Annual Plan 2019/20 by the end of March 2020 5 - Deliver year 1 of the Health and Care Strategy by the end of March 2020

Executive Director Owner:	Teape, Joe	**Date of Review:**	07/05/2019
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	07/06/2019

Risk ID:	**686**	**Principal Risk Description:**	There is a risk of that the UHB will be unable to fully deliver Transforming Mental Health (TMH) Programme by 2023. This is caused by a number of key challenges, specifically the securing of £17m capital to implement TMH, potentially increased revenue costs from newer buildings, limited capital resources to fund implementation of both TMH and HCS, potential delays from co-production with service users, staff and key stakeholders, understanding of IT requirements, and adequate programme support. This could lead to an impact/affect on the UHB's ability to meet the rising demand on mental health services, meeting service users' expectations, recruitment and retention of professional staff, and result in adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	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:

Delivery of TMH is critical to the UHB's ability to manage the increasing demand on mental health services and improving recruitment and retention in key professional groups. Whilst there are work streams in place to identify keys risks and issues, the delivery of TMH is reliant on a significant amount of capital. Capital resources are limited and there is a risk that some elements of TMH may need to align with the UHB's Transforming Clinical Services programme which could result in a delay in the overall delivery of TMH. Capital is also dependent on the UHB demonstrating that it will be able to manage the increasing revenue costs associated with the increasing demand on services since the development of the TMH.

Rationale for TARGET Risk Score:

The Mental Health and Learning Disabilities Directorate has completed a consultation in respect of a revised service model which should reduce the reliance on our inpatient services. Delivery of the TMH programme within the timescales agreed by Board is dependent on securing the required capital and programme support therefore the target score reflects the uncertainty associated with both these requirements.

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**
Open commitment and mandate from the Board on the implementation of the TMH Programme. Board approved implementation plan (Jan18). Mental Health Implementation Group established to oversee delivery of the TMH Implementation Programme. Established work streams in place for Pathway and Access Design, Workforce and Cultural Change, Transport, and Estates and infrastructure, IT, Partnerships & Commissioning and Data & Evaluation.	Lack of dedicated Programme Director and adequate programme support. Lack of agreed capital investment which is dependent on a balanced revenue position which will be able to address estates, IT and infrastructure requirements.	Establishment of additional workstreams for Partnerships and Commissioning, IT and Data Evaluation.	Jones, Richard	Completed	Additional work streams now in place.
		Further development of the Communications and Engagement Plan to support delivery phase of TMH.	Jones, Richard	Completed	Progressing and will remain a working document throughout implementation.
		Develop a programme business case to secure required capital allocation (currently estimated at £15m) to deliver TMH.	Jones, Richard	~~30/04/2019~~ 30/06/2019	Business case writers appointed. Business case in progress and expected to be finalised by end of Jun19.

	Competing demand for capital with Transforming Clinical Services Programme.	Secure additional programme management support to the programme.	Jones, Richard	~~31/01/2019~~ 30/04/2019 30/07/2019	New programme resources have been allocated. Posts out to advert for new PMs and administration support. Further detail around clinical support and service user/carer input being finalised.
		TMH programme fully aligned with TCS to ensure that risk of delays to TMH developments are minimised and opportunities for support are maximised.	Jones, Richard	Completed	TMH now formally sits and reports as one of three arms of the delivery of the new healthcare strategy.

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**
N/A	Work streams report progress, key risks and issues to MHIG	1st			* TMH Progress Report - Board - Sep18&Nov18 * HOS reports - MHQSESC - Sep18 * MHLAC Update - Board - Jul18 * TMH update - Planning Subcommittee - Nov18	No gaps identified.				
	TMH Plan is monitored by TMH Implementation Group and Planning Sub-Committee, and to Board every 6 months	2nd								

Strategic Objective:	1 - Deliver the Annual Plan 2019/20 by the end of March 2020

Executive Director Owner:	Teape, Joe	**Date of Review:**	03/05/2019
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	03/06/2019

Risk ID:	**684**	**Principal Risk Description:**	There is a risk of radiology service provision from breakdown of key radiology imaging equipment (specifically MRI in WGH and BGH, fluoroscopy room in GGH, insufficient CT capacity UHB-wide and the general rooms in PPH) and generally a poor image quality offering to all patients. This is caused by equipment not being replaced in line with RCR (Royal College of Radiographers) 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 and increased staffing costs to minimise the impact on patients when breakdowns occur.
Does this risk link to any Directorate (operational) risks?	644		

Risk Rating:(Likelihood x Impact)	***No trend information available***
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):	2×3=6
Tolerable Risk:	6
Trend:	*New risk*

Rationale for CURRENT Risk Score:
The UHB's stock of imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites which has a significant impact on the UHB's ability to meet its RTT target and impact to patients can include delays in diagnosis and treatment. Presently equipment downtime can be up to a week which can put significant pressures on all diagnostic services.

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. Regular quality assurance checks (eg daily checks). Use of other equipment/transfer of patients across UHB during times of breakdown. Ability to change working arrangements following breakdowns to minimise impact to patients. Site business continuity plans in place. Disaster recovery plan in place.	Limitation of spare parts for some older equipment leading to extended outages. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Lack of coordination between services and radiology department during service disruption.	Review and strengthen site business continuity plans with individual site leads to ensure robust response to breakdown.	Evans, Amanda	30/06/2019	RSM has met with planning colleagues in Feb19. Site leads in process of developing up-to-date and robust business continuity plans which will operationalise procedures following breakdowns.
		Present report to executive team outlining the current situation and request support for more robust replacement programme.	Evans, Amanda	Completed	Paper presented to the Executive Team. Some further work required.
		Work with planning colleagues about sourcing capital funding through DCP and AWCP.	Evans, Amanda	30/06/2019	Initial discussions have taken place at CEIMT Sub-Committee (Mar19).

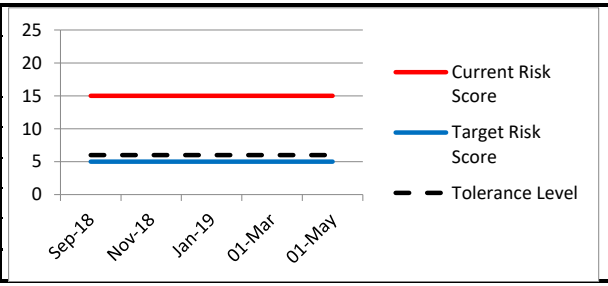
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Reduction of waiting times to under 6 weeks by Mar22. Reduction in overtime costs to nil by Mar22.	Monthly reports on equipment downtime and overtime costs	1st			Radiology Equipment SBAR - Executive Team - Mar19	Lack of process of formal post breakdown review.	Formalise post breakdown review process to ensure lessons are learnt and improvements implemented following the most impactful breakdowns.	Evans, Amanda	30/06/2019	RSM has discussed with site leads and further work is underway.
	IPAR report overseen by BPPAC and Board bi-monthly	2nd								
	Internal Review of Radiology Service Report (Reasonable Rating	3rd								
	External Review of Radiology - Jul18	3rd								
	WAO Review of Radiology - Apr17	3rd								

Strategic Objective:	1 - Deliver the Annual Plan 2019/20 by the end of March 2020

Executive Director Owner:	Teape, Joe	**Date of Review:**	08/05/2019
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	08/06/2019

Risk ID:	**634**	**Principal Risk Description:**	There is a risk of avoidable harm of maternity patients who require an emergency c-section (category 1) at Bronglais General Hospital (BGH) outside of normal working hours. This is caused by not being able to meet the required standard of 'call to knife' within 30 minutes as there is no overnight theatre provision located on site. This could lead to an impact/affect on complications for mother and baby resulting in long term, irreversible health effects.
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):	3×5=15
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:

There is currently a resident Operating Department Practitioner 24/7 at Bronglais Hospital along side a resident anaesthetic and obstetric team. The theatre scrub currently work on an on-call basis from home, which must be within 20 minutes travelling distance from the site. There is the potential for outside factors to impede timely arrival on site which are outside the control of the team which is reflected in the likelihood score of 3. While there have been no breaches of the 30 minute target it remains a potential risk which could have significant consequences. The Bronglais unit is classified as a low risk midwifery centre, with mothers assessed as being at high risk of complications during labour requiring medical intervention, being managed though the Maternity Unit in Carmarthen.

Rationale for TARGET Risk Score:

The UHB is aspiring to reduce this risk to the minimum by establishing a resident primary theatre team 24/7 in Bronglais Hospital to mitigate against the potential for outside factors to impact upon the delivery of care.

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**
Resident Operating Department Practitioners (OPD) Team 24/7 anaesthetic cover on site (obstetrician and consultant anaesthetist). All families are informed by the Maternity Service at Bronglais Hospital of the services available at the hospital and that they will be a Continual	Not having 24/7 resident theatre team.	Establish funding for 24/7 resident theatre team.	Teape, Joe	Completed	Funding approved by Executive Team. Implementation Plan in place to be delivered by Apr19.
		Advertise and appoint to expanded theatre Team following agreement on funding.	Hire, Stephanie	~~31/03/2019~~ 30/06/2019	Ongoing recruitment - Band 5 positions outstanding and are currently being advertised.

Risk Assessment throughout pregnancy for the suitability of the Mother to deliver at BGH. Maternity staff are trained to deal with emergencies, with protocols in place for transfer out to appropriate centre is issues are identified. Principle of removal of on-call compensatory rest approved by Executive Team.		Agreement with theatre teams (employee relations) for removal of compensatory rest. Formal 90 day OCP for Scrub and Band 3 circulatory staff to commence 16/01/19.	Barker, Karen	~~30/11/2018~~ ~~30/04/2019~~ 14/06/2019	OCP completed. Delayed start of implementation due to staffing concerns and numbers. Delayed start of implementation due to staffing concerns and numbers. Plan to commence ATOs (now fully recruited) on 24/7 roster and start either full 24/7 roster for Scrub from Mon 27 May - or hybrid of part night/part weekend (until full recruitment). Either will reduce ~~compensatory rest days for scrub~~
		E-roster build to support the new resident on call theatre team rota	Barker, Karen	~~31/03/2019~~ ~~31/05/2019~~ 30/06/2019	On progress for delivery by end of Jun19.
		Develop a formal implementation plan for the new staffing arrangements.	Barker, Karen	~~31/12/2018~~ ~~30/04/2019~~ 14/06/2019	Delayed start of implementation due to staffing concerns and numbers. Plan to commence ATOs (now fully recruited) on 24/7 roster and start either full 24/7 roster for Scrub from Mon 27 May - or hybrid of part night/part weekend (until full recruitment)

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**		
No of incidents reported where 30 minute response target is missed.	Maternity Services governance systems review of incident reports	1st			* Executive Team - Jul18 * Executive Team - Dec18
	Management audit of cases presented to QSEAC	2nd			
	Discussions with WG Chief Nursing Officer & UHB Medical & Nursing Director	3rd			

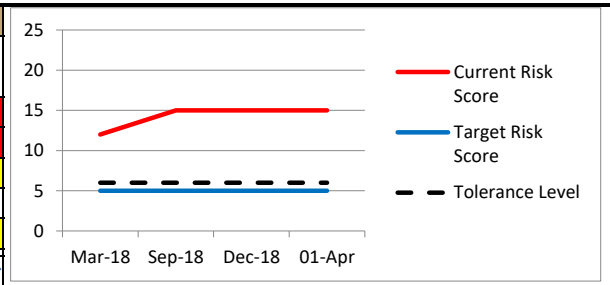
Gaps in ASSURANCES				
Identified Gaps in Assurance:	**How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
None identified.				

Strategic Objective:	1 - Deliver the Annual Plan 2019/20 by the end of March 2020

Executive Director Owner:	Teape, Joe	**Date of Review:**	12/04/2019
Lead Committee:	Business Planning and Performance Assurance Committee	**Date of Next Review:**	12/05/2019

Risk ID:	**508**	**Principal Risk Description:**	There is a risk of harm to patients, staff and general public for failing to fully comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005. This is caused by a lack of available resources in fire safety management to undertake appropriate planned preventative maintenance, risk assessments and audits. This could lead to an impact/affect on safety of patients, staff and general public, HSE investigations and enforcement, fines and/or custodial sentences, adverse publicity/reduction in stakeholder confidence.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	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):	1×5=5
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
Significant progress has been made since the NWSSP IA Fire Precautions Report in May 2017 to improve fire safety. Additional resources have been now been approved and posts commenced in Apr19. These posts will help to increase the pace of delivery of required improvements which will lead to an improvement in compliance and the level of fire safety in the UHB.

Rationale for TARGET Risk Score:
The target score reflects the importance of fire safety and the UHB aims to have a robust system that is fit for purpose.

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**
Fire Safety Policy approved Mar18 - implemented through fire training. Fire Management Structure in place (Head of Fire Safety plus 3.8wte fire advisors). 400+ valid fire risk assessments undertaken across UHB. Staff training programme in place with level 1 compliance at 67.41% and level 2 at 44.27% as at Jan19. Also the introduction of Managers training to ensure that managers are made fully aware of their responsibilities (These are being delivered throughout 2019). A further change is also being made to fire safety training where the merger of L1 and L2 training content will take place.	Shortfall in resources to have an effective fire safety management team which will resulting in slow progress of further improvements and inability to maintain current level of compliance. 62 fire risk assessments are currently out of date as at Apr19. Ability to record accurate fire safety training attendance of staff within the HB and address current shortfall in	An SBAR is required to identify the issues surrounding the resource pressures faced by the Facilities Directorate regarding fire safety. This SBAR needs to set out clearly the expected number of resources for an organisation of such size and geography.	Teape, Joe	Completed	Additional resources have now been approved by executive team and can now be appointed to. Head of fire safety management has now been appointed. Fire Safety Advisor at Prince Philip Hospital now appointed with interviews for Fire Safety Advisor at Withybush scheduled for 04/03/19.
		An SBAR on gaps in maintenance programme to be presented to the Executive Team.	Lewis, Mark	Completed	Paper submitted to Formal Executive Team in Oct18 and has been put forward for the IMTP 2019/20.

Estate and statutory maintenance programme in place with focus on high risk in-patient facilities. 7 x local fire safety groups which report to the HB wide Fire Safety Group, which feeds into the Health and Safety & Emergency Planning Sub Committee (HSEPSC). Prioritised plan for fire safety investment in place which tackles highest risks coming out of the risk assessments as first calling.	compliance Lack of fire wardens to improve local fire safety awareness across UHB. Lack of evidence of fire safety arrangements in leasehold properties used by the UHB staff. Lower risk capital investment issues in respect of fire will remain for some time due to limited capital availability and the focus on high risk only. Analysis of KPIs to fully ascertain PPM compliance.	Complete all outstanding high risk fire risk assessments (FRA) by April 2019 and complete all further medium and low risk fire risk assessments by August 2019.	Evans, Paul	~~30/04/2019~~ 30/08/2019	Significant progress has already been shown with a reduction of the out of date fire risk assessments from 110 in Feb19 to 62 by Apr19 representing a 44% decrease. Although there remain threats to achieving the targets set out in the revised time line agreed at the Feb19 HBW Fire Meeting, the current status is an improving situation. This takes into consideration the fire safety resource levels from Apr19 where the additional resources will be fully embedded.
		The Fire Team and Workforce Team will undertake a joint review of the current systems used to record fire training to understand the underlying issues with accurate recording of training.	Evans, Paul	Completed	The workforce team and fire safety team have now undertaken a deep dive exercise to understand how fire training is being recorded in ESR. There has historically been discrepancies between the figures retained by the fire safety team and ESR. This has now been resolved.
		Introduction of fire wardens (FSW) on every department/service across the UHB to increase fire safety awareness.	Evans, Paul	30/11/2019	A number of global emails requesting expressions of interest have been issued. As at Jan19 it is confirmed that circa 72 FSW's are in place across the HB in a variety of clinical and non-clinical departments and FSW's checks are being carried out. Despite this, further work still needs to be undertaken to understand the number of fire wardens required and focused effort to ensure appropriate coverage across UHB.
		Obtain fire risk assessments for all leasehold properties utilised by UHB.	Evans, Paul	~~31/03/2019~~ 31/05/2019	Formal letter has been issued in Nov18 by the Fire Brigade on the UHB's behalf to request copies of fire risk assessments.

Establish the risk to staff, patients and public in properties not owned by HB where a HB fire risk assessment has not been undertaken.	Evans, Paul	~~31/12/2018~~ 30/04/19	The fire safety team has now formally met with the fire brigade to discuss this issue and it has been agreed that the fire brigade will now provide the HB with a formal letter requesting information from property owners where the HB has been unable to obtain such detail. This letter will be issued by the fire safety team of the HB clearly stipulating a response time. If this action proves unsuccessful then the fire brigade may decide to put these properties onto their inspection programme. This action is being monitored by the Fire Safety Group - next meeting scheduled for Apr19.
Monitor the published KPI figures produced by the operational maintenance function in monthly performance meetings to assess ongoing achievements and report any discrepancies.	Evans, Paul	Completed	KPI figures for facilities information is regularly being monitored and presented at monthly performance meetings chaired by the Dir of Facilities at each of the acute sites. This information highlights any shortcomings in respect of achievement targets. Business critical and high risk PPM's remain the key focus of attention.
Improve mandatory fire safety training compliance to 75% by Nov19.	Evans, Paul	30/11/2019	Revised TNA for fire safety training to clarify training requirements for staff completed. Training awaiting uploading to the L&D staff intranet page. Fire Safety Advisors are now based on each acute hospital site who will deliver face to face training. Compliance figures reviewed bi-monthly with workforce and overseen by HS&EP Sub-committee. Directorate/Service training compliance is monitored at Executive Performance Reviews.

ASSURANCE MAP | **Control RAG** | **Latest Papers** | **Gaps in ASSURANCES**

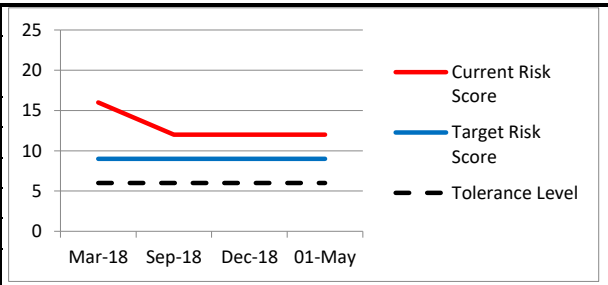
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level	Rating (what the assurance is telling you about your controls	(Committee & date)	Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
* Improve mandatory fire safety training compliance for level 1 & 2 ideally above the 75% target by Nov19. * Increasing no of valid in date risk assessments to >95% by April 2019. * Reduce the no of unwanted fire signals (UwFS) to Fire Brigade by 40% by end of 2018 (from 119 UwFS for 2017 period). * Planned and Preventative Maintenance programme in place for high risk business critical areas with a target of >95% completion(defined by the operational maintenance	Review of compliance through fire safety groups	2nd			IA Fire Precautions Report - ARAC 19/06/18. Quarterly reports to H&S EM SC.	None identified.				
	Compliance reports regularly issued to HSEPSC	2nd								
	Fire inspections by Fire Service	3rd								
	NWSSP fire advisor inspections	3rd								
	NWSSP IA Fire Precautions Follow Up May-18 - Reasonable Assurance	3rd								

Strategic Objective:	1 - Deliver the Annual Plan 2019/20 by the end of March 2020

Executive Director Owner:	Jervis, Ros	**Date of Review:**	13/05/2019
Lead Committee:	Business Planning and Performance Assurance Committee	**Date of Next Review:**	13/07/2019

Risk ID:	**295**	**Principal Risk Description:**	There is a risk of the Health Board being unable to maintain routine & emergency service provision across the organisation in the event of a severe pandemic influenza event. This is caused by a novel influenza virus 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 influenza 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):	4×4=16
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	3×3=9
Tolerable Risk:	6
Trend:	⟺



Rationale for CURRENT Risk Score:
Pandemic Flu is the highest risk on the UK National Risk Register. Current likelihood scored at a 3 to reflect the risk of the Health Board being able to respond to the scale and severity of the pandemic - not the likelihood of the pandemic actually occurring.

Rationale for TARGET Risk Score:
Following outcome of Cabinet Office review and subsequent updating of Hywel Dda plans, in line with new and revised Welsh Government Guidance and planning assumptions, it is hoped to reduce either the likelihood and/or impact score.

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

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

Local Resilience Forum (LRF) multi-agency plans for managing pandemic influenza (updated in accordance with current data and approved by Strategic LRF 14/11/18). LRF Excess Deaths Plan (which supports the LRF multi-agency pandemic influenza management arrangements) developed as a recommendation from Exercise Cygnus. Plan was ratified by the LRF Strategic Group on 11/07/2018. Health Board Pandemic Influenza Response Framework and associated plans (currently outdated awaiting review). Quality assurance process via national & local exercise programmes. Access to national counter measures stockpile. Welsh Government Pandemic Influenza Guidance and National Pandemic Flu Service. Hywel Dda participation in Welsh Government Pandemic Influenza Group.	Current Health Board pandemic framework will need to updated to incorporate new Cabinet Office review implications/recommendations however Pan Flu agenda and Cabinet Office review still delayed due to refocus of key staff to Brexit agenda at Cabinet Office and Welsh Governments levels.	Reinstate local Pan Flu Group to enact Cabinet Office Review implications (originally due Sept 2018) and develop ongoing work programme.	Hussell, Sam	~~12/01/2018~~ 31/03/2019 31/12/2019	First meeting held on 09 Oct 2018. Workshop to be scheduled once Cabinet Office (CO) review is published (CO review currently delayed due to Brexit focus).

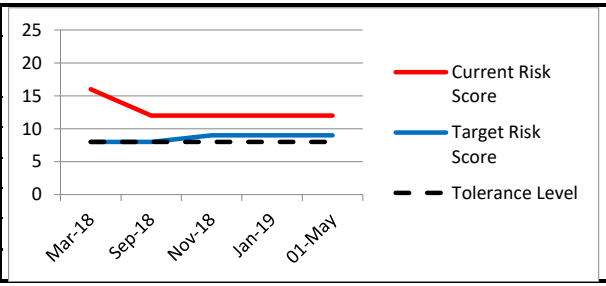
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Reports to Health & Safety and Emergency Planning Sub-Committee	2nd			No recent reports.					
	Emergency Planning Action Group (EPAG) Wales meetings re Pandemic Flu	2nd								
	NHS Wales wide workshops	3rd								
	LRF Cygnus Test of plans	3rd								
	Reviewed LRF Pandemic Flu Plan	3rd								

Strategic Objective:	*1 -Deliver the Annual Plan 2019/20 by the end of March 2020*

Executive Director Owner:	Teape, Joe	**Date of Review:**	01/05/2019
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	01/07/2019

Risk ID:	**384**	**Principal Risk Description:**	There is a risk of avoidable non-compliance with statutory and implied statutory standards where medical devices are concerned. This is caused by inadequate management of systems and the supporting governance in medical device management plus equipment not being maintained in accordance with manufacturers' instructions. This could lead to an impact/affect on overall treatment or suboptimal services with a potential impact of reputational harm and regulatory enforcement.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Statutory duty/inspections
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	3×3=9
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:

The Medical Device Policy is approved however needs operationalising. There have been issues regarding medical devices governance resulting in clinical incidents. OCP (Organisational change Policy) to be concluded within Clinical Engineering in order to take remaining actions forward.

Rationale for TARGET Risk Score:

The UHB needs to safeguard staff and patients against medical devices issues and improve its systems and governance. Given the number devices within the UHB, there is a probability that an adverse event will happen from time to time however the planned actions and focus on high risk devices should mean that enforcing authorities will see the merits of the systems that have been developed to protect patients and staff safety.

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**
Medical and Non-Medical Devices Control Group reviewing performance. HSE Action Plan is nearing completion. Management information including regular reports provided for scrutiny. Identification of devices and categorisation and inventory refresh complete and new database procured and commissioned. System review processes operating to ensure missed inspections are not allowed to go unchecked. 5 tier risk stratification system developed for Health Board device holding which facilitates high risk devices targeted for first attention. Increased capital allocation has been realised	Non-implementation of Medical Device Policy. Lack of capital resources to address backlog of Equipment. Medical Devices Safety Officer issue to be resolved. Resolution to current alert system remains outstanding. Community and managed practices devices remain elusive to achieving a complete inventory. However these items have been established as presenting low risk to those in	Implement Medical Devices Action Plan (inc development of inventory, categorisation of incidents) - delivery is monitored by Medical Devices Control Group.	Rees, Gareth	~~30/04/2019~~ 07/01/2019	Good progress can be evidenced with only two key actions remaining to be implemented by Jul19 - 1. Resolution to current alert system remains outstanding. 2. OCP to be concluded within Clinical Engineering in order to take remaining actions forward.
		Operations Priorisation System and Programme in place which feeds into annual capital planning process.	Rees, Gareth	Completed	Completed.
		Review Medical Devices Assurance Group which reports to Operational QSE Sub-Committee to improve reporting of assurance.	Rayani, Mandy	Completed	This has been resolved and the Medical Devices group now formally reports to Operational QSE Sub-Committee with escalation to QSEAC.

Increased capital allocation has been realised. Strategic replacement plan for the Health Board's medical device holding now in place and servicing capital decision making. Improved ultrasound governance in place. Training Needs Analysis has been undertaken in conjunction with L&D Team. Servicing and inspection capacity restored to 2015 levels in clinical engineering. Broader control over all aspects of all aspects of medical device management to include pathology, radiology and estates now in place.	presenting low risk to those in existence on the acute inventories. Further work required on Ultrasound Governance training and competence user requirements. Further work required on Pathology inventory.	Establish Information Governance requirements for medical devices.	Rees, Gareth	Completed	List of all equipment that holds PII or connects to the internet has now been forwarded to the IG team.
		Agree current Medical Device alert system to be implemented.	Rayani, Mandy	~~30/04/2019~~ 07/01/2019	Resolution to current Medical Device alert system remains outstanding. Meeting has taken place with the Patient Safety team and agreement has been reached on opting for the ECRI system. Unable to secure £9K PA recurrent funding. Further discussion required on funding arrangements.

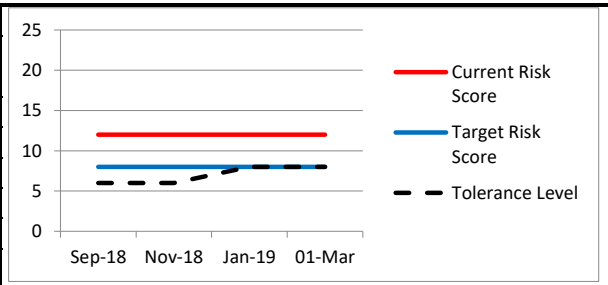
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**			**Identified Gaps in Assurance:**	**How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
Maintain accuracy level at >95% items on Medical Devices inventory. Performance data from Planned Preventative Maintenance set out in IPAR. Performance data reported to control Medical Device Group. Incident reports relating to medical devices.	Internal Management Review 2018	1st			* Update on Medical Devices Management - QSEAC - Aug18 * Medical Devices Assurance Group Update - Operational QSE Sub Committee- Nov18 *IPAR Month12 - BPPAC - Apr19	Limited assurance has been secured via previous assurance committee.	Review Medical Devices Assurance Group which reports to Operational QSE Sub-Committee to improve reporting of assurance.	Rayani, Mandy	Completed	This has been resolved and the Medical Devices Group now formally reports to Operational QSE Sub-Committee with escalation to QSEAC.
	Medical and Non-Medical Devices Control Group reviewing performance data	2nd								
	Oversight of incidents by Health & Safety & Emergency Planning Sub-Committee	2nd								
	PPM Performance reviewed by Medical Devices Assurance Group (which reports to Operational QSE Sub-Committee	2nd								
	PPM Performance on medical devices reported in IPAR to BPPAC and Board	2nd								
	HSE Improvement notices	3rd								

Strategic Objective:	1 - Deliver the Annual Plan 2019/20 by the end of March 2020

Executive Director Owner:	Teape, Joe	**Date of Review:**	20/03/2019
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	20/05/2019

Risk ID:	**44**	**Principal Risk Description:**	There is a risk of harm to patients on follow up waiting lists who have exceeded their follow up date. This is caused by the high number of patients on the follow up lists, the lack of capacity to review these patients in clinics, the lack of a sustainable plan to decrease the number of patients on follow up lists, the availability of clinical, OPD staffing and clinic space, the requirement to review clinical pathway management on W-PAS, and the necessity to rebalance patient pathways across primary and secondary care. This could lead to an impact/affect on the ability to meet follow up waiting times across all scheduled care specialties, poorer outcomes for patients, increased complaints, litigation and reputational harm.
Does this risk link to any Directorate (operational) risks?	180		

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	⟺



Rationale for CURRENT Risk Score:
It is acknowledged that too many patients experience lengthy delays in receiving their follow-up care and that significant improvement work is required to improve patient experience and reduce the potential for clinical harm to patients who experience delays. An improvement plan has been implemented under the Outpatient Improvement Group and Patient Pathway Management Group. The year-on-year growth in the number of patients experiencing a delay in follow-up review has been halted in 2018/19, with a reduction in the total number to patients awaiting a follow-up appointment beyond their target date has reduced by 800 between Nov18-Jan 19.

Rationale for TARGET Risk Score:
The clinical risk for long-term condition patients remains high for all patients if they are not reviewed / seen in line with clinical follow-up intervals.

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**
The programme of work underway within the Health Board is focussing on a number of key stages, urology and cancer. Admin validation, cleaning up the waiting lists and removing obvious duplicate entries or patients that have been seen and the pathway not closed.	Variations in practice in application of access policy. Duplicate patient pathways creating inaccurate waiting list.	Review of Myrddin to ensure that the system is able to identify sub-specialties and clinical conditions within the waiting list.	Hire, Stephanie	Completed	Subspecialty and clinical conditions set up in some specialties, work on-going.
		Redesign of services through IMTP planning to reduce capacity gap	Hire, Stephanie	31/03/2020	Service transformation plans being prioritised via Planned Care IMTP.

Engaging Clinical Leads for each specialty in the prioritisation of their patients and the identification of those most at risk of harm. Specialty Service Delivery Manager (SDM) and clinical lead have identified patients on their follow up list who might be at risk. Lessons learned from SUI / adverse events / complaints relating to delayed care shared through Directorate QSE meetings.	Workforce issues create an on-going demand/capacity imbalance. High new/follow up ratio.	Efficiency & productivity work streams for all teams to reduce ratios to levels comparable to other Health Boards.	Hire, Stephanie	31/03/2020	Target performance set for all specialties and monitored through Transformation Workstream governance. A significant increase in the total number of patients delayed year to date has been avoided with an overall increase since Apr18 of 1.6%. The number of patients delayed in the 0%-25%, 26%-50% and 51%-100% delayed categories show an overall reduction year-to-date which indicates that improvement work to change follow-up practice in various specialties is having a positive effect.
		Pathway management training to ensure that all staff groups are trained in the application of the RTT / Access Policy and WPAS usage.	Jones, Keith	31/03/2020	Project plan developed to role out the bespoke training has been developed for different staff groups.
		Clinical Validation: Clinical time to be established in Job Planning to support protected validation time.	Hire, Stephanie	31/03/2020	Part of the Medical Job Planning exercise undertaken by Service Development Managers within Planned Care.
		Clinical Outcomes: monitoring of outcome reporting against guidelines and recording of clinical condition to support pathway management.	Jones, Keith	31/03/2020	Work programme overseen by the Outpatient Improvement Group to support appropriate pathway management.
		Development and implementation of Clinical Guidance for discharge.	Hire, Stephanie	31/03/2020	Pilot undertaken in Gynaecology to support detailed audit of follow-up practice in order to establish agreed practice for follow-up / discharge. Implementation under way in Respiratory and Paediatrics.
		Development and implementation of Self-Management strategies as alternatives to traditional clinic based follow-up reviews.	Jones, Keith	31/03/2020	Longer term strategy of self management and digital transformation to develop alternative ways to follow up patients. Opportunities are begin assessed by the Outpatient Improvement Group for project planning.
		Implementation of WG National Planned Care Programme (PCP).	Jones, Keith	31/03/2020	National project / guidance are being implemented under the PCP for ENT, Ophthalmology, Urology & Orthopaedics to support appropriate follow-up care.

				Development and agreement of a strategy and programme of work to reduce delays in follow-up care.	Hire, Stephanie	Completed	Presented to BPPAC in Feb19.

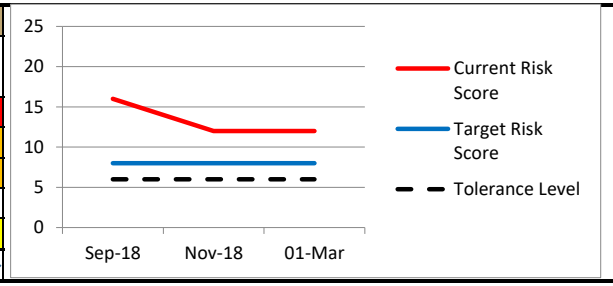
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Watchtower meetings are held weekly to review all patient waits	1st			* IPAR Report Month 9 - Board - Jan19 * IPAR Report Month 10 - BPPAC - Jan19 * Delayed Follow Up Improvement Plan 19/20 - BPPAC - Feb19	None identified to date				
	Ophthalmology ECM specifically report compliance with the follow up intervals	1st								
	Outpatients Turnaround Group reviewing levels of follow-up	2nd								
	Planned Care Programme Board (WG) reviewing HB implementation of PCP	3rd								
	Scrutiny of FUNB forms part of the Delivery Unit remit for scrutiny	3rd								

Strategic Objective:	*1 -Deliver the Annual Plan 2019/20 by the end of March 2020*

Executive Director Owner:	Kloer, Dr Philip	**Date of Review:**	21/03/2019
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	21/05/2019

Risk ID:	**631**	**Principal Risk Description:**	There is a risk of the UHB failing to recognise increasing mortality rates. This is caused by a lack of consistent mortality review process across the UHB. This could lead to an impact/affect on missed opportunities to reduce avoidable deaths and improve clinical outcomes.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:

Mortality review process is not sufficiently consistent across the UHB. A new process for stage 1 reviews has now been implemented across all acute sites. The Health board is now achieving 85% compliance to meet the 28 day target for mortality reviews. Learning from mortality reviews is not sufficiently embedded in the HB processes which risks learning from the reviews not being acted upon. The risk is maintained at 12 as the Stage 1 review process has been standardised across the Health Board, however more consistency is needed around developing themes and learning from reviews which will be taken forward by the newly established Mortality Review Group by end of Apr19

Rationale for TARGET Risk Score:

The newly established mortality review group will report to the Effective Clinical Practice Sub-Committee and is planning on agreeing a new standardised process for stage 2 process at its meeting in Apr19 for implementation in early Summer 2019.

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**
Stage 1 reviews are a standardised process across all sites in the Health Board	28 day review target not consistently being met.	New review process put in place at PPH and GGH to mirror that already in BGH and WGH.	Davies, Mandy	Completed	Completed.
Learning from mortality review learning shared at Whole Hospital audit Meetings.	WHAMs not always well attended and themes too general to embed learning.	Each specialty to implement quality and safety meetings with mortality as a standing item.	Brown, Dr Ceri	~~31/03/2019~~ 30/06/2019	Discussions initiated with specialties.
Stage 2 mortality reviews are in place on all sites however is being reviewed and standardised.	Learning and key themes from stage 2 reviews need to be discussed by clinical teams.	Action plans to be developed by each clinical team that address areas identified in stage 2 reviews.	Brown, Dr Ceri	~~31/03/2019~~ 30/06/2019	Work to be commenced in 2019.
	Lack of trend analysis of mortality reviews.	Establish clear links with Datix system re stage 2 reviews to improve learning from mortalities and trends.	Davies, Mandy	Completed	Mortality Review Group has been established to drive the mortality review process. This group will identify improved processes to the stage 2 review including developing the links with Datix.

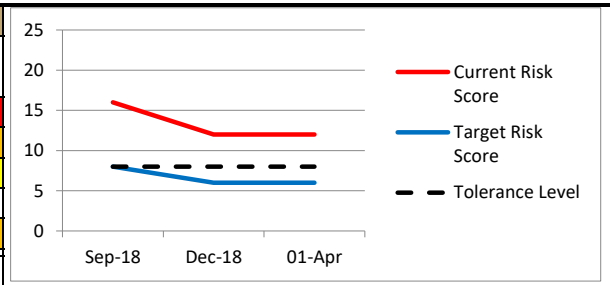
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
No. of stage 1 mortality reviews undertaken in 28 days. No. of stage 2 mortality reviews undertaken. No of Datix incident reports.	Mortality reviews	1st				Lack of formal process for addressing concerns from stage 2 reviews.	Standardised method of reporting of Stage 2 reviews to be agreed by the Mortality Review Group	Davies, Mandy	~~31/01/2019~~ 30/06/2019	The newly established Mortality Review Group will be looking to improve the process around Stage 2 reviews.
	IPAR reviewed by BPPAC/PMAF Reviews	2nd								
	Each specialty to have established a quality and safety forum with mortality reviews as a standing agenda item	2nd								
	Quality improvement meetings with WG	3rd								

Strategic Objective:	1 - Deliver the Annual Plan 2019/20 by the end of March 2020

Executive Director Owner:	Teape, Joe	**Date of Review:**	15/04/2019
Lead Committee:	Business Planning and Performance Assurance Committee	**Date of Next Review:**	15/06/2019

Risk ID:	**633**	**Principal Risk Description:**	There is a risk of the UHB not being able to meet the anticipated waiting time target for the new Single Cancer Pathway by the confirmed shadow reporting implementation date of August 2019.(SCP Performance targets tbc). This is caused by the lack of capacity to meet expected increase in demand for diagnostics. This could lead to an impact/affect on meeting patient expectations in regard to timely access for appropriate treatment, adverse publicity/reduction in stakeholder confidence and increased scrutiny/escalation from WG.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	4×3=12
Target Risk Score (L x I):	3×2=6
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:
It is likely that public reporting of shadow reporting in respect of the new single cancer pathway will significantly reduce performance across Wales compared to current USC/NUSC pathways, as evidenced by current monitoring. The current impact is rated as a 3 due to the current absence of confirmed targets in respect of the SCP.

Rationale for TARGET Risk Score:
The aim is to treat patients within target waiting times (which are yet to be confirmed).

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**
Working with all Wales Cancer Network to gain full understanding of implications of new pathway. Implementation Group established, reporting to Cancer Board with awareness / engagement sessions held on each hospital site. Shadow monitoring in place. Demand & Capacity planning in progress to assess anticipated impact on diagnostic services.	Anticipated significant gaps within key diagnostic services to address required levels of activity to support SCP - unlikely to be addressed by August 2019 Full engagement for all supporting services. Performance is lower than USC/NUSC published performance. Key diagnostic information systems do not support effective demand / capacity planning. Need for new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment	Demand & capacity assessment work continuing. Solutions will necessitate regional cooperation to address anticipated capacity gaps.	Perry, Sarah	31/03/2020	Currently managing SCP workload via pathway redesign.
		Additional awareness / engagement sessions planned across HB.	Jones, Keith	Completed	Initial round of health board awareness sessions were held during September 2018, followed by a second round of awareness sessions, including attendance at MDT Site Specific Business meetings and hospital Grand Round sessions in early 2019
		See above re diagnostic services plus improved systems to support identification of 'date of suspicion'.	Jones, Keith	~~31/03/2019~~ 31/08/2019	HB performance compares well with other HBs however below current USC/NUSC performance level. Ongoing work in progress with OPD, Diagnostic & ED teams along with the informatics department to improve real time identification of date of suspicion

	pathways.	Planned upgrade of Tracker 7 system via NWIS targeted for Summer 2019.	Jones, Keith	31/08/2020	The new Tracker 7 system was implemented within in the health board in Mar19. The service is currently looking at staffing levels to enable us to use the system fully.
		Each MDT to review and adopt recommended optimal tumour site specific pathways	Jones, Keith	31/08/2020	Each MDT is currently assessing implications of published proposed pathways. A Macmillan Cancer Quality Improvement Manager has been appointed to work with the teams with regards to implementing the new pathways, starting with Lung and Urology pathways.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**		
Performance indicators for Tier 1 targets. Shadow performance data.	Daily/weekly/monthly/ monitoring arrangements by management	1st			* IPAR Report Mth11- Board - Mar19 * Implement-ation of Single Cancer Pathway Report - BPPAC - Feb19
	Executive Performance Reviews	2nd			
	IPAR Performance Report to BPPAC & Board	2nd			
	Monthly oversight by WG	3rd			

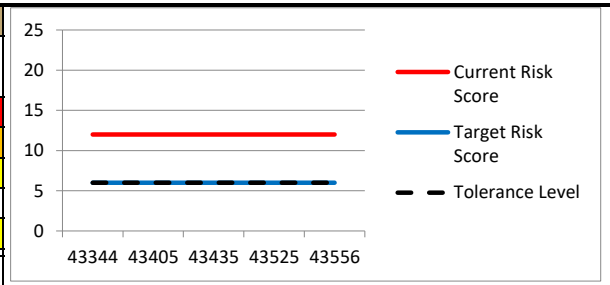
Gaps in ASSURANCES				
Identified Gaps in Assurance:	**How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
No gaps identified.				

Strategic Objective:	2 - Deliver the agreed financial total for 2019/20 by the end of March 2020 3 - Achieve the agreed savings requirement for 2019/20 by the end of March 2020

Executive Director Owner:	Thomas, Huw	**Date of Review:**	16/05/2019
Lead Committee:	Finance Committee	**Date of Next Review:**	16/06/2019

Risk ID:	**646**	**Principal Risk Description:**	There is a risk of the Health Board not achieving breakeven over the medium term. This is caused by the inability to either: 1. Develop a sufficiently robust financial plan which shows an achievable improvement trajectory, or 2. Manage the necessary changes in such a way that the financial gains are realised and an improvement trajectory is achieved. This will lead to an impact/affect on a detrimental impact on the Health Board's reputation with Welsh Government and other stakeholders.
Does this risk link to any Directorate (operational) risks?		Corporate risk	

Risk Rating:(Likelihood x Impact)	
Domain:	Finance inc. claims
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:
The Health Board has not developed a full long term financial base-case model, which can then be used to assess the impact of TCS and other medium term changes. The Health Board's underlying deficit also requires further work to fully explore and understand the opportunities for improvement which can be realised over the medium term.

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Understanding the underlying deficit. An initial assessment has been completed. Very high level base-case long term financial model. Assessing the full financial implications of Transforming Clinical Services.	Calculation has not been subject to operational scrutiny. Assessment not subject to planning scrutiny. High level assessment of resource requirements for social model for health.	Testing the underlying deficit assumptions with directorates.	Thomas, Huw	~~30/11/2018~~ ~~31/05/2019~~ 31/12/2019	Welsh Government and UHB commissioning external advisors to prepare report on deficit position. Specification being agreed.
		Refining assessment in conjunction with W&OD and Planning.	Thomas, Huw	30/11/2018	Initial calculations regarding the effect of the zero based review allocation and early high level affordability for option B of the consultation has been shared via the TCS Design Team and with the Director of Finance. The Strategic Financial Planning Group (Strategy Finance Enabling Group) met on the 2nd May and agreed a series of actions to inform the work of the forthcoming meetings of the 3 Strategy Programme Delivery Groups and Integrated Enabling Group.

					Developing a high level assessment of the resource requirements of "A Heathier Mid and West Wales" Strategy. Understanding full financial implications of TCS, including the Community/Social Care model.	Thomas, Huw	~~31/03/2019~~ 31/03/2020	Activity Based costing refined based on updated Activity and Capacity Assumptions and impact on the 2017/18 baseline financial data + Zero based Review funding (Completed) Collated detail in draft Strategy to begin to build up a bottom up financial costing. Integrated Enabling Group working with Health and Care Strategy Programme Groups to both inform the groups regarding current detail and translate into financial and workforce end point model.

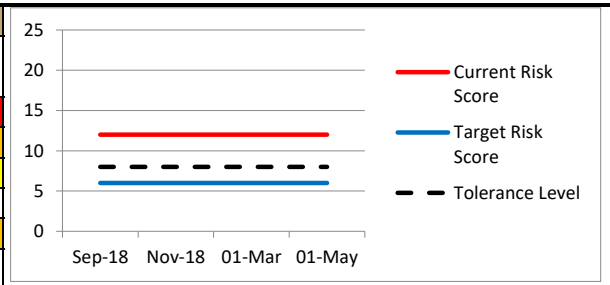
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance** **(1st, 2nd, 3rd)**	**Required Assurance** **Current Level**			**Identified Gaps in Assurance:**	**How are the Gaps in ASSURANCE will be addressed** **Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
Operational agreement to underlying deficit assessment. Plan in place to develop a long term financial plan. High level financial assessment of TCS in place.	Reporting to Finance Committee .	1st			N/A	Process to be put in place over May and June. Approach to costing impact of TCS to be developed.	Communication with directorates and responses required in July.	Thomas, Huw	~~31/10/2018~~ ~~31/07/2019~~ 31/12/2019	Welsh Government and UHB commissioining external advisors to prepare report on deficit position. Specification being agreed.
							Now Strategy is agreed we are moving on to a bottom up assessment of the Financial Planning options and implications of "A Heathier Mid and West Wales". TCS Finance Enabling "Plan for a Plan" - has been considered by the Strategic Financial Planning Group and Finance Committee.	Thomas, Huw	~~31/03/2019~~ 31/03/2020	Initiating the establishment of a multidisciplinary Integrated Enabling Group as agreed by the Board on 28/03/19 tied into the Strategy Governance to begin to flesh out service design options and trade-offs to inform and promote debate in co-design process. Draft Financial Plan submitted to FDU; comments received. Response and actions to be completed before final submission by the end of Jan19. Intensive work initiated for 2019-20 to support design process, inform 10 year finacial plan and feed into IMTP for 2020-2023.

Strategic Objective:	1 - Deliver the Annual Plan 2019/20 by the end of March 2020

Executive Director Owner:	Rayani, Mandy	**Date of Review:**	02/05/2019
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	02/07/2019

Risk ID:	**647**	**Principal Risk Description:**	There is a risk of the Board not receiving accurate and timely information regarding variation from the planned staffing roster in line with requirements of S25B of the Nurse Staffing Levels (Wales) Act 2016 (NSLA). This is caused by not having sufficient capacity to (locally) develop robust arrangements and systems to support this requirement of the Act. This could lead to an impact/affect on the UHB being unable to report and review, in a timely manner, any variations in staffing levels, effectively workforce plan and review current staffing establishments, resulting in increased scrutiny from Welsh Government and reduced confidence from stakeholders.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Statutory duty/inspections
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:
The Board agreed NSLA Implementation plan is progressing with the first annual report being presented to QSEAC in Apr19 which demonstrates progress to date. A national approach to capturing variations from the planned staffing levels via the Health and Care Monitoring Software System (HCMS) is under development by NWIS and has been piloting in this Health Board. Both this system and an alternative (more labour intensive) data capture system was tested with Heads of Nursing in Apr19. The options for data capture were discussed with the Heads of Nursing with the agreement that the HCMS option was the preferred option. This system is currently being tested with a view to rolling this system to the wards in Jun19. An implementation plan has been agreed.

Rationale for TARGET Risk Score:
The target risk score reflects that any system will rely on staff inputting timely and accurate information.

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**
Temporary staffing arrangements in place. Risk based escalation arrangements and process in place in services. Emergency Pressure & Escalation Policy ((Approved Sept 2018). Nurse Staffing Levels (Wales) Act Steering Group. (Inconsistent) reporting arrangements in place.	Lack of a single, Health Board wide robust system to record variations from the planned roster as per requirements of S25B/C.	Phased implementation plan for the Nurse Staffing Levels (Wales) Act which includes the development of a single system of recording.	Rayani, Mandy	~~31/03/2019~~ 30/06/2019	Option appraisal undertaken The HCMS option was the preferred option. This system is currently being tested with a view to rolling this system to the wards in Jun19 for a period of testing. An implementation plan has been agreed.
		Prepare a report for Formal Executive Team setting out resourcing requirements.	Rayani, Mandy	Completed	NWIS committed to developing all Wales system therefore no request for resources was submitted.

Full implementation of the plan to fully comply with the Nurse Staffing Levels (Wales) Act which includes the development of a single system of recording.	Rayani, Mandy	31/07/2019	Implementation plan agreed at Board is progressing as planned. Updated position scheduled to be reported to QSEAC (which has been delegated responsibility for providing assurance to the Board) in Jul19.
Daily use of HCMS system to capture required data to be rolled out across HDUHB in Apr/May19 if enhancements are delivered by NWIS in line with current stated timetable: If NWIS fail to deliver, an alternative (interim) solution (selected by Heads of Nursing from two current options - one in use in one area of this HB and in one other HB in NHS Wales) will be implemented as an interim solution.	Rayani, Mandy	~~31/05/2019~~ 30/09/2019	Regular contact being maintained with NWIS to monitor progress with HCMS enhancement work: The system is currently being tested with a view to rolling it out to the wards in Jun19 for a period of testing. It anticipated that reliable data will be available from Sep19.

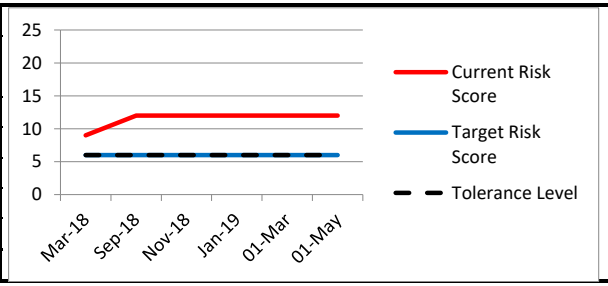
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	E-rostering system reviewed by Head of Nurses in Operation Teams	1st			* Briefing on NSLA - QSEAC Aug18 and Feb19 * NSLA Update - Board May18, Jul18 and Nov18 * NSLA Annual Report - QSEAC Jun19 and Board May19					
	Datix Reports reviewed by Corporate Nursing Team to identify reportable breaches	1st								
	Director of Nursing review of significant reported breaches	2nd								
	Workforce & OD Sub-Committee review of workforce challenges	2nd								
	Annual Report to Board	2nd								
	WG Review HB Papers in 18/19	3rd								
	3 yearly compliance report to Welsh Government	2nd								

Strategic Objective:	1 - Deliver the Annual Plan 2019/20 by the end of March 2020

Executive Director Owner:	Teape, Joe	**Date of Review:**	13/05/2019
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	12/07/2019

Risk ID:	**129**	**Principal Risk Description:**	There is a risk of disruption to business continuity of the Hywel Dda Out of Hours (OOH) Service. This is caused by a lack of available of labour supply as GPs near retirement age and pay rate differentials across Health Boards in Wales, implementation of the '111' service, workforce flexibility and other service change. This could lead to an impact/affect on further weakening of an already fragile service and a detrimental demand impact on patient experience and the unscheduled care pathway.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×3=15
Current Risk Score (L x I):	4×3=12
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:

Gaps in rota cover throughout the 3 counties continue with very limited additional work being undertaken by the sessional workforce.

Shift fill is improving over a weekday, with increasing numbers of GPs also available to support on most weekends. The exception to this continues to be Carmarthenshire (PPH) which is frequently adversely affected by rota gaps, although base closures have been noted in all areas in recent months

APP model is providing significant resilience (when available)

Rationale for TARGET Risk Score:

A long term viable plan is needed for OOH Services to reduce this risk and ensure the out of hours service provision is not interrupted.

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

GP's rotas are constantly reviewed and updated by the OOH staffing team with a view to improve resilience.

111 programme board with 111 now live across the HB area.

The clinical advice hub as part of the '111' service is assisting with OOH demand

Dedicated Advice GP rota in place at times of high demand (weekends).

Health Professional feedback form in use between clinicians, service management and 111 leads.

Patients directed to alternate OOH care where capacity allows. ED and MIU direction is made for most urgent cases

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**
Workforce availability still fragile and results in frequent disruption. Need for formalised workforce plan required- support form OD to achieve this has been obtained	The service is actively looking to recruit Advanced Paramedic Practitioners to the service.	Rees, Gareth	Completed	Completed and in place.
	Develop long term service model for OOH.	Rees, Gareth	Completed	Completed - A long term model has been developed however this will need to align with the UHB Clinical Services Strategy going forward.
	Ensure Transforming Clinical Services Programme incorporates a long term, viable plan for OOH.	Rees, Gareth	31/03/2020	A short to medium term plan is under development for inclusion in the IMTP 2019/22 to manage the current gaps in rotas in the Out of Hours Service.
	Development of home working provision for GPs.	Rees, Gareth	Completed	Completed and evolving.

GP Advisory Group established to improve communication/relationships with local GPs.

WAST APP support in place and provides significant mitigation to risk when other staff unavailable.

Health care support workers augmenting GP workloads by undertaking basic observations.

Pharmacist deployed locally into GGH but working as extended arm of support hub.

Recruitment programmes for increasing nurses and doctors into the services.	Rees, Gareth	Completed	APP posts with WAST commenced on 01.11.18 - 2 WTE APP deployed at peak demands to provide a degree of rota resilience. Additional APPs being deployed on an ad hoc basis. Rolling recruitment for salaried GP continues- high view count however no uptake - to be reviewed with recruitment. 5 new GPs have signed up for shifts in the Carms locality (Adhoc) in last 5 months.
Rollout of 111 to all 3 counties.	Rees, Gareth	Completed	Completed and in place from 31st October 2018.
Develop short to medium plan for out of hours service which builds resilience into service ahead of longer term action materialising.	Davies, Nick	~~31/12/2018~~ 31/07/19	Two meetings have been held with Asst Director Primary Care to scope the potential opportunities for 24 hour collaboration/ improved relationship with primary care teams. A concept paper will now be generated (first draft anticipated be end of July 19)- it is agreed that the existing service fragility and other changes to the service will need to improve significantly / be completed successfully before introduction of new ways of working.
OOH and MIU services in PPH to assess potential for closer working with a view to increasing rota resilience.	Davies, Nick	28/06/2019	Executive Team approval gained to further develop options. Initial scoping meeting held 17/4/19 with next meeting planned 20/6/19 to form task and finish.

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 Wales Quality and Monitoring for Delivery of OOH standards	Daily sitreps/Weekend briefings for OOH	1st			Internal Review of 111 - BPPAC Jun-18.	None identified.				
	Monitoring of performance against OOH standards	1st								

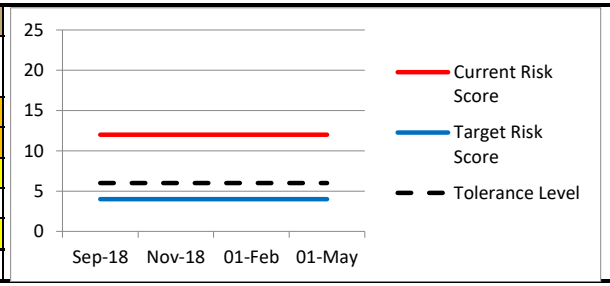
standards. Filled rotas.	Executive Performance Reviews	2nd									
	BPPAC monitoring (last month)	2nd									
	WAO Review of OOH in Wales	3rd									
	WG Peer Review completed Sep-18	3rd									

Strategic Objective:	*1 -Deliver the Annual Plan 2019/20 by the end of March 2020*

Executive Director Owner:	Teape, Joe	**Date of Review:**	07/05/2019
Lead Committee:	Business Planning and Performance Assurance Committee	**Date of Next Review:**	07/07/2019

Risk ID:	**652**	**Principal Risk Description:**	There is a risk of persons gaining unauthorised access to certain parts of the hospital sites. This is caused by the poor condition of certain external doors which compromises the security of the site and the ability to promptly lock down perimeter doors from a central point. This could lead to an impact/affect on the security of the site in terms of unauthorised access, increased risk to staff and patients from unauthorised persons and increased risk of thefts out of hours.
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):	3×4=12
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	1×4=4
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:

In the event of an incident or an increase in threat level, the ability to restrict access to external doors will be important. This is currently only achievable by porters physically locking doors. Arrangements are in place to lock external exit doors to secure each hospital premises. However many of these exit doors are having to be manually locked and unlocked by porters physically securing them using a variety of keys. This task can take a considerable amount of time and will inevitably leave certain access points vulnerable if an emergency lock down is activated. In addition Porters are often otherwise engaged in patient transport/fire response and other duties when exterior doors require manually locking, effectively leaving them open when they should be secured. Barriers to full implementation of an effective lockdown capability remain as no identified security role has been identified on each site.

Rationale for TARGET Risk Score:

Planned actions will reduce risk of unauthorised access to certain parts of hospital sites however will investment to deliver the actions.

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**
Doors are in place. Porters locking each door in person at specific times. Staff wearing ID badges at all times across sites. Survey of access points on acute hospital sites identified gaps in access controls - Access controls in large number of areas.	Lack of risk based approach to strengthening access controls to acute hospital sites. Lack of robust process to instigate lockdown procedures on hospital sites.	Develop and implement a work programme to address gaps in access controls based on availability of capital funding.	Harrison, Tim	30/09/2020	Work plan developed and discretionary Capital bid submitted for approval to improve the capability of routinely locking up and, if required, locking down the Acute General Hospital Sites. The capital bid has been prioritised and is spread over 2 years.
		Issuing swipe card controls across all hospital sites.	Elliott, Rob	~~30/04/2019~~ 31/05/2019	SBAR prepared for Operations Business meeting and H&S/EP SC with recommendations for improving current arrangements.

	Development of systematic lockdown plans developed by site management - support by emergency planning & security teams.	Lloyd, Mr Philip	~~31/03/2019~~ 30/06/2019	Acute General Hospital Lockdown plans will be developed starting with WGH which is currently in draft. These Plans require site Management acceptance and allocation of appropriate personnel and infrastructure in order to implement an efficient and effective departmental or hospital wide lockdown.
	Testing lockdown plans.	Lloyd, Mr Philip	~~30/06/2019~~ 30/06/2019	As part of hospital lockdown plan development.
	Approval of Lockdown Policy at Health & Safety/Emergency Planning Sub-Committee.	Harrison, Tim	Completed	Lockdown policy approved at Jan19 meeting.
	Develop action plan in response to Counter Terrorism Security Advisor (CTSA) Report for review at H&S Sub-Committee.	Harrison, Tim	Completed	Annual Work Plan covers the external lockdown improvements (pending Capital Funding approval).

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**		
Reduction in no of incidents unauthorised access.	Management investigation of unauthorised access and issues / H&S & Security Team identify trends across sites	1st			* Lockdown policy - H&S SC - Jan19 * Access Control, CCTV, Lockdown Report - H&S/EP SC - May18
	Site inspections by night staff	1st			
	Security compliance reports to H&S/ EM Planning Sub-Committee	2nd			
	Security issues discussed at Site Staff Partnership forums	2nd			
	Counter Terrorism Advisor Report on Security Controls in UHB	3rd			
	IA Physical Security Follow up - May 2015 - Limited Rating	3rd			

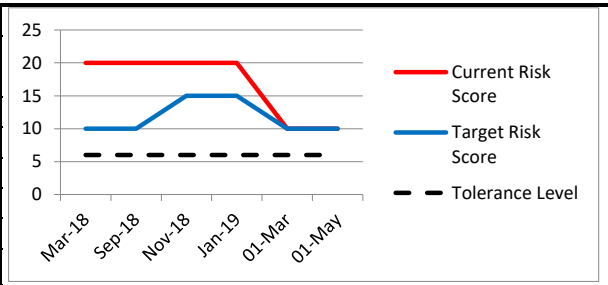
Gaps in ASSURANCES				
Identified Gaps in Assurance:	**How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**

Strategic Objective:	1 - Deliver the Annual Plan 2019/20 by the end of March 2020

Executive Director Owner:	Teape, Joe	**Date of Review:**	21/03/2019
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	17/05/2019

Risk ID:	**117**	**Principal Risk Description:**	There is a risk of avoidable patient harm or death and serious deterioration in clinical condition, with patients having poorer outcomes. This is caused by the delay in transfers to tertiary centre for those requiring urgent cardiac investigations, treatment and surgery. This could lead to an impact/affect on delayed treatments leading to significant adverse outcomes for patients (the 72 hour timescales as per N-STEMI clinical guidance designed to provide urgent cardiac patients the best outcomes), prolonged hospital stays of up to 21 days, impaired patient flow into appropriate coronary pathway with beds in coronary care unit exceeding capacity and poorer outcomes for patients.
Does this risk link to any Directorate (operational) risks?			

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



Rationale for CURRENT Risk Score:

The UHB is still experiencing delays in transferring patients to tertiary service within the recommended 72 hours as per N-STEMI guidance. The absence of a cardiac CT service within Hywel Dda is constraint as this would reduce angiography demand. The current score is now reduced to 10 on account of recent success of the Regional 'Treat & Repat' arrangement.

Rationale for TARGET Risk Score:

The target of 15 is predicated on effective local and regional solutions coming forward, albeit these need to be developed. Once clarity on these is available, a review of the target can be undertaken. The target score is now reduced to 10 on account of recent success of the Regional 'Treat & Repat' arrangement.

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**
Medical and nursing staff review patients daily and update the referral database as appropriate. Bi-monthly operational meeting with Abertawe Bro Morgannwg (ABMU) to improve flow. Daily telephone call Coronary Care Unit (CCU) to review all patients awaiting transfer with review of patients waiting for transfer to ABMU. Escalation process in place. All patients are risk scored by cardiac team in ABMU. Local evaluation of catheter laboratory project to identify more local solutions. Additional cardiac capacity for Winter 2018/19 providing 6 ring-fenced	Lack of Catheter Laboratory in Hywel Dda to reduce reliance on tertiary centre. Lack of capacity in tertiary centre.	Review cardiology service to minimise transfer for some diagnostics (perfusion scanning, angio, cardiac CT).	Jenkins, Daniel	Completed	Myocardial Perfusion Scanning Service established in WGH. Cardiac CT provided at BGH.
		Develop a business case to improve regional capacity.	Teape, Joe	Completed	Business case has been developed and submitted to Executive Team for consideration on 14th November 2018. Agreement with ABMUHB to hold a additional surgical list on Saturdays.
		Develop a local solution for Winter 2018/19	Teape, Joe	Completed	Additional cardiac capacity included in Winter Plan to provide 6 ring-fenced beds. Ring fenced beds in place Jan19 and as of 22/2/19 there are no patients waiting to go to ABMU. Further funding needs to be identified to continue arrangement to Apr19.

beds at PPH to enable timelier transfer to ABMU. ABMU have agreed to 2 transfers per day for HDUHB patients form 7/1/19 - this has achieved an average reduction from 10 to 3 days in the wait from 'referrals for angio' to ' angio undertaken'.		The Regional Working Group to identify regional solutions to improve patient outcomes.	Kloer, Dr Philip	Completed	Workshop took place on 22/02/19 and was chaired by Medical Directors from ABMU and HD UHBs. The work will be led by the regional cardiac group chaired by Dr Mark Ramsey.
		Developing a proposal for a Catheter Laboratory for inclusion in Annual Plan for 2019/20.	Perry, Sarah	~~31/01/2019~~ 30/06/2019	Discussions have been undertaken with Planning Team. Draft paper sent to Director of Operations and further updates required and to review costs. Meeting with site GM's and finance Apr19.
		Develop proposal for Executive strategic decision to establish a local Cardiac CT service in 2019/20.	Perry, Sarah	Completed	Draft paper submitted to Executive Team in Feb19. Sent back with comments for further work. Meeting with GMs and finance arranged for 11/04/19.
		Develop long term regional plan.	Teape, Joe	30/09/2019	Regional network to be established to take this forward.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**		
Performance indicators for Tier 1 targets.	Daily/weekly/monthly/ monitoring arrangements by management	1st			
	Audit of N-STEMI referral undertaken by Clinical Lead show average wait of 10.7 days	1st			
	Executive Performance Reviews	2nd			
	IPAR Performance Report to BPPAC & Board	2nd			
	Monthly oversight by WG	3rd			

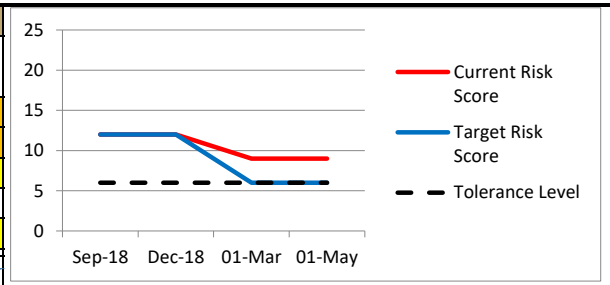
Gaps in ASSURANCES				
Identified Gaps in Assurance:	**How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
Lack of oversight at the Board and Committees.	Review reporting arrangements of emergency and elective waits.	Teape, Joe	~~10/01/2018~~ 30/04/19	Discussions are underway with ABMuHB for information on cardiac patients (n-stemi pathway)to be provided to Hywel Dda for inclusion in the IPAR. This will include no of referrals, those seen within 72 hours, average and longest waiting times.

Strategic Objective:	*1 -Deliver the Annual Plan 2019/20 by the end of March 2020*

Executive Director Owner:	Jervis, Ros	**Date of Review:**	13/05/2019
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	13/07/2019

Risk ID:	**635**	**Principal Risk Description:**	There is a risk of There is a risk of the consequences of a no-deal Brexit impacting on the business continuity of health care services. This is caused by a lack of clarity regarding UK position on Britain's exit from EU. This could lead to an impact/affect on the UHB being unable to continue to run services, patients being able to access appropriate and timely treatment, the UHB being able to maintain safe and effective levels of staffing, financial loss and adverse publicity/reduction in stakeholder confidence and 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):	3×4=12
Current Risk Score (L x I):	3×3=9
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	6
Trend:	



Rationale for CURRENT Risk Score:
We have reduced the current risk score as this reflects the work that on-going to clearly identify the risks and impacts to the UHB in conjunction with Wales and UK Governments. Plans are now in place at local, regional and national levels supported through a robust governance infrastructure.

Rationale for TARGET Risk Score:
This will be affected by confirmation of Brexit outcome by UK Government. As planning/contingency work continues, it is hoped to reduce either the likelihood and/or impact score further.

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**
* Regular meetings with CEO, DPH & Head of Emergency Planning plus verbal updates/discussions and papers at Executive Team and Board. * Brexit Steering Group has been established to manage the consequences of Brexit and its interface with partners. * Wider governance infrastructure in place - of note the Dyfed Powys LRF Brexit Group and Welsh Government led groups. * Risk assessments and business continuity plans feed into a dynamic risk summary document which continues to track on-going risks and controls assurance with business continuity. * Scoping exercise undertaken within Workforce to identify EU nationals and resolve data gaps in ESR. Workforce Brexit Plan developed. * Information flows are being co-ordinated to ensure that any discussions with respective Health Board services and national services and/or professional leads are captured within our planning. * The Health Board is represented at the WG SRO's, Comms and Brexit Health & Social Care Civil Contingencies Group and also within the DP LRF Brexit Group. * Staff Brexit Intranet page developed as single point of information plus a closed Facebook Group for EU staff.	Full understanding of potential impacts and implications for the UHB due to the unknown final outcome of Brexit.	Scoping Exercise and liaison with other HBs and WG.	Hussell, Sam	Completed	Completed.
		Completion of suite of risk assessment and business continuity plans (BCPs) by service leads to mitigate highest risks.	Hussell, Sam	Completed	Completed.
		Completion of workforce scoping exercise and resolution of ESR data gap.	Gostling, Lisa	~~31/01/2019~~ 30/06/2019	ESR Data Gap significantly reduced with on-going campaign to complete.

* Exercise Brexit Challenge undertaken resulting in recommendations and an action plan that will be progressed via the Brexit Steering Group. * Sitrep process in place at local, regional and national level for reporting and escalating impacts of consequences of Brexit. * Systems in place to review and respond to new consequences of Brexit at local, regional and national level.		NHS Wales exercise planned for Jan19 to rehearse Brexit no-deal contingencies.	Hussell, Sam	Completed	Completed.

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
To be identified when risk is fully understood.	Response submitted on 19Nov18 to Andrew Goodall letter of 05 October stating approach to be taken by Health Boards confirming progress	1st			None to date.	Further sources to be identified when risk is fully understood.	Respond to WG letter of 05/10/18 requesting further information on the approach taken by UHB and progress to date.	Hussell, Sam	Completed	Response sent by 19/11/18.
	Response submitted to Wales Audit Office letter notifying of intention to undertake an initial baseline of arrangements by 30Nov19	1st					Respond to WAO request for information to inform their baseline assessment of arrangements for Brexit.	Hussell, Sam	Completed	Response provided by 30/11/18.
	Emergency Planning Team to review UHB no deal Brexit arrangements and associated BCPs	1st								
	Executive oversight of Brexit arrangements and BCPs	2nd								
	Review of Exercise planned for Jan19	3rd								
	WAO Review of Brexit Preparedness	3rd								

Strategic Objective:	1 - Deliver the Annual Plan 2019/20 by the end of March 2020

Executive Director Owner:	Teape, Joe	**Date of Review:**	16/04/2019
Lead Committee:	Business Planning and Performance Assurance Committee	**Date of Next Review:**	16/06/2019

Risk ID:	**718**	**Principal Risk Description:**	There is a risk of the UHB will face enforcement action under the Health and Safety at Work Act 1974 and subordinate regulations. This is caused by a failure to comply with prevailing legislation by not undertaking proactive health and safety (H&S) management (such as audits, inspections and case reviews) due to a lack of capacity within the Health, Safety and Security Team. This could lead to an impact/affect on harm to patients, staff and the public, improvement notices, large fines and/or criminal prosecutions following HSE investigations, adverse publicity/reduction in stakeholder confidence.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)		***No trend information available***
Domain:	Statutory duty/inspections	
Inherent Risk Score (L x I):	4×3=12	
Current Risk Score (L x I):	3×3=9	
Target Risk Score (L x I):	2×3=6	
Tolerable Risk:	8	
Trend:	*New risk*	

Rationale for CURRENT Risk Score:
The team have undertaken a high level gap analysis identifying gaps in the current staffing resource. When benchmarked against other health boards in Wales, it demonstrated that other H&S teams had over double the staffing resource and that they did not cover the counter terrorism remit that Hywel Dda's team does. The lack of capacity in the team means that key aspects of H&S management are not being undertaken, such as audits, inspections and case reviews, timely learning and follow up after incident investigations, promotion and implementation of H&S policies.

Rationale for TARGET Risk Score:
H&S risks will inevitably exist within healthcare and therefore a reasonable level of risk rating has been considered as a score of 8.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
1 x Head of H&S, 1 x H&S Manager and 1 x Security/Case Manager/Prevent Co-ordinator who currently take a reactive approach to health and safety issues, as opposed to a more beneficial proactive approach. Datix Risk module in place. The Health Board has invested in the Datix module which enables services to identify, assess and manage risks associated with health and safety. Standard operating procedures in laboratory, radiology, theatre environments which reflect some of the hazards/ risks (Policy approved, most departments have material safety data sheets but very few COSHH risk assessments, pathology have undertaken monitoring for Xylene and Formaldehyde) Incident/concerns investigations are undertaken however depth of	Lack of staff capacity to undertake proactive H&S management. Lack of UHB support for victims of assault and also lack of follow up with potential prosecutions. Lack of incident/concerns follow-up to identify and address lessons learnt Due to lack of capacity, limited monitoring and assistance is currently being provided by the Health, Safety and Security team in relation to the 'H&S' risks identified on Datix, preventing the analysis and identification of trends/issues across	Look at existing resources across Estates and Facilities Directorate to address gap in control and take more proactive approach to health and safety (proactive reviewing of H&S risk assessments on Datix, provision of support for victims of assault, follow and learning lessons following incidents)	Elliott, Rob	Completed	Completed however no spare capacity identified with appropriate skill mix. A gap analysis has also been undertaken on the operational estates staff which identified 10.4wte shortfall for undertaking HTM compliance.
		Request funding to recruit 3 additional posts to H&S structure.	Elliott, Rob	Completed	SBAR submitted to Executive Team in Oct18. The paper was accepted and concerns acknowledged with a commitment to fund when resources becomes available. Advised to mitigate risks as far as reasonably practicable and escalate those risks that cannot be managed.

investigations could be improved to ensure there is appropriate follow up, support for those affected and lessons are learnt across the organisation. H&S policies and procedures are in place and are published on staff intranet. Incident/concerns investigations are undertaken however depth of investigations could be improved to ensure there is appropriate follow up, support for those affected and lessons are learnt across the organisation. H&S policies and procedures are in place and are published on staff	the UHB and ability to take the appropriate organisational actions. Limited environmental/personal exposure monitoring (COSHH). Implementation of policies also needs strengthening across UHB.	Develop annual work plan aligned to prioritised goals agreed by Health and Safety and Emergency Planning Sub-committee (H&SEPSC).	Harrison, Tim	Completed	Completed
		Improve COSHH compliance (as part of annual work plan).	Harrison, Tim	31/03/2019	COSHH Policy approved Training in spillage techniques and respiratory protection has been delivered to endoscopy staff in BGH.
		CCTV Policy, Face-fit Procedure, Violent Patient Marker Procedure, Security Policy will be approved by Emergency Planning/Health and Safety Sub-Committee in line with the annual work plan schedule	Harrison, Tim	31/03/2019	COSHH Policy & Procedure, Violence & Aggression Policy, First Aid at Work Procedure, New & Expectant Mothers Procedure have been approved during 2018.

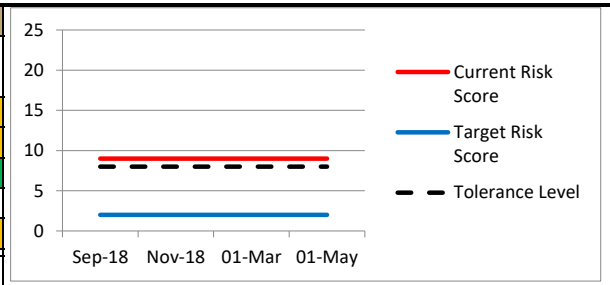
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Incident and RIDDOR and progress against workplan reports to H&S/EP Sub-Committee	2nd			SBAR Exec Team Oct-18 H&S/EP Sub-Committee	Lack of internal H&S audits and inspections				
	Progress against workplan reports to H&S/EP Sub-Committee	2nd								
	IA report on Health and Safety Sep16 (Reasonable Rating)	3rd								

Strategic Objective:	1 - Deliver the Annual Plan 2019/20 by the end of March 2020 6 - Deliver year 1 of Board approved strategies (Health and Well-Being, Continuous Engagement and Quality Improvement) by the end of March 2020

Executive Director Owner:	Rayani, Mandy	**Date of Review:**	07/05/2019
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	07/07/2019

Risk ID:	**650**	**Principal Risk Description:**	There is a risk of Board not receiving early intelligence and escalation of adverse/poor quality and safety (Q&S) standards within the organisation. This is caused by current Q&S arrangements not being fully embedded within operational and committee structures. This could lead to an impact/affect on the UHB's ability to respond quickly and appropriately to improve Q&S standards within organisation, adverse publicity/reduction in stakeholder confidence, and increased scrutiny/escalation from WG.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	4×3=12
Current Risk Score (L x I):	3×3=9
Target Risk Score (L x I):	1×2=2
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:
Systems in place however not sufficiently mature or fully embedded within organisation to provide the level of assurance that Board requires that they are effective in reducing risks to clinical care and safety and issues are being escalated early and managed appropriately.

Rationale for TARGET Risk Score:
Whilst the Sub-Committee within the QSEAC committee structure have been reviewed, further work to review the role, responsibly and reporting lines of the groups within QSEAC Committee structure needs to be undertaken.

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**
Review of QSEAC Sub-Committee Structure undertaken. Nurse staffing levels reports. Quality metrics in place including Fundamentals of Care, Incident reporting, and concerns, etc. Quality & Safety Dashboard reviewed by QSEAC and assurance reports provided at each QSEAC.	Lack of confidence re early escalation of Q&S issues. Lack of capacity to analyse/triangulate Q&S data effectively.	Review the QSE Groups under QSEAC committee structure.	Rayani, Mandy	Completed	Initial Review Completed. It is recognised that on-going evaluation of the local Quality Groups is required. This will be undertaken during Q1 of the new financial year with the support of the Director of Therapies and Health Sciences.
		Development of a decision and action tracker across the QSEAC Sub-Committee Structure.	Gittins, Alison	Completed	Sub-Committee Decision Tracker in place and reported as a standing agenda item to QSEAC from 16 Oct 18.
		Implementation of the QSEAC Development Plan.	Rayani, Mandy	~~31/03/2019~~ 30/09/2019	It was agreed at QSEAC that the actions currently being implemented would be reviewed in Sep19 to allow time for the improvements implemented to become embedded.

Raising awareness of Quality across operational services through visibility of corporate nursing team at operational meetings and ensure this is incorporated within the Leadership Improvement Programme.	Passey, Sian	Completed	All Operational Governance Meetings are attended by a member of the ASI Team. A senior member of the ASI team attending the Managers Passport Plus training to deliver key training to all band 7+ leaders. There was a patient safety awareness day wc 11Mar19
Develop skill set in the Assurance, Safety and Improvement (ASI) Team.	Passey, Sian	Completed	Training provided on Root Cause Analysis for team members by Welsh Risk Pool and Delivery Unit.
Scope future needs to develop analyst capabilities to produce intelligence from Q&S information.	Passey, Sian	~~31/03/2019~~ 31/12/2019	A draft JD has been developed and is being considered by the quality directorate. This will be considered further when the new Head of Quality & Safety commences in Apr19.
Implementation the Quality Improvement Strategic Framework.	Davies, Mandy	Completed	QISF was launched on 21Mar19. Delivery of QISF monitored by Collaborative Steering Group.

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**		
Incident reports Q&S Dashboard	Q&S metrics reported through IPAR to BPPAC	2nd			
	Monthly meetings with WG Q&S Unit	2nd			
	Q&S Dashboard and Sub-committee reports to QSEAC (QSEAC report to Board)	2nd			
	HIW Reports indicate areas of improvement of Q&S	3rd			
	WAO Structured Assessment 2018 - focus on Q&S governance	3rd			

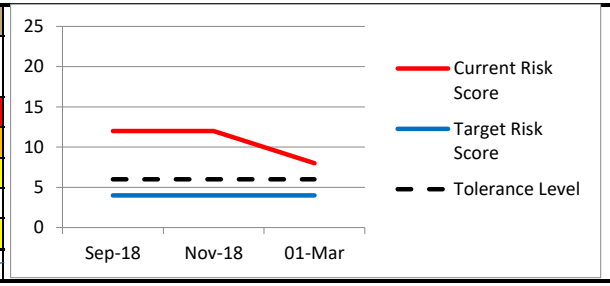
Gaps in ASSURANCES				
Identified Gaps in Assurance:	**How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**

Strategic Objective:	1 - Deliver the Annual Plan 2019/20 by the end of March 2020 6 - Deliver year 1 of Board approved strategies (Health and Well-Being, Continuous Engagement and Quality Improvement) by the end of March 2020

Executive Director Owner:	Rayani, Mandy	**Date of Review:**	21/03/2019
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	21/05/2019

Risk ID:	**648**	**Principal Risk Description:**	There is a risk of the UHB not delivering improved outcomes and overall experience of care for patients. This is caused by a lack of resources within the Quality Improvement Team to fully implement its Quality Improvement Strategic Framework (QISF). This could lead to an impact/affect on the UHB's ability to reduce major causes of harm, variation and waste, and deliver a value-based healthcare model to support its service transformation agenda.
Does this risk link to any Directorate (operational) risks?			

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



Rationale for CURRENT Risk Score:
The risk score has been further reduced to 8 as funding has been made available to fund the first collaborative cohort from Jun19. The QISF was launched on 21Mar19. The framework and collaborative approach to be implemented with adequate resources from quality improvement expertise within the health board and engagement from operational teams and frontline staff to achieve measurable improvements.

Rationale for TARGET Risk Score:
Delivery of the QISF is dependent on having adequate resources in place to support its implementation.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)
Small scale quality improvement activity taking place across the organisation. Quality Improvement Strategic Framework (QISF) & implementation plan developed. Launch of QISF in Mar19. Funding for first collaborative cohort has been agreed. Network of coaches identified from within and outside of organisation. Full support from 1000 Lives and the Director of Quality and Safety NHS Wales.

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**
Human resources to deliver QISF. Full engagement with the QISF from operational services. No Associate Medical Director for Quality and Safety in place.	Identify funding to deliver QISF.	Rayani, Mandy	Completed	Completed.
	Establish steering group to drive the implementation of QISF and ensure implementation plan is delivered within agreed timescales.	Rayani, Mandy	Completed	QI steering group has been established and an inaugural meeting has been held. Self assessment of readiness being undertaken to inform launch and roll out. The Steering Group will monitor implementation of the collaborative programme
	Identification of quality leads for each site.	Rayani, Mandy	Completed	This still requires further discussion with the Director of Operations as part of the considerations regarding capacity building within Triumvirate teams.

Collaborative Steering Group established and meets monthly to monitor delivery of implementation plan.	Identify human resources from the organisation to support the implementation of the QISF.	Rayani, Mandy	30/06/2019	The QISF was launched on 21Mar19. Coaches identified however project and administration support required to deliver programme.
	Implementation of QISF plan and the collaborative training programme.	Davies, Mandy	31/03/2020	Collaborative programme will start in Jun19. Delivery of QISF monitored by Collaborative Steering Group.

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**
	Collaborative Steering Group established to monitor delivery of QISF Implementation Plan	2nd			N/A	Oversight of outcome delivery following implementation of QISF. Need to establish process operational team prioritisation of Quality Goals and identification of Collaborative teams.	Reporting of achievement of project plan milestones to QISF Steering Group (when established).	Rayani, Mandy	Completed	The Steering Group been established to monitor implementation of the collaborative programme.
							Reporting of outcomes will be undertaken by QSEAC.	Rayani, Mandy	~~31/12/2018~~ 31/12/19	This will require further development during 2019/20.
							Collaborative Steering group to be established.	Rayani, Mandy	Completed	QI steering group has been established and an inaugural meeting has been held. Self assessment of readiness being undertaken to inform launch and roll out. The Steering Group will monitor implementation of the collaborative programme.

Guidance Document 01/10/2011 Produced by the Medical Imaging Sub Committee Information about the Committee is available here	GIG CYMRU NHS WALES Pwyllgor Ymgynghorol Gwyddonol Cymru Welsh Scientific Advisory Committee

Welsh Reporting Standards For Radiology Services

Introduction

There is currently a wealth of standards, guidance, regulations and advice specifically directed at the imaging community in the United Kingdom from various bodies including royal and other colleges, national imaging boards, the General Medical Council, Ionising Radiation Medical Exposure Regulations and National Patient Safety Agency (appendix).

These set many standards for the reporting of radiological examinations which endorse the underlying ethos of good practice, with a service delivered in a timely, appropriate and safe manner to patients.

Commissioners of patient services and patients alike need consistent assurance that these standards are implemented across the Health Boards and that an ongoing meaningful monitoring process is operational to assess compliance with these standards.

In the past few years there has been an increasing stepwise demand for radiological services to be delivered in a more intense and responsive form leading to performance pressures within radiology directorates. This has been compounded further by difficulties in filling the expansion of consultant vacancies (a direct result of job planning exercises) in many hospitals leading to chronic understaffing and challenging work force issues.

These two factors principally have resulted in an inability to achieve all of the standards previously set with the potential for backlogs of unreported investigations. This is clearly an undesirable situation, and imaging clinicians must act to minimise harm to patients. There must be mandatory review of reporting performance in line with their Health Boards' and radiology directorates' clinical governance structures on an ongoing basis and outstanding issues must be promptly redressed.

This brief document - Welsh Reporting Standards – does not set out to formulate new standards but crystallise the standards and guidance previously set (1,2,6,8).

These standards are challenging but achievable. It is recognised that there may be need for additional resources in directorates which experience difficulty in meeting and maintaining these standards. Any shortcomings will

be recognised through regular audit and these will need to be addressed by the directorates managerial and governance structures.

The standards will:

provide a measure of how well and timely we should deliver patient care
also take into account the undeniable workforce difficulties faced by most Health Boards and radiology directorates

Standards

Standard 1. All imaging investigations must be reported. Reporters must be suitably qualified, authorised and experienced individuals.

reports may be issued by a range of professionals e.g. radiologist, radiographer, sonographer, medical physicist, cardiologist or dentist reporting within a radiology service.
automated or computer generated reports can be issued for certain specific mutually agreed investigations e.g. post manipulation fractures, dental imaging, specified serial CXR from ITU, trauma and orthopaedic outpatient serial imaging, and serial KUB's for stone size and position. A formal report will be provided if requested by any clinician and will replace the automated report.
automated reports will contain a suitably agreed text and format
in particular times of workforce shortage some specified A&E images e.g. extremities have an automated report with an option for a formal report if required (clinical risk management issue)
all "special" procedures must be reported – some automated reports may be suitable for screening procedures e.g. orthopaedic or spinal theatre cases. These must be mutually and formally agreed between radiology and relevant directorates and formal radiological reports will be provided on request.
any clinicians evaluating and reporting their own images eg orthopaedic surgeon must document their evaluation and opinion and formal reports in the patient's notes. These arrangements must be formally agreed with the radiology and directorates concerned.
governance arrangements & IR(ME)R- must be agreed, upheld and monitored.

Standard 2. All reports must be validated by the author of the report.

in exceptional circumstances a report can be validated by proxy by another approved reporter. The content of the report is the responsibility of the author of the report.

Standard 3. All imaging investigations must be accompanied by a formal documented report.

The report forms a permanent record of the interpretation of the imaging investigation and will be used as a basis for management decisions. The report is best displayed alongside the relevant image on a picture and archiving communications system (PACS) but should also be accessed via a radiology information system.

Standard 4. Where imaging interpretation and/or evaluation of radiology images is undertaken by medically qualified, nursing and other practitioners (non-radiologist) there must be formal clinical governance arrangements within health boards with joint agreements between clinical directors, chiefs of staff of radiology and the relevant directorates.

any radiological examination requiring ionizing radiation is subject to the IR(ME)R 2000 regulations. In Wales IR(MER) is enforced by Health Inspectorate Wales

all examinations must be justified, evaluated and reported.

clinicians evaluating images must be suitably trained in the correct interpretation of the examination particularly when management decisions are made prior to the receipt of a radiological or formal report.

clinicians evaluating images should do this in acceptable viewing conditions within an acceptable working environment.

clinicians evaluating images must document an opinion of their evaluation in the patient's notes.

all practitioners who interpret and/or evaluate imaging investigations must identify their name, job title and profession when making a written record of that imaging investigation (IR(ME)R 2000).

a radiologist opinion must always be available to the appropriate clinician to aid in a management decision prior to a formal report being obtained.

Standard 5. All imaging investigations must be reported in a timely manner that is appropriate to the patients' needs and clinical situations.

Imaging services should aim to provide reporting turnaround times as follows (from examination to report being available to the referrer):

urgent	immediately/same working day
inpatient	within 1 working day
A&E	within 1 working day
GP	within 3 working days
outpatients	within 10 working days

Standard 6. All outsourced imaging investigations are subject to the same scrutiny and conditions as in house reporting.

radiologists must be suitably trained, accredited and registered with the GMC or similar regulatory body.

clinical governance arrangements must be in place and transparent

patients should be informed that their imaging was reported by an outsourced body if this lies outside the U.K.

Standard 7. Audit should be conducted at least monthly on unreported images and any backlogs dealt with promptly.

no investigation is to be unreported after one calendar month
audit results to be managed by clinical director of radiology

Clinical governance arrangements

IR(ME)R regulations (ref 3) enforced by HIW.
robust and formal agreements between radiology and other directorates for delegation of reporting and evaluation of images by non radiologists.

- adequate training requirements
- documentation of opinion in notes
- identification of individual evaluating the image

robust arrangements in place when automated reports are used.

- agreed text and format of report

a formal report will be provided on request (by a relevant clinician) at any time and will replace automated reports and/or evaluated images
unvalidated reports are regarded as unreported investigations.
outsourcing is strictly regulated and monitored- patients should be assured of a consistently good service irrespective of where it is provided
continuous audit is carried out on the departments' performance. A 90% standard is acceptable.
radiographer A&E and plain film reporting and sonographer reporting

- delivered by a team of trained and accredited radiographers and sonographer
- regular meetings held and any discrepancies and "good spots" are fed back
- there is regular audit with consultant review of a random selection of examinations.
- regular teaching and learning opportunities for CME
- opportunities for reflective practice
- MDT practice encouraged

Appendix

1. **The Royal College of Radiologists. *Standards for the Reporting and Interpretation of Imaging Investigations.* London: The Royal College of Radiologists, 2006.**
   http://www.rcr.ac.uk/docs/radiology/pdf/StandardsforReportingandInetrpwebvers.pdf

2. **The Royal College of Radiologists. *Medical image interpretation by radiographers: Guidance for radiologists and healthcare providers*. London: The Royal College of Radiologists, 2010.**
   http://www.rcr.ac.uk/docs/radiology/pdf/BFCR(10)3_Medical_interpretation.pdf

3. ***The Ionising Radiation (Medical Exposure) Regulations 2000*.**
   http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_064707.pdf

4. **General Medical Council. *Regulating Doctors, Ensuring Good Medical Practice.***
   http://www.gmc-uk.org/doctors/medical_register.asp

5. **The Royal College of Radiologists. *Standards for the provision of teleradiology within the United Kingdom*. London: The Royal College of Radiologists, 2010.**
   http://www.rcr.ac.uk/docs/radiology/pdf/BFCR(10)7_Stand_telerad.pdf

6. **National Imaging Board. *Radiology Reporting Times: Best Practice Guidance*. London: NIB, 2008.**
   http://www.improvement.nhs.uk/documents/radiology_reporting_times_best_practice_guidance.pdf

7. **New guidance on report turnaround times from National Imaging Board**
   http://www.rcr.ac.uk/content.aspx?PageID=1561

8. **National Patient Safety Agency. Early identification of failure to act on a radiological reporting system. London: NPSA, 2007.**
   http://www.nrls.npsa.nhs.uk/resources/?entryid45=59817

9. **The Royal College of Radiologists. *Clinical Radiology UK Workforce Census 2009: Executive summary.* London: The Royal College of Radiologists, 2010.**
   http://www.rcr.ac.uk/docs/radiology/pdf/BFCR(10)20_census_2009.pdf

10. **Centre for Workforce Intelligence: *Medical Specialty Workforce Factsheet. Clinical Radiology.* London: CfWI, 2010.**
    http://www.cfwi.org.uk/intelligence/cfwi-medical-factsheets/recommendation-for-clinical-radiology-training-2011

Radiology Activity Data Review

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Background

As per the approved Clinical Services Plan methodology, high level activity between May 2019 and 31st July 2023 has been included for Radiology Services at Withybush Hospital, Glangwili Hospital, Prince Philip Hospital, Bronglais Hospital, Tenby Hospital, Llandovery Hospital, Cardigan Integrated Care Centre and South Pembrokeshire Hospital.

There is also data present for several other locations across the Health Board, and where relevant, any Outsourced locations.

The date period for this activity data deviates from the methodology of an August 18 period start due to the implementation of a new IT system within the Radiology Service in May 2019 to consolidate multiple historic databases and the inability to collate this historic data into one usable data set.

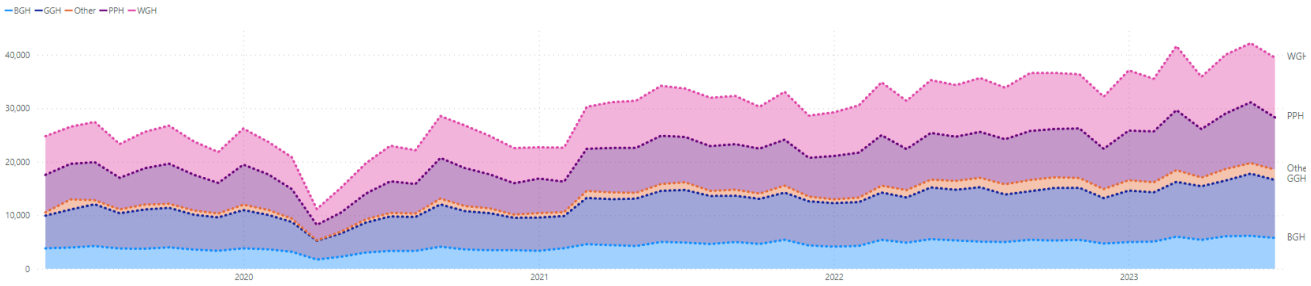
This data is accurate as of Quarter 3 2023/24.

Service Changes

There have been no service changes for Radiology within the review period and so the data set has been presented as a whole.

Radiology Activity Data

All site activity (May 2019– 31st July 2023)



Location_Performed	May-19	Jun-19	Jul-19
AMMAN VALLEY HOSPITAL	2	0	2
BRONGLAIS GENERAL HOSPITAL	3,819	3,972	4,250
CARDIGAN & DIST MEMORIAL	101	151	141
CARDIGAN INTEGRATED CARE CENRE	0	0	0
GLANGWILI GENERAL HOSPITAL	6,104	7,089	7,805
HDUHB	0	1,171	6
HDUHB ACTIVITY OUTSIDE THE HB	0	0	0
LLANDOVERY HOSPITAL	35	104	82
MACHYNLLETH HOSPITAL	28	59	56
MYNYDD MAWR HOSPITAL	0	0	0
NEWTOWN HOSPITAL	0	0	0
PRINCE PHILIP HOSPITAL	7,001	6,652	7,100
SOUTH PEMBS HOSPITAL	37	36	19
ST JOSEPH'S IH HOSPITAL	0	0	0
TENBY HOSPITAL	384	364	456
UNKNOWN	16	0	0
WERNDALE BMI HOSPITAL	0	0	0
WITHYBUSH HOSPITAL	7,218	6,924	7,512
Total	**24,745**	**26,522**	**27,429**

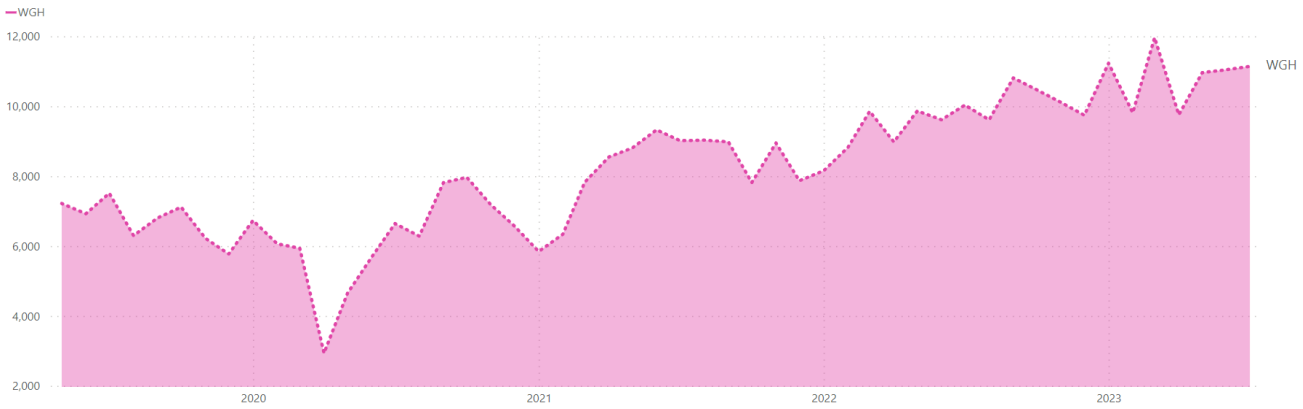
Location_Performed	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
AMMAN VALLEY HOSPITAL	13	0	3	0	5	0	0	0	0	0	0	0
BRONGLAIS GENERAL HOSPITAL	3,774	3,753	3,997	3,582	3,368	3,824	3,635	3,184	1,716	2,259	3,043	3,346
CARDIGAN & DIST MEMORIAL	164	125	117	256	11	5	0	1	0	0	0	0
CARDIGAN INTEGRATED CARE CENRE	0	0	0	17	230	421	313	273	68	228	308	343
GLANGWILI GENERAL HOSPITAL	6,598	7,322	7,401	6,513	6,230	7,144	6,412	5,562	3,508	4,357	5,611	6,447
HDUHB	0	2	1	13	3	0	0	0	0	1	0	0
HDUHB ACTIVITY OUTSIDE THE HB	0	0	0	0	0	0	0	0	0	0	0	0
LLANDOVERY HOSPITAL	58	85	77	70	41	77	78	41	0	0	0	0
MACHYNLLETH HOSPITAL	41	46	66	49	27	40	30	22	0	0	0	16
MYNYDD MAWR HOSPITAL	1	0	0	0	0	0	0	1	0	0	0	0
NEWTOWN HOSPITAL	0	0	0	0	0	0	0	1	0	0	0	0
PRINCE PHILIP HOSPITAL	5,897	6,781	7,479	6,655	5,705	7,476	6,622	5,513	2,881	3,568	4,801	5,907
SOUTH PEMBS HOSPITAL	40	38	40	46	58	59	43	22	0	3	0	0
ST JOSEPH'S IH HOSPITAL	0	0	0	0	0	0	0	0	0	0	0	0
TENBY HOSPITAL	376	401	389	339	346	388	404	223	5	94	283	272
UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0
WERNDALE BMI HOSPITAL	21	211	51	9	6	0	69	37	7	4	15	11
WITHYBUSH HOSPITAL	6,299	6,807	7,114	6,224	5,774	6,732	6,063	5,936	2,938	4,646	5,681	6,643
Total	**23,282**	**25,571**	**26,735**	**23,773**	**21,804**	**26,166**	**23,669**	**20,816**	**11,123**	**15,160**	**19,742**	**22,985**

Location_Performed	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
AMMAN VALLEY HOSPITAL	0	12	15	31	0	1	0	8	0	0	0	0
BRONGLAIS GENERAL HOSPITAL	3,342	4,134	3,616	3,464	3,482	3,349	3,848	4,583	4,415	4,246	5,030	4,898
CARDIGAN & DIST MEMORIAL	0	0	0	0	0	0	0	0	0	0	1	0
CARDIGAN INTEGRATED CARE CENRE	331	407	429	338	244	277	307	645	622	392	526	565
GLANGWILI GENERAL HOSPITAL	6,327	7,893	7,152	6,925	6,021	6,158	6,016	8,596	8,551	8,858	9,526	9,827
HDUHB	0	0	0	0	0	0	0	0	1	0	0	0
HDUHB ACTIVITY OUTSIDE THE HB	0	0	0	0	0	0	0	0	0	0	0	0
LLANDOVERY HOSPITAL	9	47	63	70	5	76	36	3	51	142	157	131
MACHYNLLETH HOSPITAL	57	84	54	82	47	64	65	76	44	77	117	106
MYNYDD MAWR HOSPITAL	0	0	0	0	0	0	0	0	0	0	0	0
NEWTOWN HOSPITAL	0	0	0	0	0	0	0	0	0	0	0	0
PRINCE PHILIP HOSPITAL	5,492	7,597	7,087	6,366	5,847	6,442	5,688	7,863	8,294	8,375	9,003	8,458
SOUTH PEMBS HOSPITAL	0	16	12	0	10	7	8	25	19	7	10	0
ST JOSEPH'S IH HOSPITAL	0	0	0	0	0	0	0	0	0	0	0	0
TENBY HOSPITAL	243	476	372	363	298	398	308	532	537	470	471	627
UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0
WERNDALE BMI HOSPITAL	19	40	3	2	0	0	0	0	0	0	0	0
WITHYBUSH HOSPITAL	6,283	7,814	7,966	7,174	6,571	5,844	6,339	7,826	8,548	8,807	9,324	9,016
Total	**22,103**	**28,520**	**26,769**	**24,815**	**22,525**	**22,616**	**22,615**	**30,157**	**31,082**	**31,374**	**34,165**	**33,628**

Location_Performed	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
AMMAN VALLEY HOSPITAL	0	0	0	0	0	0	0	0	0	0	0	0
BRONGLAIS GENERAL HOSPITAL	4,636	5,015	4,636	5,431	4,357	4,130	4,284	5,403	4,879	5,540	5,301	5,066
CARDIGAN & DIST MEMORIAL	1	0	0	0	0	0	0	0	0	0	0	0
CARDIGAN INTEGRATED CARE CENRE	467	488	417	586	381	477	651	982	820	976	833	854
GLANGWILI GENERAL HOSPITAL	8,958	8,600	8,419	8,794	8,257	8,124	8,170	8,834	8,432	9,649	9,451	10,176
HDUHB	0	1	0	0	0	0	0	0	0	0	0	0
HDUHB ACTIVITY OUTSIDE THE HB	0	0	0	0	0	0	0	0	0	0	0	0
LLANDOVERY HOSPITAL	113	145	108	98	130	59	84	156	134	102	162	91
MACHYNLLETH HOSPITAL	68	65	58	128	67	71	62	109	72	76	52	53
MYNYDD MAWR HOSPITAL	0	0	1	1	1	0	0	1	0	1	0	0
NEWTOWN HOSPITAL	0	0	0	0	0	0	0	0	0	0	0	0
PRINCE PHILIP HOSPITAL	8,337	8,508	8,386	8,564	7,222	8,082	8,394	9,433	7,653	8,719	8,220	8,568
SOUTH PEMBS HOSPITAL	0	26	11	23	10	2	0	0	0	0	0	0
ST JOSEPH'S IH HOSPITAL	0	0	0	17	0	29	39	19	0	0	21	5
TENBY HOSPITAL	305	399	388	450	296	79	0	4	353	299	580	752
UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0
WERNDALE BMI HOSPITAL	1	0	1	3	0	0	0	0	0	0	0	0
WITHYBUSH HOSPITAL	9,029	8,981	7,817	8,947	7,868	8,153	8,817	9,855	8,979	9,865	9,613	10,034
Total	**31,915**	**32,228**	**30,242**	**33,042**	**28,589**	**29,206**	**30,501**	**34,796**	**31,322**	**35,227**	**34,233**	**35,599**

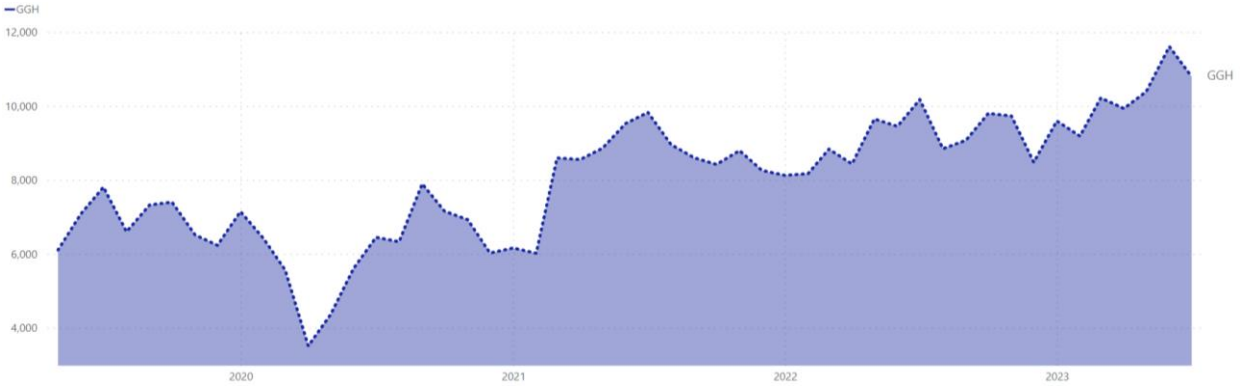
Location_Performed	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Total
AMMAN VALLEY HOSPITAL	0	0	0	0	0	0	0	0	0	0	0	0	**92**
BRONGLAIS GENERAL HOSPITAL	5,012	5,419	5,279	5,405	4,703	4,982	5,077	5,988	5,371	6,059	6,144	5,752	**223,798**
CARDIGAN & DIST MEMORIAL	0	0	0	0	0	0	0	0	0	0	0	0	**1,074**
CARDIGAN INTEGRATED CARE CENRI	743	973	939	808	803	840	851	966	742	1,018	802	1,019	**25,720**
GLANGWILI GENERAL HOSPITAL	8,845	9,072	9,802	9,731	8,479	9,596	9,186	10,219	9,932	10,392	11,609	10,794	**409,474**
HDUHB	0	0	0	0	0	0	0	0	0	0	1	1	**1,201**
HDUHB ACTIVITY OUTSIDE THE HB	0	0	0	0	0	0	0	0	0	0	0	0	**0**
LLANDOVERY HOSPITAL	137	142	152	88	90	117	151	83	73	83	90	74	**4,200**
MACHYNLLETH HOSPITAL	86	58	54	71	45	48	131	106	105	92	71	54	**3,155**
MYNYDD MAWR HOSPITAL	0	0	0	0	0	0	0	0	0	0	0	0	**7**
NEWTOWN HOSPITAL	0	0	0	0	0	0	1	1	0	1	0	0	**4**
PRINCE PHILIP HOSPITAL	8,416	9,145	9,015	9,211	7,493	9,220	9,464	11,191	9,013	10,355	11,315	9,708	**390,182**
SOUTH PEMBS HOSPITAL	0	0	0	0	0	0	0	0	0	0	0	0	**627**
ST JOSEPH'S IH HOSPITAL	0	0	0	0	0	0	0	0	0	0	0	0	**130**
TENBY HOSPITAL	920	924	856	867	751	926	738	1,031	707	949	1,011	785	**24,189**
UNKNOWN	0	0	0	1	1	0	1	3	3	3	3	4	**35**
WERNDALE BMI HOSPITAL	0	0	0	0	0	0	0	0	0	0	0	0	**510**
WITHYBUSH HOSPITAL	9,612	10,810	10,470	10,110	9,742	11,231	9,813	11,963	9,755	10,961	11,045	11,139	**418,632**
Total	**33,771**	**36,543**	**36,567**	**36,292**	**32,107**	**36,960**	**35,413**	**41,551**	**35,701**	**39,913**	**42,091**	**39,330**	**1,503,030**

Withybush Hospital by Month (to 31st July 2023)



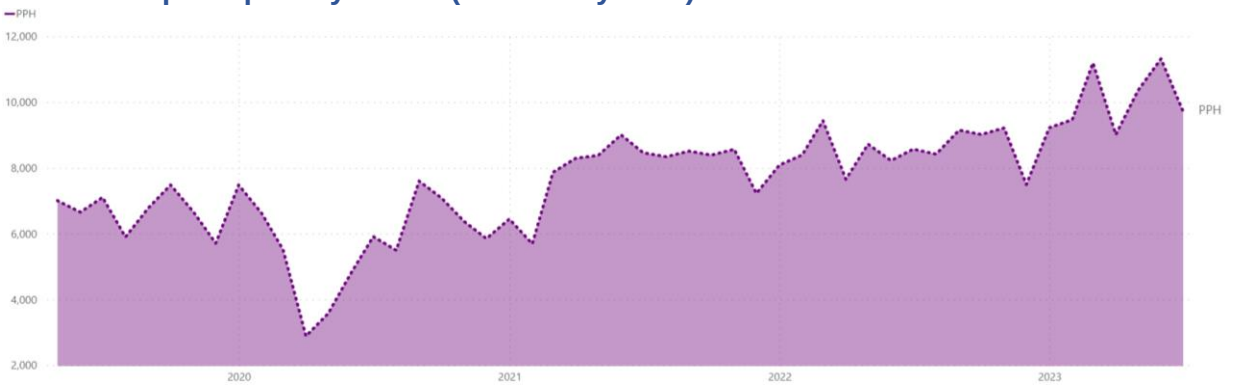
				May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	2019
				7218	6924	7512	6299	6807	7114	6224	5774	53872
Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	2020
6732	6063	5936	2938	4646	5681	6643	6283	7814	7966	7174	6571	74447
Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	2021
5844	6339	7826	8548	8807	9324	9016	9029	8981	7817	8947	7868	98346
Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	2022
8153	8817	9855	8979	9865	9613	10034	9612	10810	10470	10110	9742	116060
Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23						2023
11231	9813	11963	9755	10961	11045	11139						75907
												418632

Glangwili General Hospital by Month (to 31st July 2023)



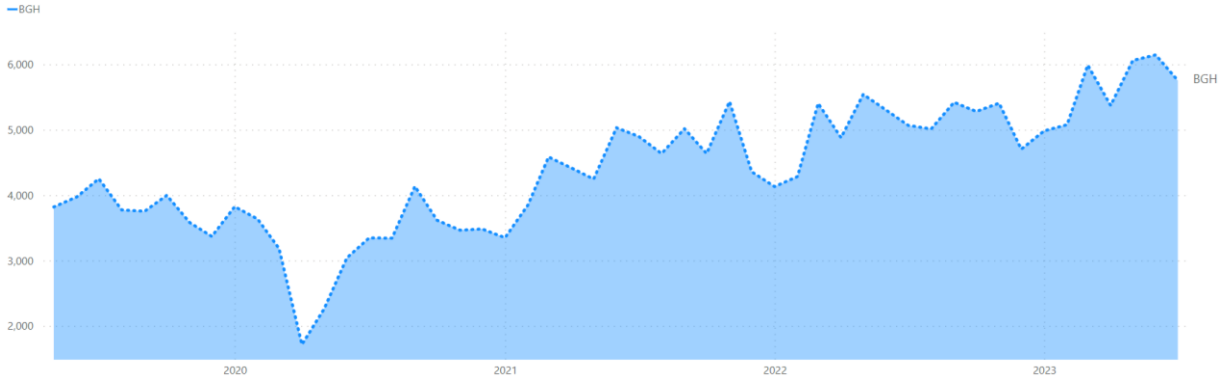
				May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	2019
				6104	7089	7805	6598	7322	7401	6513	6230	55062
Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	2020
7144	6412	5562	3508	4357	5611	6447	6327	7893	7152	6925	6021	73359
Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	2021
6158	6016	8596	8551	8858	9526	9827	8958	8600	8419	8794	8257	100560
Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	2022
8124	8170	8834	8432	9649	9451	10176	8845	9072	9802	9731	8479	108765
Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23						2023
9596	9186	10219	9932	10392	11609	10794						71728
												409474

Prince Philip Hospital by Month (to 31st July 2023)



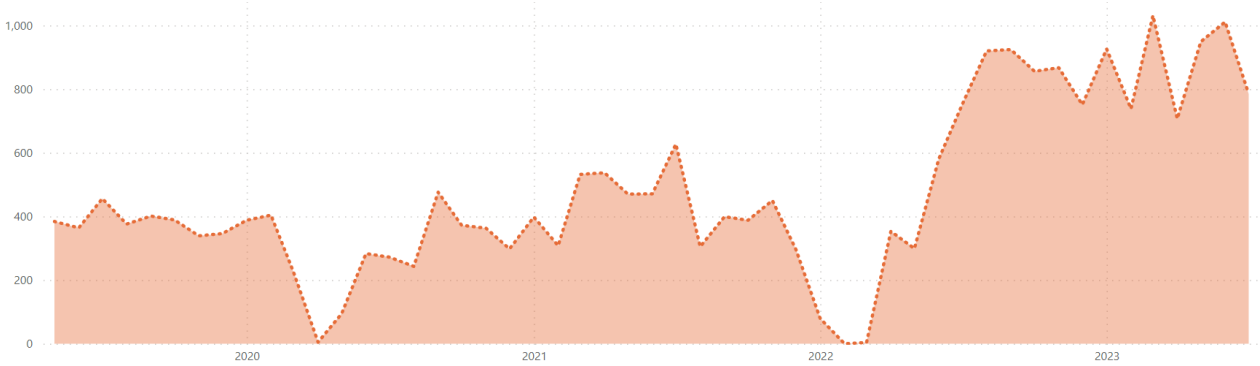
				May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	2019
				7001	6652	7100	5897	6781	7479	6655	5705	53270
Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	2020
7476	6622	5513	2881	3568	4801	5907	5492	7597	7087	6366	5847	69157
Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	2021
6442	5688	7863	8294	8375	9003	8458	8337	8508	8386	8564	7222	95140
Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	2022
8082	8394	9433	7653	8719	8220	8568	8416	9145	9015	9211	7493	102349
Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23						2023
9220	9464	11191	9013	10355	11315	9708						70266
												390182

Bronglais General Hospital by Month (to 31st July 2023)



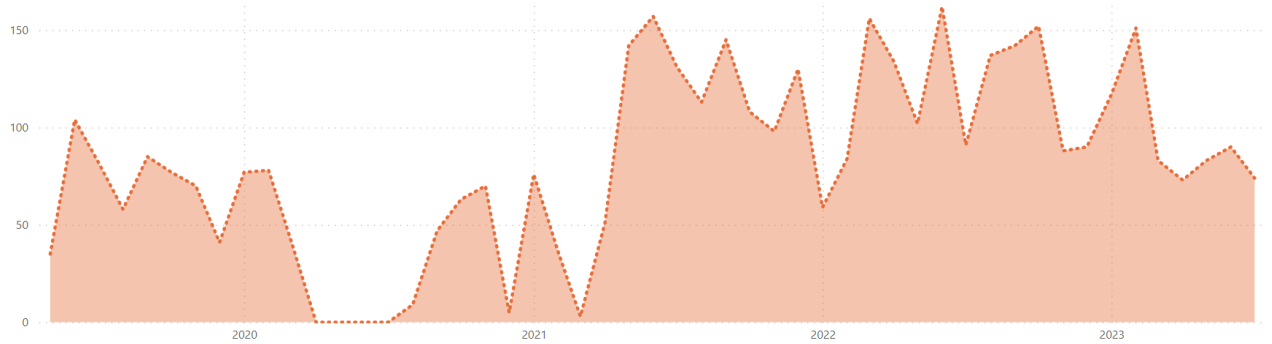
				May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	2019
				3819	3972	4250	3774	3753	3997	3582	3368	30515
Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	2020
3824	3635	3184	1716	2259	3043	3346	3342	4134	3616	3464	3482	39045
Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	2021
3349	3848	4583	4415	4246	5030	4898	4636	5015	4636	5431	4357	54444
Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	2022
4130	4284	5403	4879	5540	5301	5066	5012	5419	5279	5405	4703	60421
Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23						2023
4982	5077	5988	5371	6059	6144	5752						39373
												223798

Tenby Hospital by Month (to 31st July 2023)



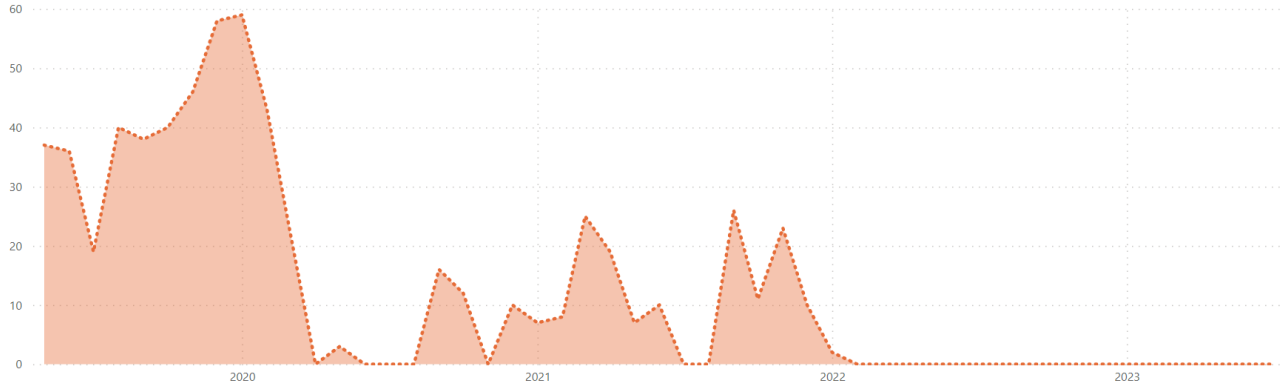
				May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	2019
				384	364	456	376	401	389	339	346	3055
Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	2020
388	404	223	5	94	283	272	243	476	372	363	298	3421
Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	2021
398	308	532	537	470	471	627	305	399	388	450	296	5181
Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	2022
79	0	4	353	299	580	752	920	924	856	867	751	6385
Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23						2023
926	738	1031	707	949	1011	785						6147
												24189

Llandovery Hospital by Month (to 31st July 2023)



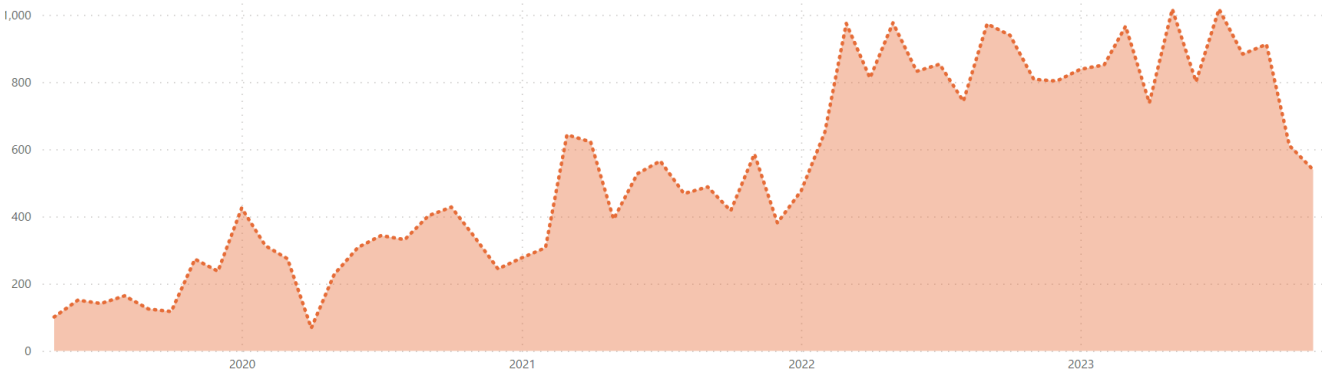
				May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	2019
				35	104	82	58	85	77	70	41	552
Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	2020
77	78	41	0	0	0	0	9	47	63	70	5	390
Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	2021
76	36	3	51	142	157	131	113	145	108	98	130	1190
Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	2022
59	84	156	134	102	162	91	137	142	152	88	90	1397
Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23						2023
117	151	83	73	83	90	74						671
												4200

South Pembrokeshire Hospital by Month (to 31st July 2023)



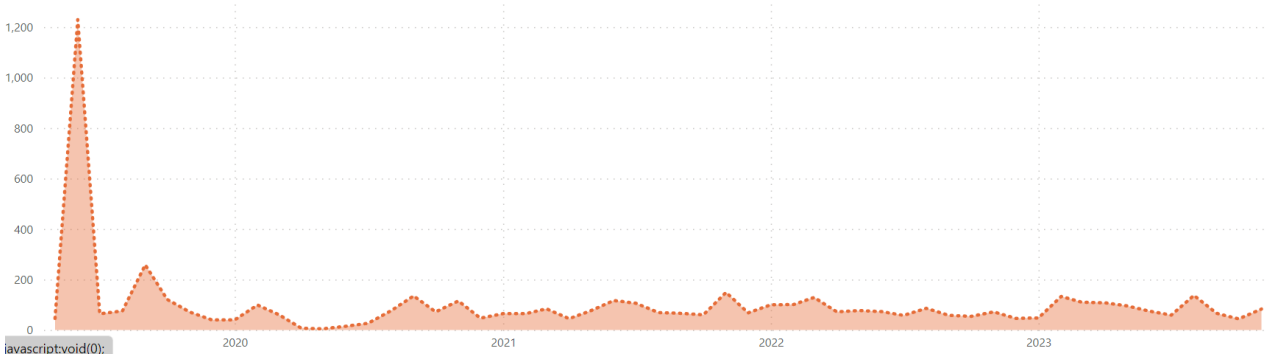
				May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	2019
				37	36	19	40	38	40	46	58	314
Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	2020
59	43	22	0	3	0	0	0	16	12	0	10	165
Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	2021
7	8	25	19	7	10	0	0	26	11	23	10	146
Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	2022
2	0	0	0	0	0	0	0	0	0	0	0	2
Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23						2023
0	0	0	0	0	0	0						0
												627

Cardigan and District Memorial and Cardigan Integrated Care Centre by Month (to 31st July 2023)



				May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	2019
				101	151	141	164	125	117	273	241	1313
Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	2020
426	313	274	68	228	308	343	331	407	429	338	244	3709
Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	2021
277	307	645	622	392	527	565	468	488	417	586	381	5675
Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	2022
477	651	982	820	976	833	854	743	973	939	808	803	9859
Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23						2023
840	851	966	742	1018	802	1019						6238
												26794

Other Sites (to 31st July 2023)



Location	2019	2020	2021	2022	2023	Grand Total
AMMAN VALLEY HOSPITAL	25	58	9	0	0	92
HDUHB	1196	1	2	0	2	1201
MACHYNLLETH HOSPITAL	372	432	935	809	607	3155
MYNYDD MAWR HOSPITAL	1	1	3	2	0	7
NEWTOWN HOSPITAL	0	1	0	0	3	4
ST JOSEPH'S IH HOSPITAL	0	0	17	113	0	130
UNKNOWN	16	0	0	2	17	35
WERNDALE BMI HOSPITAL	298	207	5	0	0	510
Grand Total	**1905**	**699**	**971**	**26**	**959**	**5460**

Radiology Incident Data Review

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By Severity/Level 8

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By Severity/Level 10

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By Type 11

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By Type 11

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By Type 16
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Assessment, Investigation, Diagnosis Type **(1st April 2021 – 31st July 2023)** ..... **Error! Bookmark not defined.**

Background

As per the approved Clinical Services Plan methodology, Incidents reported between 1st August 2018 and 31st July 2023 have been included for Radiology Services at Bronglais Hospital, Withybush Hospital, Glangwili Hospital, Prince Philip Hospital and Llandovery Hospital. Due to data formatting across the current Datix system and historical records, data has been visualised within two dashboards representing the implementation of the current system. Data tables and graphics reflect the dates of this change.

In April 2021, Datix Cymru, a Once for Wales Concerns Management System, was introduced. Hywel Dda UHB were the first Health Board in Wales to adopt the new system.

Prior to implementation of Datix Cymru work had been undertaken to develop a system which made reporting of incidents simpler and therefore this may account for the rise in incident reports seen in April 2021.

It is possible that the data shows a variation in the number of reported incidents attributable to Radiology when comparing the old system to the current. This relates to the system being able to distinguish between different specialties within the Service that may be related to other services within the previous system.

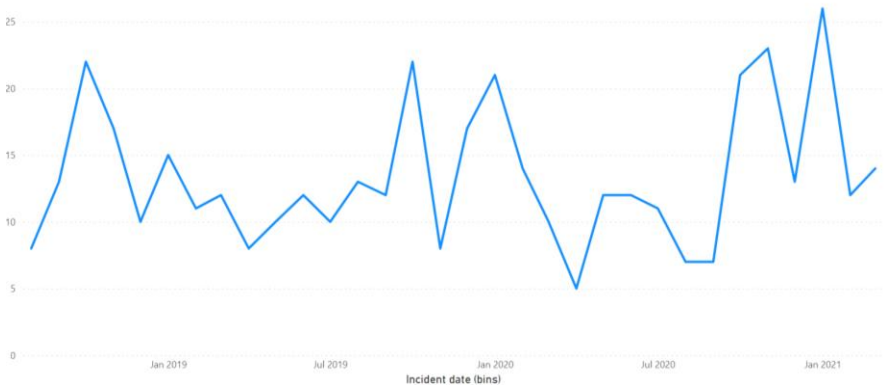
Due to gaps at the reporting stage of records, categorised totals may not equal the overall totals for the Service.

Service Changes

There have been no service changes for Radiology within the review period and so the data set has been presented as a whole.

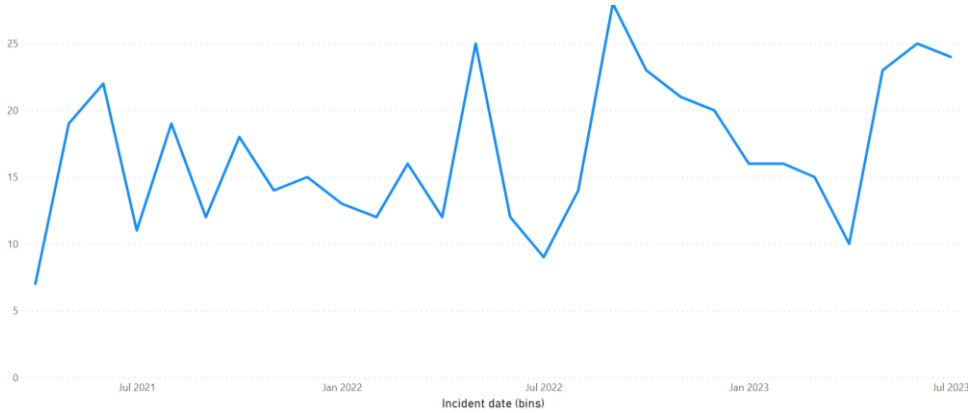
Incidents

All Sites (1st August 2018 – 31st March 2021)



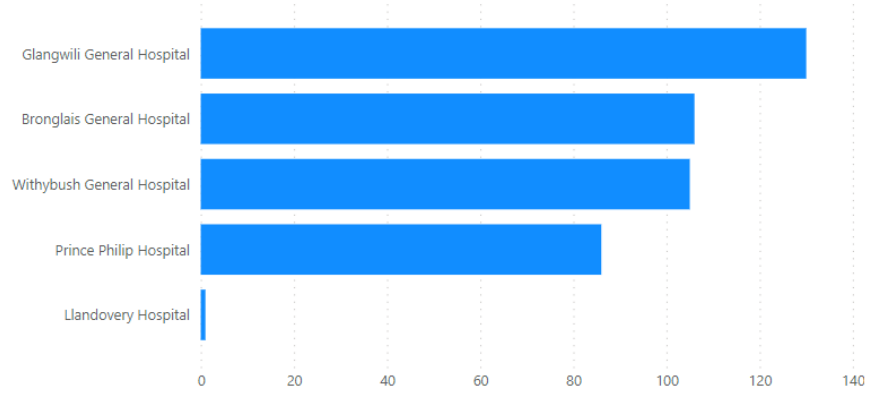
							Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	2018
							8	13	22	17	10	70
Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	2019
15	11	12	8	10	12	10	13	12	22	8	17	150
Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	2020
21	14	10	5	12	12	11	7	7	21	23	13	156
Jan 21	Feb 21	Mar 21										2021
26	12	14										52
												428

All Sites (1st April 2021 – 31st July 2023)



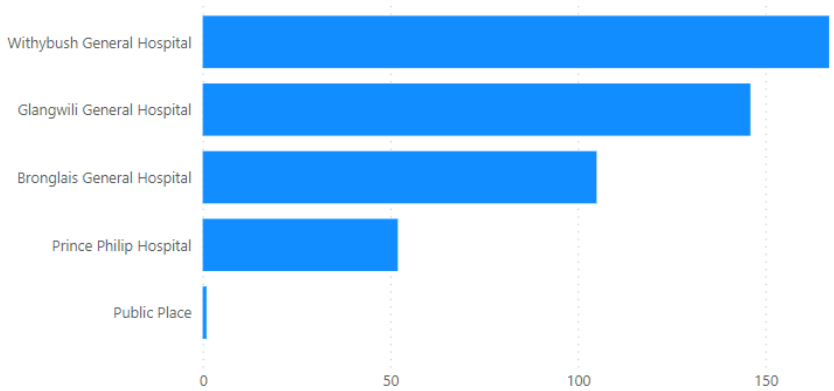
			Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	2021
			7	19	22	11	19	12	18	14	15	137
Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	2022
13	12	16	12	25	12	9	14	28	23	21	20	205
Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23						2023
16	16	15	10	23	25	24						129
												471

By Location (1st August 2018 – 31st March 2021)



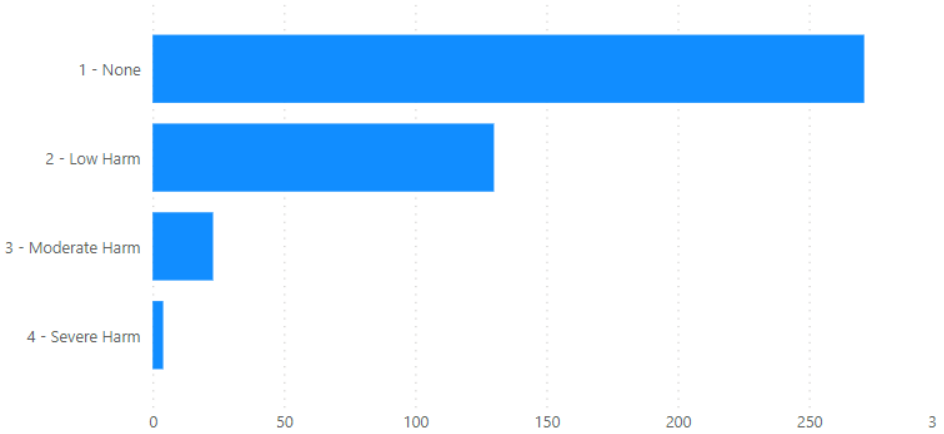
Primary Location	Count
Glangwili General Hospital	130
Bronglais General Hospital	106
Withybush General Hospital	105
Prince Philip Hospital	86
Llandovery Hospital	1

By Location (1st April 2021 – 31st July 2023)



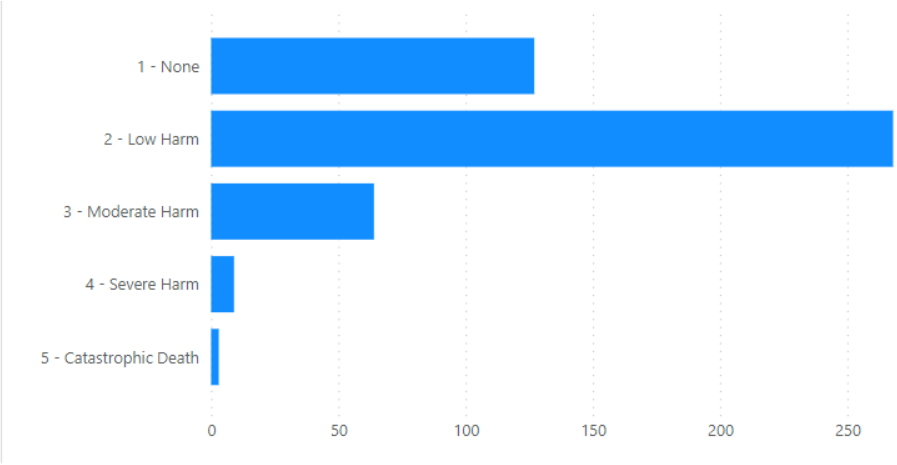
Primary Location	Count
Withybush General Hospital	167
Glangwili General Hospital	146
Bronglais General Hospital	105
Prince Philip Hospital	52
Public Place	1

By Severity/Level (1st August 2018 – 31st March 2021)



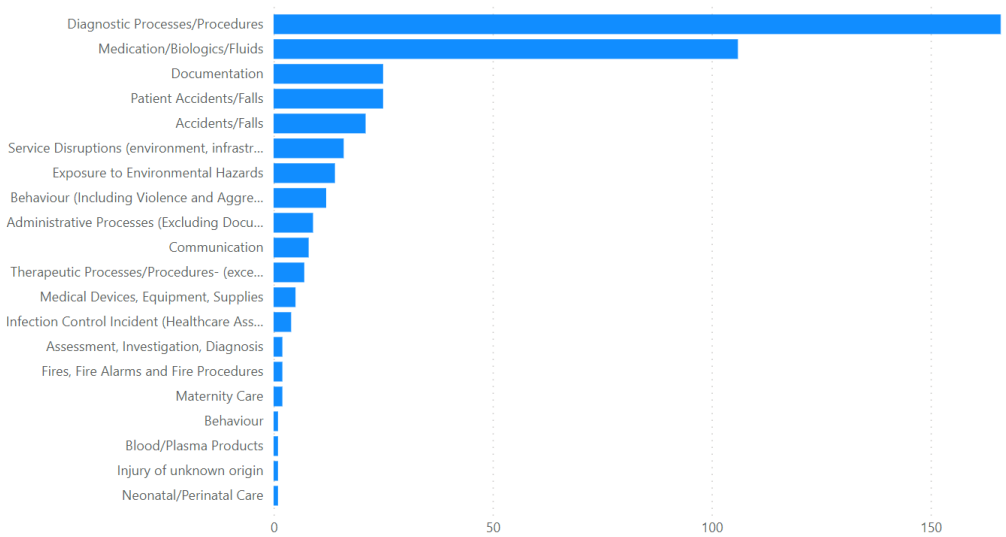
Severity	Count
1 - None	271
2 – Low Harm	130
3 – Moderate Harm	23
4 – Severe Harm	4
5 – Catastrophic Death	0

By Severity/Level (1st April 2021 – 31st July 2023)



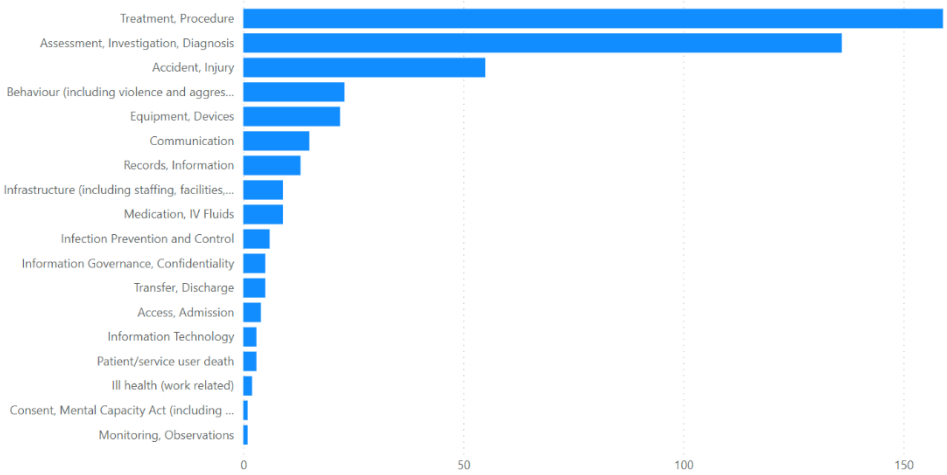
Severity	Count
1 - None	127
2 – Low Harm	268
3 – Moderate Harm	64
4 – Severe Harm	9
5 – Catastrophic Death	3

By Type (1st August 2018 – 31st March 2021)



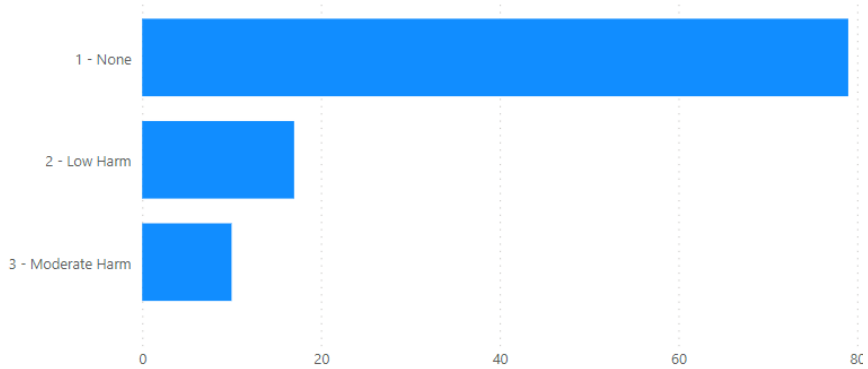
Incident type tier one	Count
Diagnostic Processes/Procedures	166
Medication/Biologics/Fluids	106
Documentation	25
Patient Accidents/Falls	25
Accidents/Falls	21
Service Disruptions (environment, infrastructure, human resources)	16
Exposure to Environmental Hazards	14
Behaviour (Including Violence and Aggression)	12
Administrative Processes (Excluding Documentation)	9
Communication	8
Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	7
Medical Devices, Equipment, Supplies	5
Infection Control Incident (Healthcare Associated Infection)	4
Assessment, Investigation, Diagnosis	2
Fires, Fire Alarms and Fire Procedures	2
Maternity Care	2
Behaviour	1
Blood/Plasma Products	1
Injury of unknown origin	1
Neonatal/Perinatal Care	1

By Type (1st April 2021 – 31st July 2023)



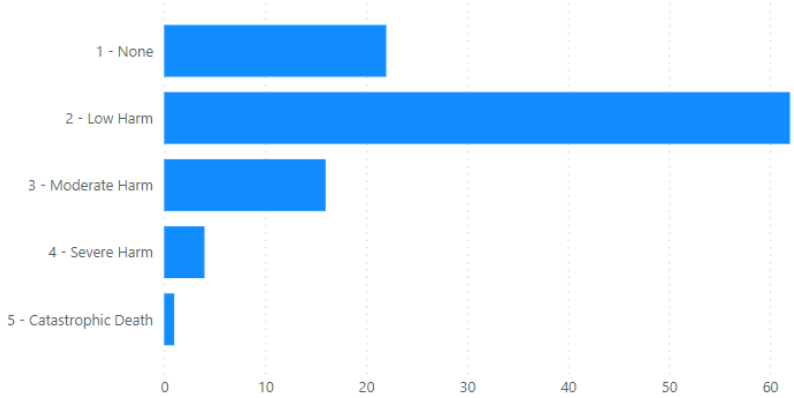
Incident type tier one	Count
Treatment, Procedure	159
Assessment, Investigation, Diagnosis	136
Accident, Injury	55
Behaviour (including violence and aggression)	23
Equipment, Devices	22
Communication	15
Records, Information	13
Infrastructure (including staffing, facilities, environment)	9
Medication, IV Fluids	9
Infection Prevention and Control	6
Information Governance, Confidentiality	5
Transfer, Discharge	5
Access, Admission	4
Information Technology	3
Patient/service user death	3
Ill health (work related)	2
Consent, Mental Capacity Act (including DoLS)	1
Monitoring, Observations	1

Bronglais Hospital (1st August 2018 – 31st March 2021) By Severity/Level



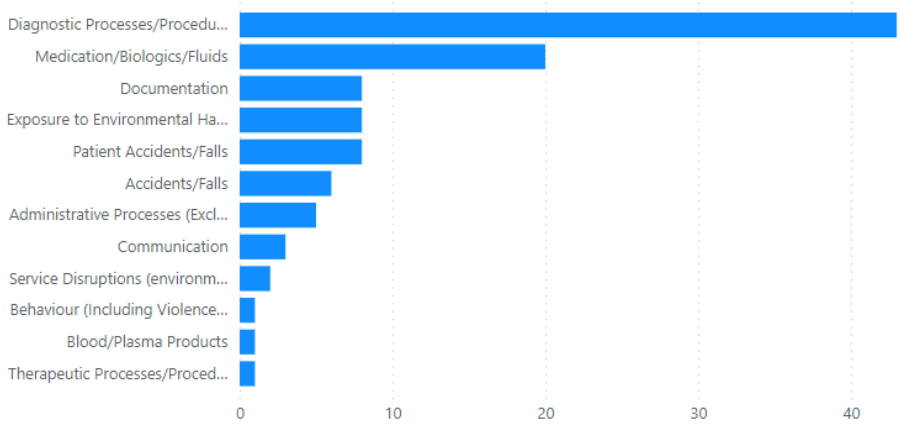
Severity	Count
1 - None	79
2 – Low Harm	17
3 – Moderate Harm	10
4 – Severe Harm	0
5 – Catastrophic Death	0

Bronglais Hospital (1st April 2021 – 31st July 2023) By Severity/Level



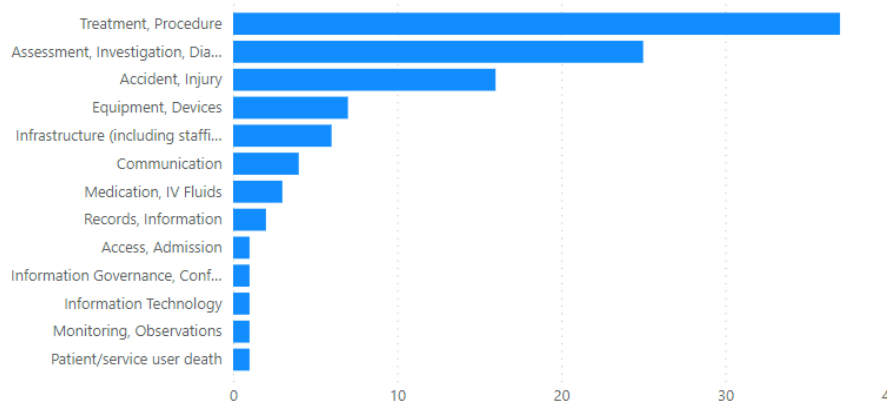
Severity	Count
1 - None	22
2 – Low Harm	62
3 – Moderate Harm	16
4 – Severe Harm	4
5 – Catastrophic Death	1

Bronglais Hospital (1st August 2018 – 31st March 2021)
By Type



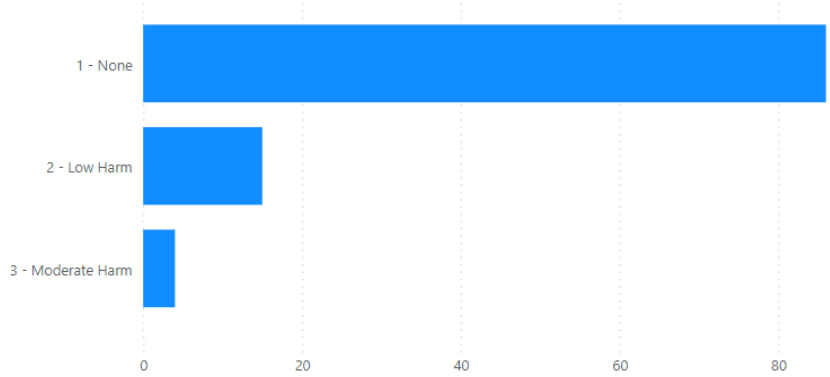
Incident type tier one	Count
Diagnostic Processes/Procedures	43
Medication/Biologics/Fluids	20
Documentation	8
Exposure to Environmental Hazards	8
Patient Accidents/Falls	8
Accidents/Falls	6
Administrative Processes (Excluding Documentation)	5
Communication	3
Service Disruptions (environment, infrastructure, human resources)	2
Behaviour (Including Violence and Aggression)	1
Blood/Plasma Products	1
Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	1

Bronglais Hospital (1st April 2021 – 31st July 2023)
By Type



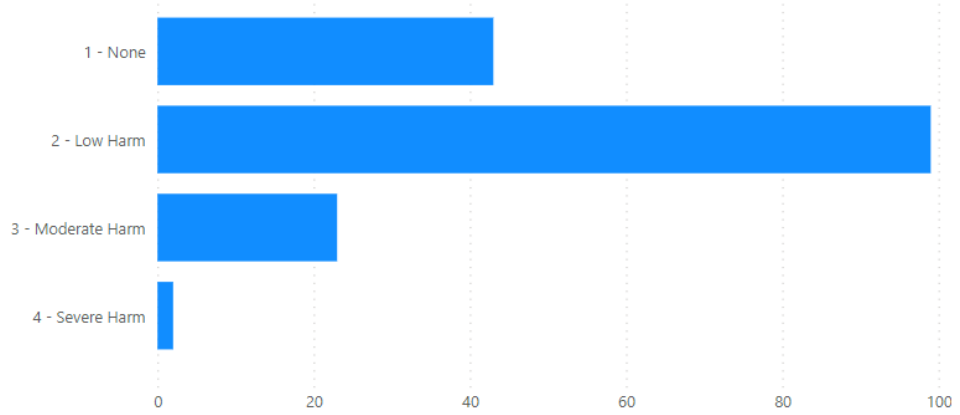
Incident type tier one	Count
Treatment, Procedure	37
Assessment, Investigation, Diagnosis	25
Accident, Injury	16
Equipment, Devices	7
Infrastructure (including staffing, facilities, environment)	6
Communication	4
Medication, IV Fluids	3
Records, Information	2
Access, Admission	1
Information Governance, Confidentiality	1
Information Technology	1
Monitoring, Observations	1
Patient/service user death	1

Withybush Hospital (1st August 2018 – 31st March 2021) By Severity/Level



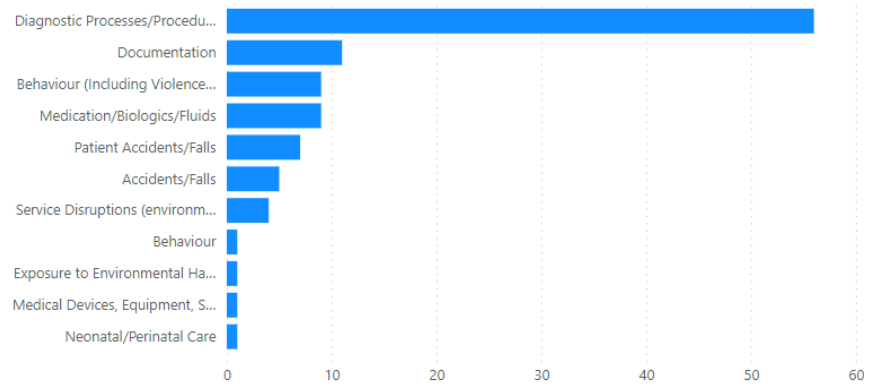
Severity	Count
1 - None	86
2 – Low Harm	15
3 – Moderate Harm	4
4 – Severe Harm	0
5 – Catastrophic Death	0

Withybush Hospital (1st April 2021 – 31st July 2023) By Severity/Level



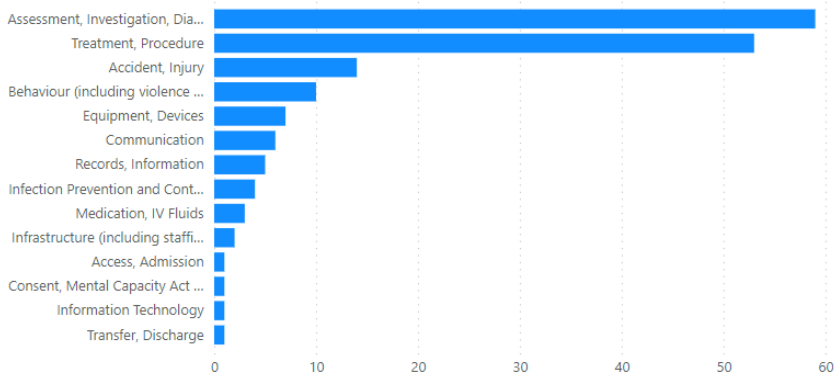
Severity	Count
1 - None	43
2 – Low Harm	99
3 – Moderate Harm	23
4 – Severe Harm	2
5 – Catastrophic Death	0

Withybush Hospital (1st August 2018 – 31st March 2021)
By Type



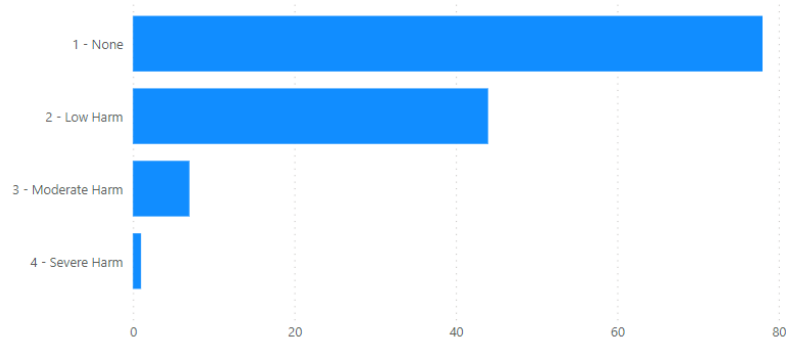
Incident type tier one	Count
Diagnostic Processes/Procedures	56
Documentation	11
Behaviour (Including Violence and Aggression)	9
Medication/Biologics/Fluids	9
Patient Accidents/Falls	7
Accidents/Falls	5
Service Disruptions (environment, infrastructure, human resources)	4
Behaviour	1
Exposure to Environmental Hazards	1
Medical Devices, Equipment, Supplies	1
Neonatal/Perinatal Care	1

Withybush Hospital (1st April 2021 – 31st July 2023)
By Type



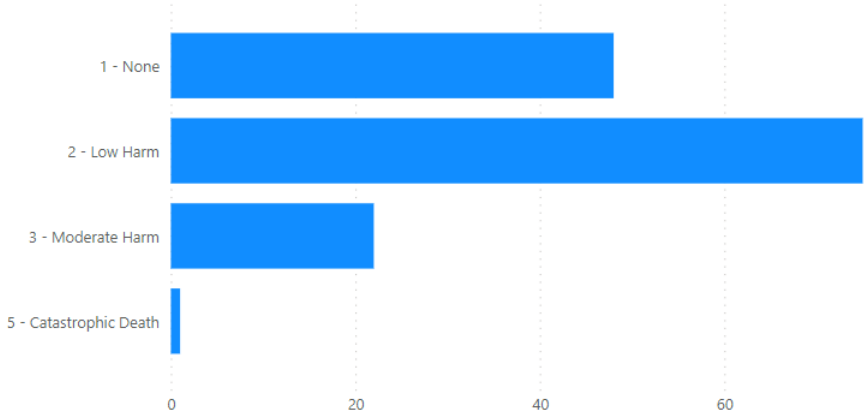
Incident type tier one	Count
Assessment, Investigation, Diagnosis	59
Treatment, Procedure	53
Accident, Injury	14
Behaviour (including violence and aggression)	10
Equipment, Devices	7
Communication	6
Records, Information	5
Infection Prevention and Control	4
Medication, IV Fluids	3
Infrastructure (including staffing, facilities, environment)	2
Access, Admission	1
Consent, Mental Capacity Act (including DoLS)	1
Information Technology	1
Transfer, Discharge	1

Glangwili Hospital (1st August 2018 – 31st March 2021) By Severity/Level



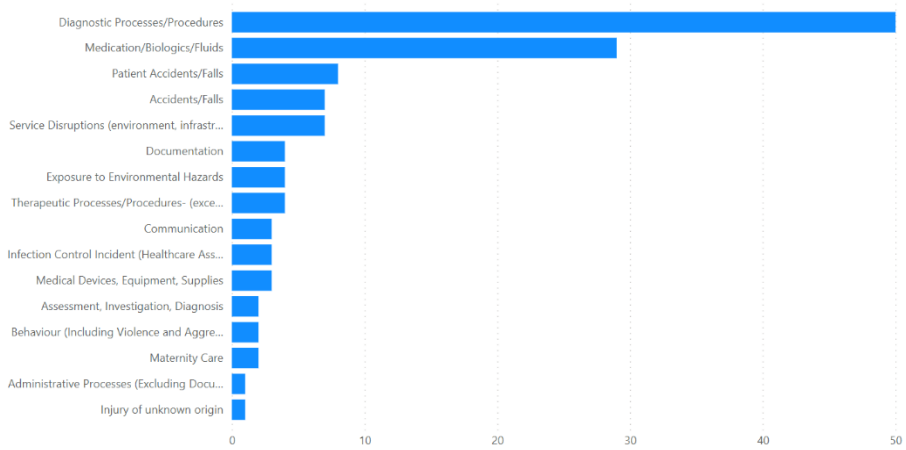
Severity	Count
1 - None	78
2 – Low Harm	44
3 – Moderate Harm	7
4 – Severe Harm	1
5 – Catastrophic Death	0

Glangwili Hospital (1st April 2021 – 31st July 2023) By Severity/Level



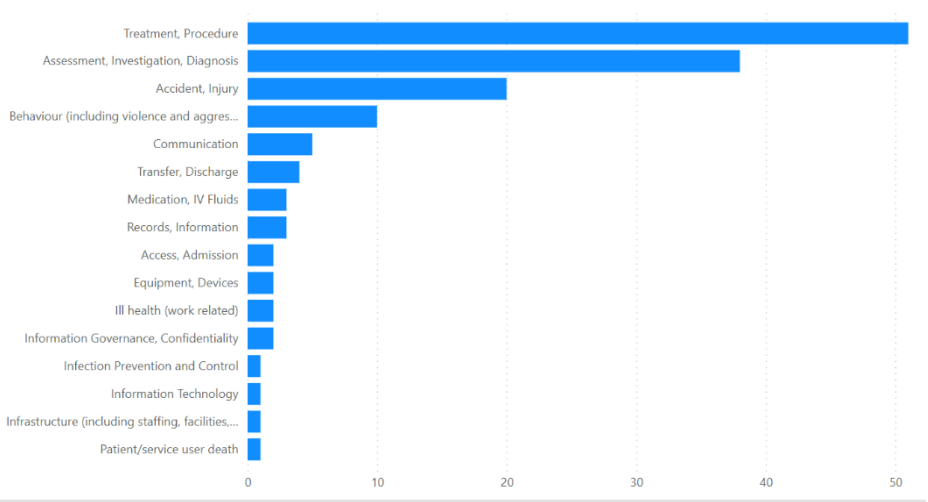
Severity	Count
1 - None	48
2 – Low Harm	75
3 – Moderate Harm	22
4 – Severe Harm	0
5 – Catastrophic Death	1

Glangwili Hospital (1st August 2018 – 31st March 2021)
By Type



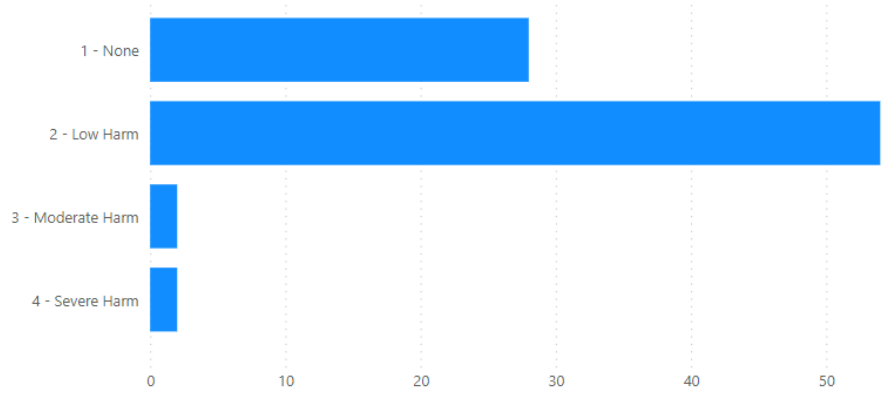
Incident type tier one	Count
Diagnostic Processes/Procedures	50
Medication/Biologics/Fluids	29
Patient Accidents/Falls	8
Accidents/Falls	7
Service Disruptions (environment, infrastructure, human resources)	7
Documentation	4
Exposure to Environmental Hazards	4
Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	4
Communication	3
Infection Control Incident (Healthcare Associated Infection)	3
Medical Devices, Equipment, Supplies	3
Assessment, Investigation, Diagnosis	2
Behaviour (Including Violence and Aggression)	2
Maternity Care	2
Administrative Processes (Excluding Documentation)	1
Injury of unknown origin	1

Glangwili Hospital (1st April 2021 – 31st July 2023)
By Type



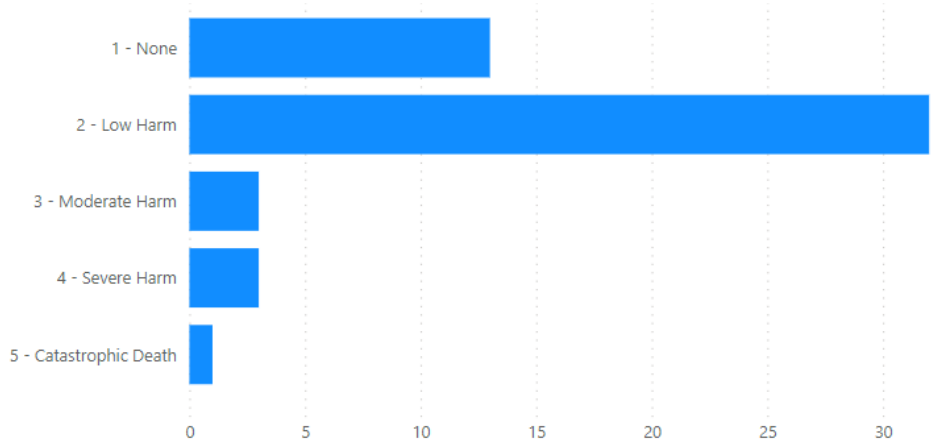
Incident type tier one	Count
Treatment, Procedure	51
Assessment, Investigation, Diagnosis	38
Accident, Injury	20
Behaviour (including violence and aggression)	10
Communication	5
Transfer, Discharge	4
Medication, IV Fluids	3
Records, Information	3
Access, Admission	2
Equipment, Devices	2
Ill health (work related)	2
Information Governance, Confidentiality	2
Infection Prevention and Control	1
Information Technology	1
Infrastructure (including staffing, facilities, environment)	1
Patient/service user death	1

Prince Philip Hospital (1st August 2018 – 31st March 2021) By Severity/Level



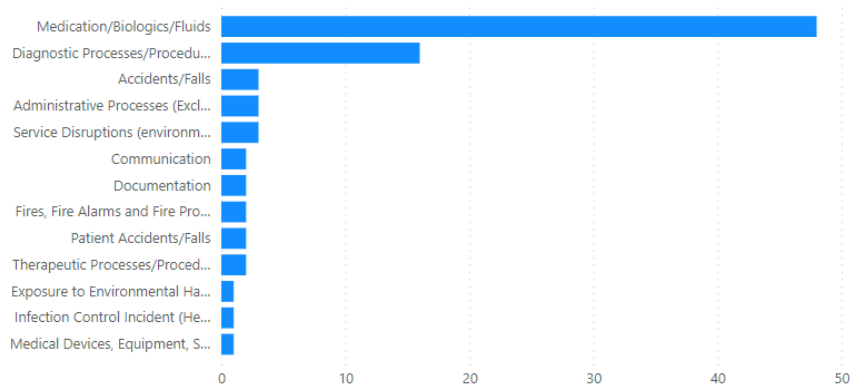
Severity	Count
1 - None	28
2 – Low Harm	54
3 – Moderate Harm	2
4 – Severe Harm	2
5 – Catastrophic Death	0

Prince Philip Hospital (1st April 2021 – 31st July 2023) By Severity/Level



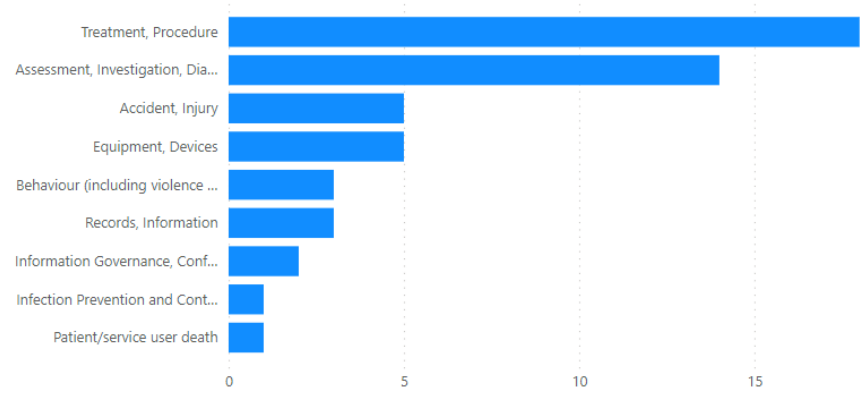
Severity	Count
1 - None	13
2 – Low Harm	32
3 – Moderate Harm	3
4 – Severe Harm	3
5 – Catastrophic Death	1

Prince Philip Hospital (1st August 2018 – 31st March 2021)
By Type



Incident type tier one	Count
Medication/Biologics/Fluids	48
Diagnostic Processes/Procedures	16
Accidents/Falls	3
Administrative Processes (Excluding Documentation)	3
Service Disruptions (environment, infrastructure, human resources)	3
Communication	2
Documentation	2
Fires, Fire Alarms and Fire Procedures	2
Patient Accidents/Falls	2
Therapeutic Processes/Procedures- (except medications/fluids/blood/plasma products administration)	2
Exposure to Environmental Hazards	1
Infection Control Incident (Healthcare Associated Infection)	1
Medical Devices, Equipment, Supplies	1

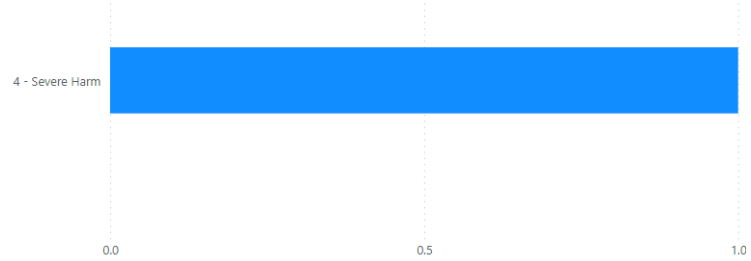
Prince Philip Hospital (1st April 2021 – 31st July 2023)
By Type



Incident type tier one	Count
Treatment, Procedure	18
Assessment, Investigation, Diagnosis	14
Accident, Injury	5
Equipment, Devices	5
Behaviour (including violence and aggression)	3
Records, Information	3
Information Governance, Confidentiality	2
Infection Prevention and Control	1
Patient/service user death	1

Other sites - Llandovery Hospital (1st August 2018 – 31st March 2021)

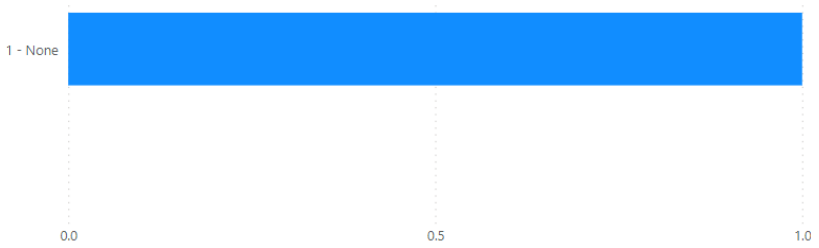
By Severity/Level



Severity	Count
4 – Severe Harm	1

Other sites - Public Place (1st April 2021 – 31st July 2023)

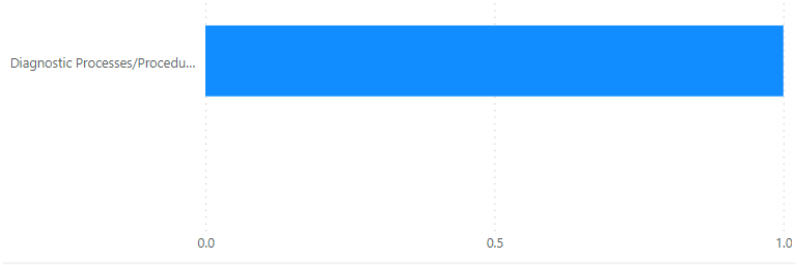
By Severity/Level



Severity	Count
1 - None	1

Other sites - Llandovery Hospital (1st August 2018 – 31st March 2021)

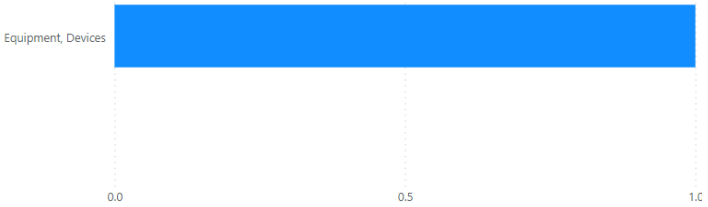
By Type



Incident type tier one	Count
Diagnostic Processes/Procedures	1

Other sites - Public Place (1st April 2021 – 31st July 2023)

By Type



Incident type tier one	Count
Equipment, Devices	1

Radiology Complaints Data Review

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By Grading 8

Bronglais Hospital (1st April 2021 – 31st July 2023) 8

By Grading 8

Bronglais Hospital (1st August 2018 – 31st March 2021) 9

By Type 9

Bronglais Hospital (1st April 2021 – 31st July 2023) 9

By Type 9

Withybush Hospital (1st August 2018 – 31st March 2021) 10

By Grading 10

Withybush Hospital (1st April 2021 – 31st July 2023) 10

By Grading 10

Withybush Hospital (1st August 2018 – 31st March 2021) 11

By Type 11

Withybush Hospital (1st April 2021 – 31st July 2023) 11

By Type 11

Glangwili Hospital (1st August 2018 – 31st March 2021) 12

By Grading 12

Glangwili Hospital (1st April 2021 – 31st July 2023) 12

By Grading 12

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By Type 13

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By Grading 14
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By Type 15
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By Type 15

Background

As per the approved Clinical Services Plan methodology, Complaints reported between 1st August 2018 and 31st July 2023 have been recorded for Withybush Hospital, Glangwili Hospital, Prince Philip Hospital and Bronglais Hospital. Due to data formatting across the current Datix system and historical records, data has been visualised within two dashboards representing the implementation of the current system. Data tables and graphics reflect the dates of this change.

In April 2021, Datix Cymru, a Once for Wales Concerns Management System, was introduced. Hywel Dda UHB were the first Health Board in Wales to adopt the new system.

Prior to implementation of Datix Cymru work had been undertaken to develop a system which made reporting of incidents simpler and therefore this may account for the rise in incident reports seen in April 2021.

It is possible that the data shows a variation in the number of reported incidents attributable to Service when comparing the old system to the current. This relates to the system being able to distinguish between different specialties within the Service that may be related to other services within the previous system.

Due to gaps at the reporting stage of records, categorised totals may not equal the overall totals for the Service.

Service Changes

There have been no service changes for Radiology within the review period and so the data set has been presented as a whole.

Complaints

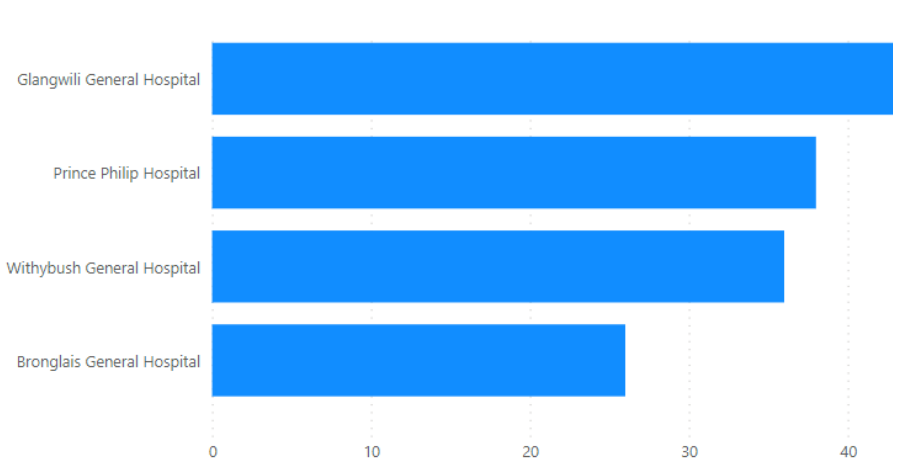
All Sites (1st August 2018 – 31st March 2021)

							Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	2018
							6	2	5	3	3	19
Jan 19	Feb 19	Mar 19	April 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	2019
7	3	3	0	3	7	5	5	5	7	2	8	55
Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	2020
6	9	6	6	0	9	7	7	6	5	4	3	68
Jan 21	Feb 21	Mar 21										2021
5	2	4										11
												153

All Sites (1st April 2021 – 31st July 2023

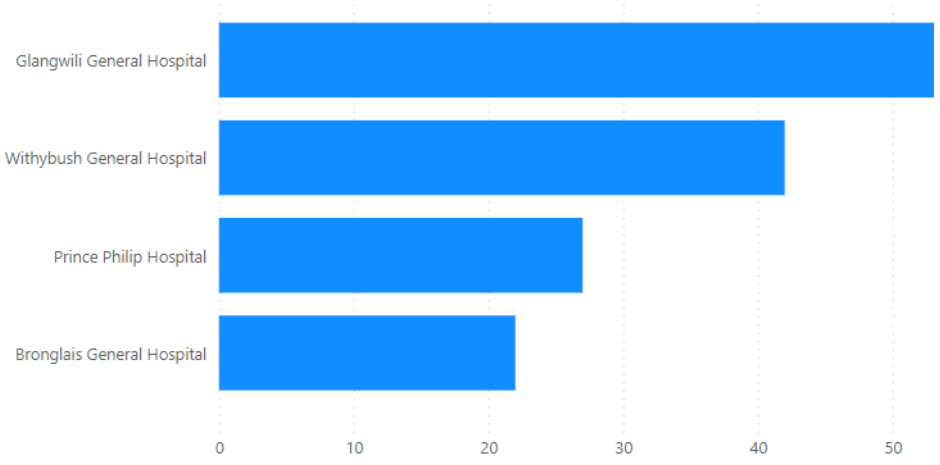
			Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	2021
			1	5	3	5	5	8	3	9	2	41
Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	2022
5	6	8	2	10	7	5	15	8	8	3	3	80
Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23						2023
3	6	4	2	6	2	1						24
												145

By Location (1st August 2018 – 31st March 2021)



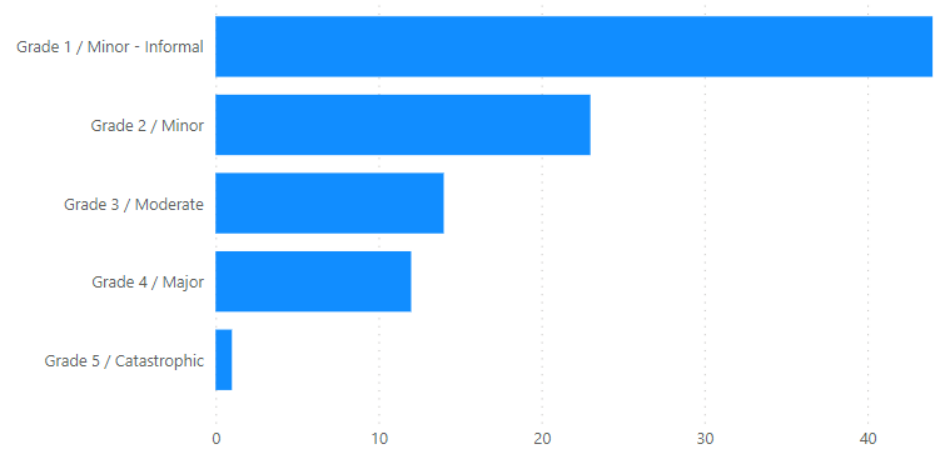
Primary Location	Count
Glangwili General Hospital	43
Prince Philip Hospital	44
Withybush General Hospital	35
Bronglais General Hospital	28

By Location (1st April 2021 – 31st July 2023)



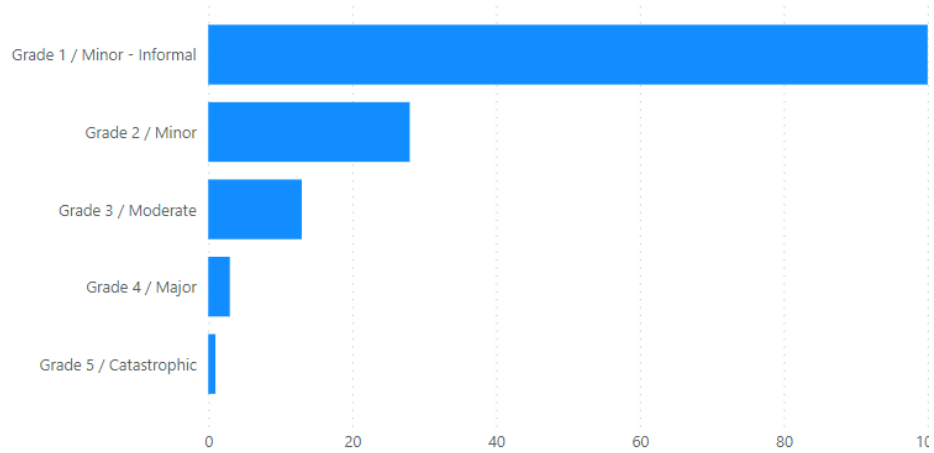
Primary Location	Count
Glangwili General Hospital	54
Withybush General Hospital	42
Prince Philip Hospital	27
Bronglais General Hospital	22

By Grading (1st August 2018 – 31st March 2021)



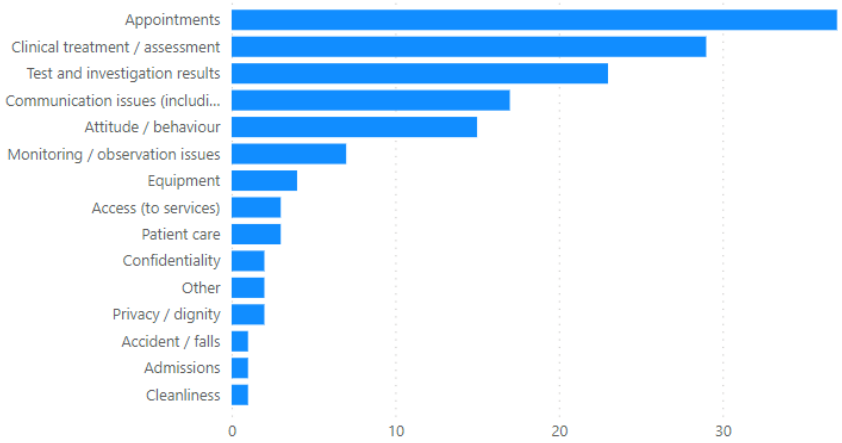
Grade	Count
Grade 1 – Minor - Informal	44
Grade 2 - Minor	23
Grade 3 - Moderate	14
Grade 4 - Major	12
Grade 5 - Catastrophic	1

By Grading (1st April 2021 – 31st July 2023)



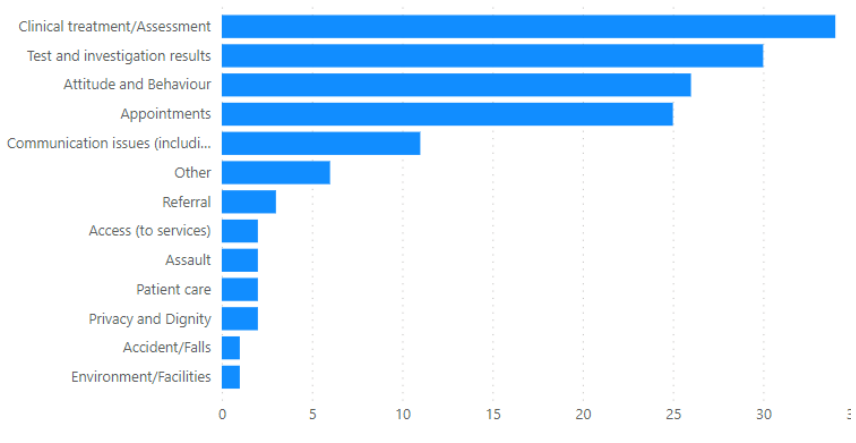
Grade	Count
Grade 1 – Minor - Informal	100
Grade 2 - Minor	28
Grade 3 - Moderate	13
Grade 4 - Major	3
Grade 5 - Catastrophic	1

By Type (1st August 2018 – 31st March 2021)



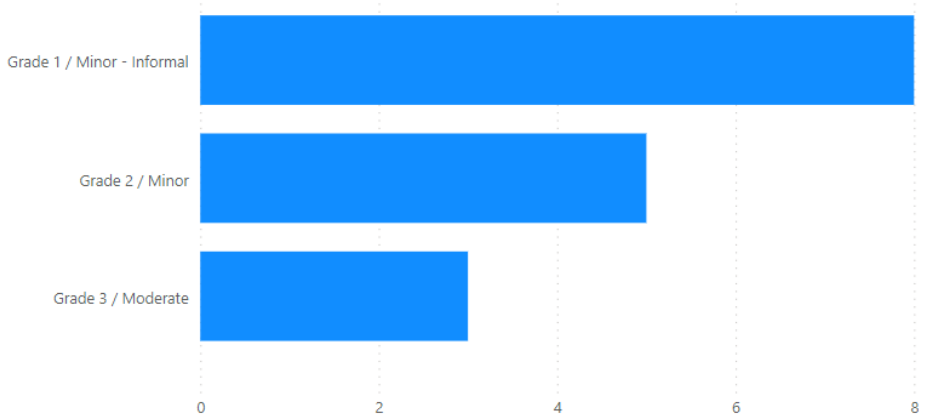
Subject (primary)	Count
Appointments	37
Clinical treatment / assessment	29
Test and investigation results	23
Communication issues (including language)	17
Attitude / behaviour	15
Monitoring / observation issues	7
Equipment	4
Access (to services)	3
Patient care	3
Confidentiality	2
Other	2
Privacy / dignity	2
Accident / falls	1
Admissions	1
Cleanliness	1
Infection control	1
Medication	1
Record keeping	1
Referrals	1
Resources	1

By Type (1st April 2021 – 31st July 2023)



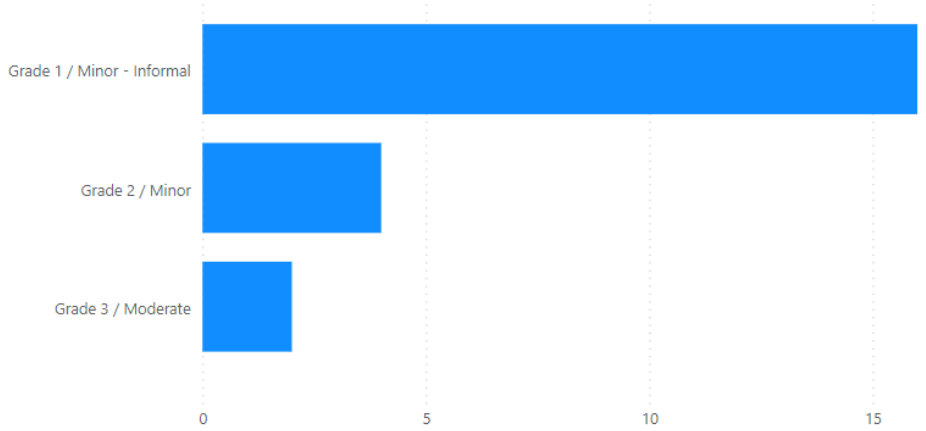
Subject (primary)	Count
Clinical treatment/Assessment	34
Test and investigation results	30
Attitude and Behaviour	26
Appointments	25
Communication issues (including language)	11
Other	6
Referral	3
Access (to services)	2
Assault	2
Patient care	2
Privacy and Dignity	2
Accident/Falls	1
Environment/Facilities	1

Bronglais Hospital (1st August 2018 – 31st March 2021) By Grading



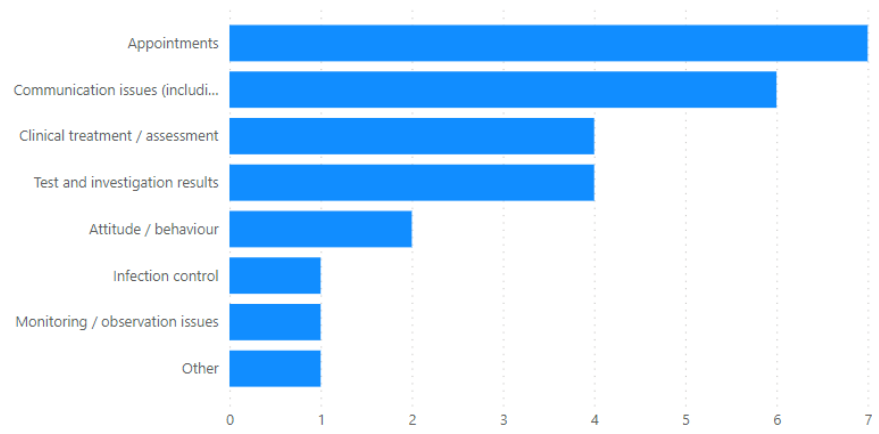
Grade	Count
Grade 1 – Minor - Informal	8
Grade 2 - Minor	5
Grade 3 - Moderate	3
Grade 4 - Major	0
Grade 5 - Catastrophic	0

Bronglais Hospital (1st April 2021 – 31st July 2023) By Grading



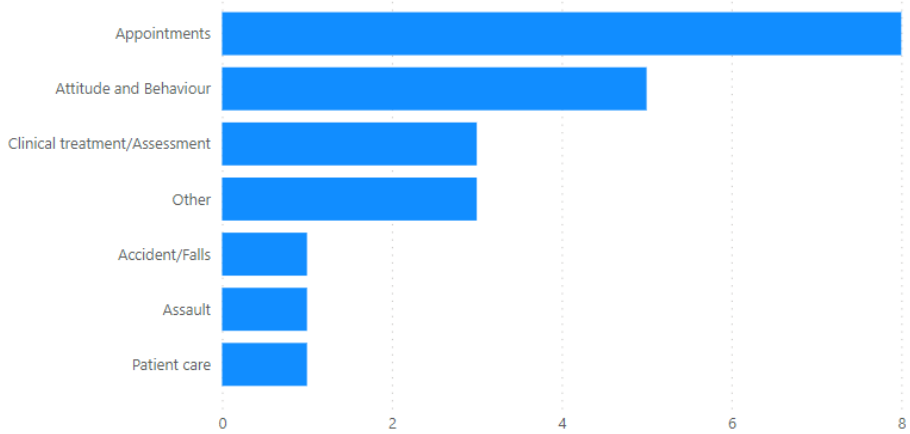
Grade	Count
Grade 1 – Minor - Informal	16
Grade 2 - Minor	4
Grade 3 - Moderate	2
Grade 4 - Major	0
Grade 5 - Catastrophic	0

Bronglais Hospital (1st August 2018 – 31st March 2021)
By Type



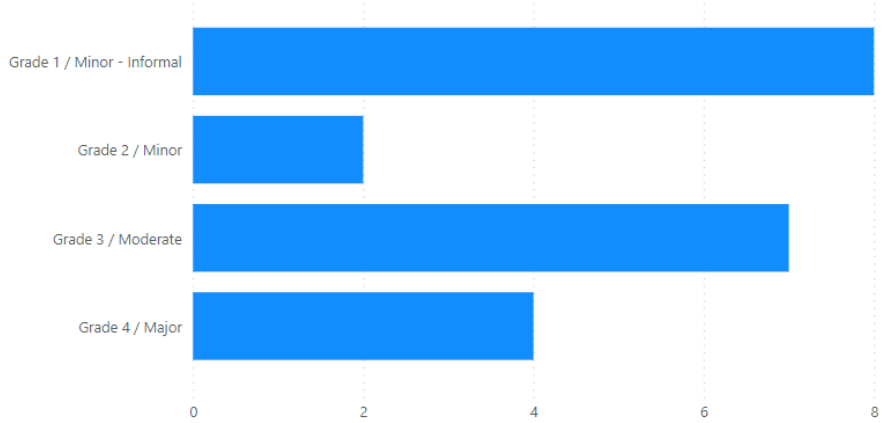
Subject (primary)	Count
Appointments	7
Communication issues (including language)	6
Clinical treatment / assessment	4
Test and investigation results	4
Attitude / behaviour	2
Infection control	1
Monitoring / observation issues	1
Other	1

Bronglais Hospital (1st April 2021 – 31st July 2023)
By Type



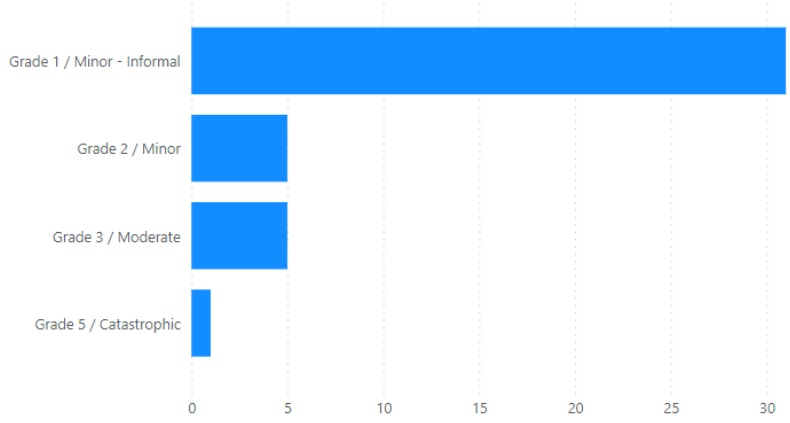
Subject (primary)	Count
Appointments	8
Attitude and Behaviour	5
Clinical treatment/Assessment	3
Other	3
Accident/Falls	1
Assault	1
Patient care	1

Withybush Hospital (1st August 2018 – 31st March 2021) By Grading



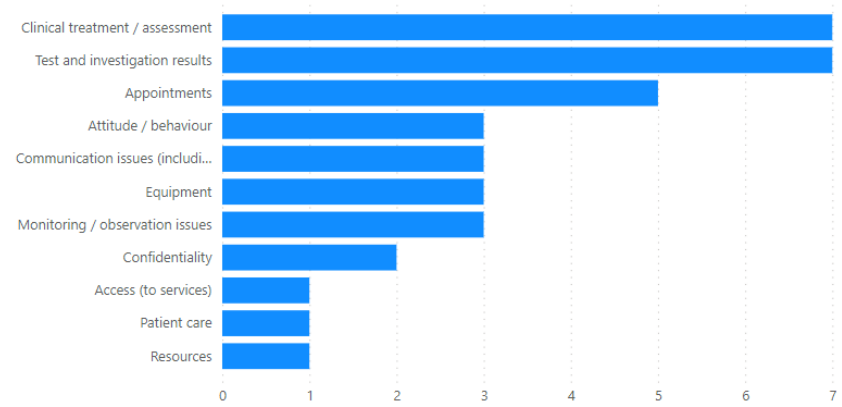
Grade	Count
Grade 1 – Minor - Informal	8
Grade 2 - Minor	2
Grade 3 - Moderate	7
Grade 4 - Major	4
Grade 5 - Catastrophic	0

Withybush Hospital (1st April 2021 – 31st July 2023) By Grading



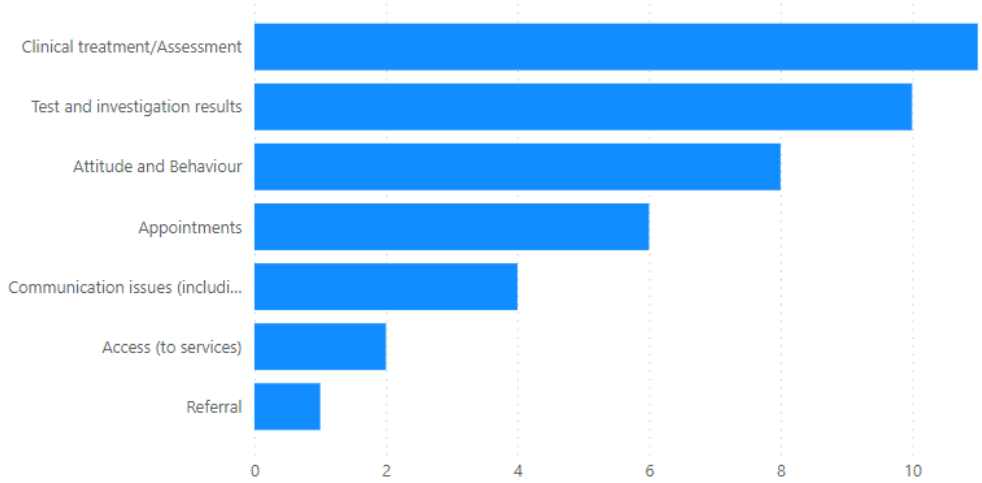
Grade	Count
Grade 1 – Minor - Informal	31
Grade 2 - Minor	5
Grade 3 - Moderate	5
Grade 4 - Major	0
Grade 5 - Catastrophic	1

Withybush Hospital (1st August 2018 – 31st March 2021)
By Type



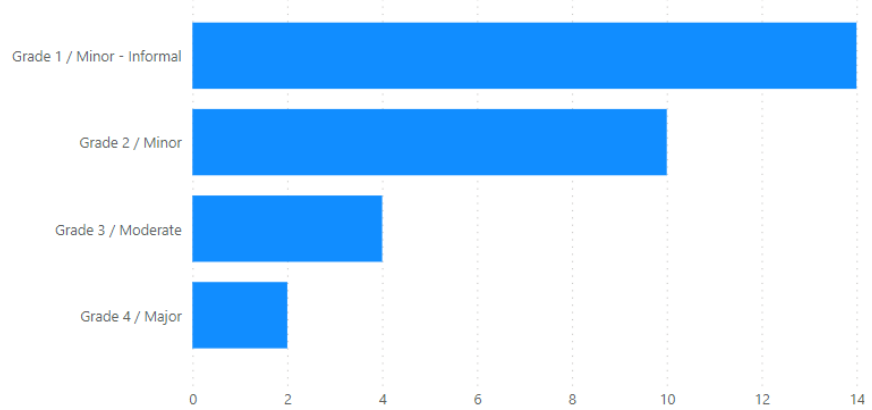
Subject (primary)	Count
Clinical treatment / assessment	7
Test and investigation results	7
Appointments	5
Attitude / behaviour	3
Communication issues (including language)	3
Equipment	3
Monitoring / observation issues	3
Confidentiality	2
Access (to services)	1
Patient care	1
Resources	1

Withybush Hospital (1st April 2021 – 31st July 2023)
By Type



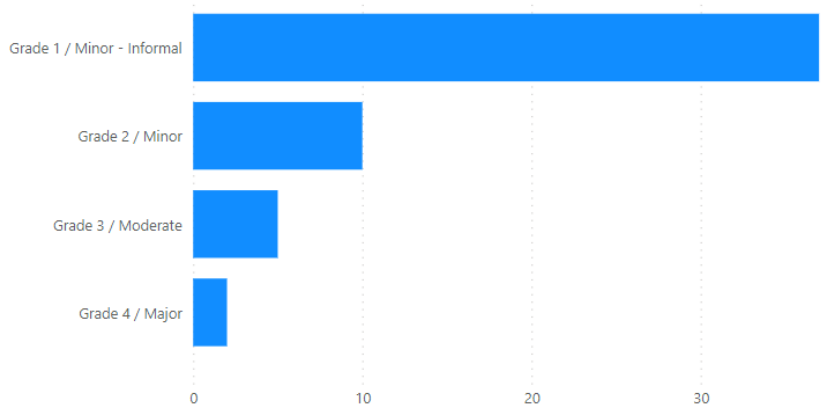
Subject (primary)	Count
Clinical treatment/Assessment	11
Test and investigation results	10
Attitude and Behaviour	8
Appointments	6
Communication issues (including language)	4
Access (to services)	2
Referral	1

Glangwili Hospital (1st August 2018 – 31st March 2021) By Grading



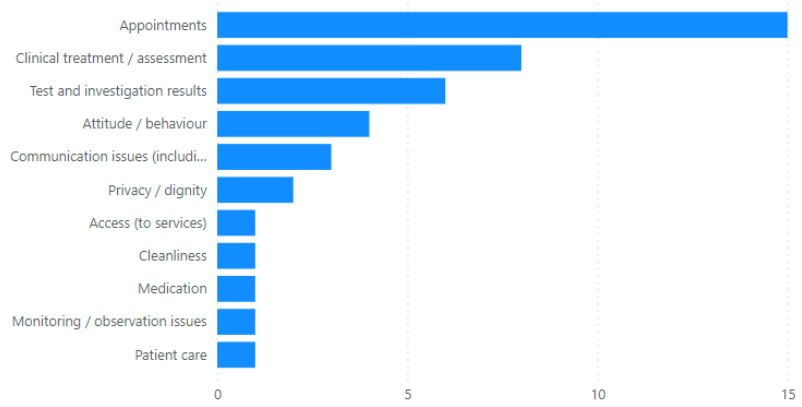
Grade	Count
Grade 1 – Minor - Informal	14
Grade 2 - Minor	10
Grade 3 - Moderate	4
Grade 4 - Major	2
Grade 5 - Catastrophic	0

Glangwili Hospital (1st April 2021 – 31st July 2023) By Grading



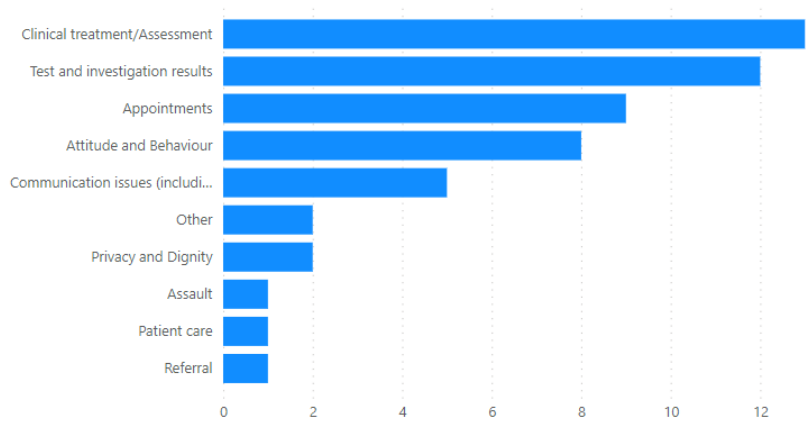
Grade	Count
Grade 1 – Minor - Informal	37
Grade 2 - Minor	10
Grade 3 - Moderate	5
Grade 4 - Major	2
Grade 5 - Catastrophic	0

Glangwili Hospital (1st August 2018 – 31st March 2021)
By Type



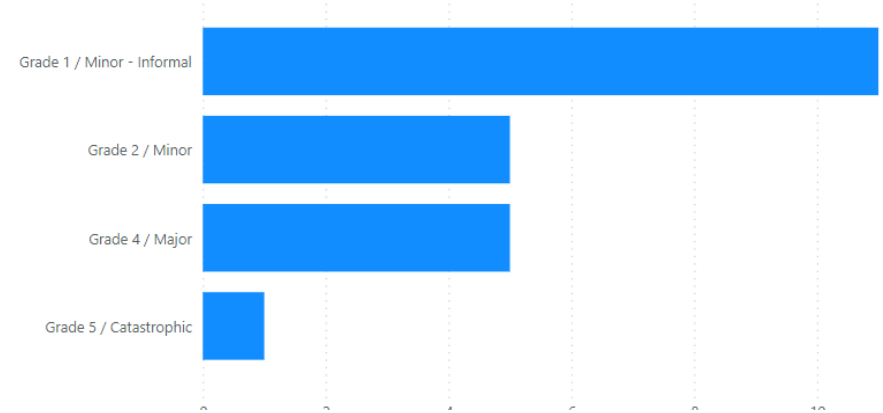
Subject (primary)	Count
Appointments	15
Clinical treatment / assessment	8
Test and investigation results	6
Attitude / behaviour	4
Communication issues (including language)	3
Privacy / dignity	2
Access (to services)	1
Cleanliness	1
Medication	1
Monitoring / observation issues	1
Patient care	1

Glangwili Hospital (1st April 2021 – 31st July 2023)
By Type



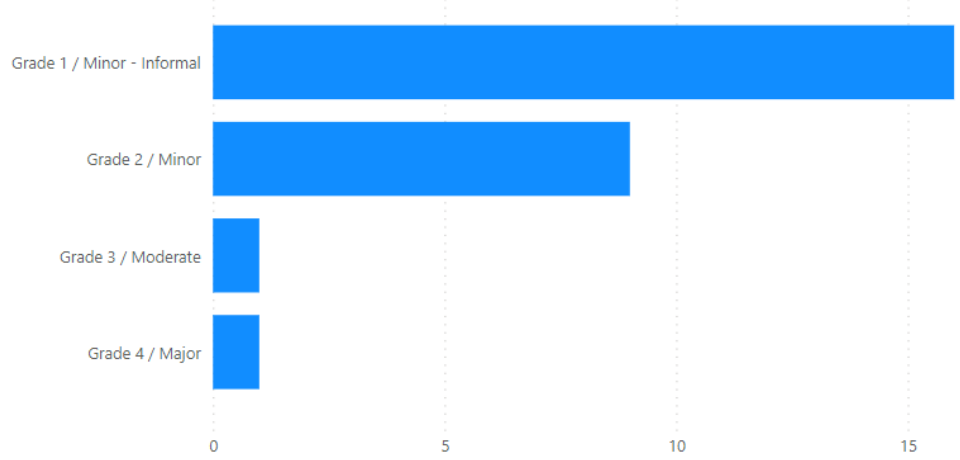
Subject (primary)	Count
Clinical treatment/Assessment	13
Test and investigation results	12
Appointments	9
Attitude and Behaviour	8
Communication issues (including language)	5
Other	2
Privacy and Dignity	2
Assault	1
Patient care	1
Referral	1

Prince Philip Hospital (1st August 2018 – 31st March 2021) By Grading



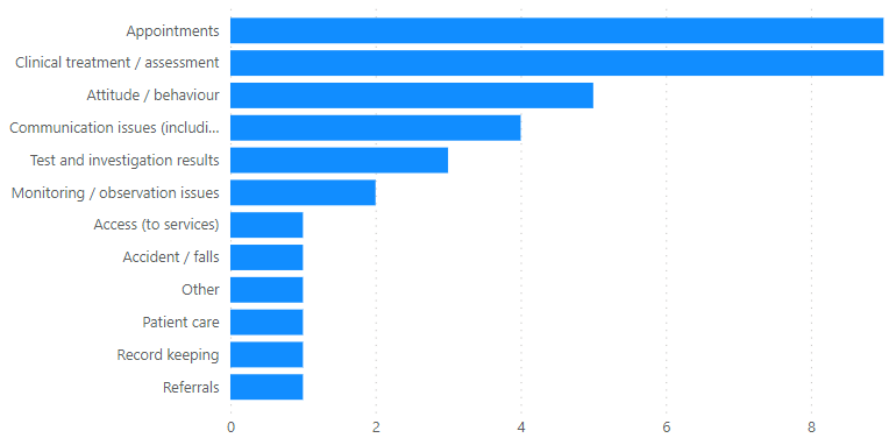
Grade	Count
Grade 1 – Minor - Informal	11
Grade 2 - Minor	5
Grade 3 - Moderate	0
Grade 4 – Major	5
Grade 5 - Catastrophic	1

Prince Philip Hospital (1st April 2021 – 31st July 2023) By Grading



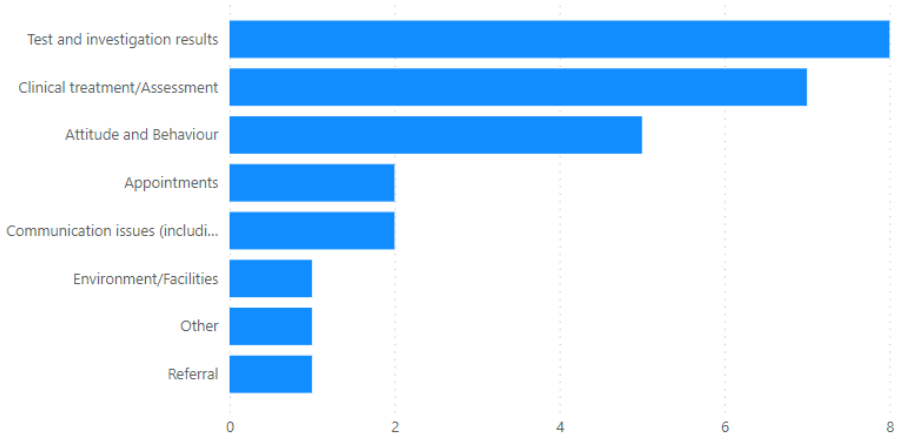
Grade	Count
Grade 1 – Minor - Informal	16
Grade 2 - Minor	9
Grade 3 - Moderate	1
Grade 4 - Major	1
Grade 5 - Catastrophic	0

Prince Philip Hospital (1st August 2018 – 31st March 2021)
By Type



Subject (primary)	Count
Appointments	9
Clinical treatment / assessment	9
Attitude / behaviour	5
Communication issues (including language)	4
Test and investigation results	3
Monitoring / observation issues	2
Access (to services)	1
Accident / falls	1
Other	1
Patient care	1
Record keeping	1
Referrals	1

Prince Philip Hospital (1st April 2021 – 31st July 2023)
By Type



Subject (primary)	Count
Test and investigation results	8
Clinical treatment/Assessment	7
Attitude and Behaviour	5
Appointments	2
Communication issues (including language)	2
Environment/Facilities	1
Other	1
Referral	1

Radiology Patient Experience and Compliments Data Review

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Service Changes 2
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3 Health Board Values that relate to Compliment 6
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Background

As per the approved Clinical Services Plan methodology, Patient Experience data captured has been included for Radiology Services across all sites in which the Service operates.

Due to data formatting across the current Civica system and historical records, data has only been analysed from 1st April 2021 to 31st July 2023. Historical records, pre-April 2021, cannot be assigned to particular Services in their entirety and so the methodology was updated to only analyse the current Civica system data.

Due to the implementation of the new Civica system, there was an initial decline in patient feedback as the system was being established and rolled out across the Health Board. The new system was implemented on a phased basis and therefore some services had a higher percentage of the feedback in the early stages. There will be an ongoing increase since the introduction of Civica as the Health Board's priority is to increase the volume of feedback.

Traditionally, emergency departments have always had a larger number of claims, complaints and patient feedback due to activity numbers. Patients that have a number of appointments in a relatively short period of time within a Service will generate more feedback.

It is possible that the data shows a variation in the number of reported complaints attributable to a Service. This relates to the system not always being able to distinguish between different specialties within the Service that may be related to other services within the system.

Due to the way records have been captured within the system and potential gaps in the data, the categorised totals may not equal overall totals per Service.

Data that has been analysed includes All Wales Patient Experience data, Friends and Family Test data and Compliments data. The Big Thank You has been discarded in its entirety as the formatting of the data follows the same structure as pre 2021 data and therefore cannot be assigned to a particular service.

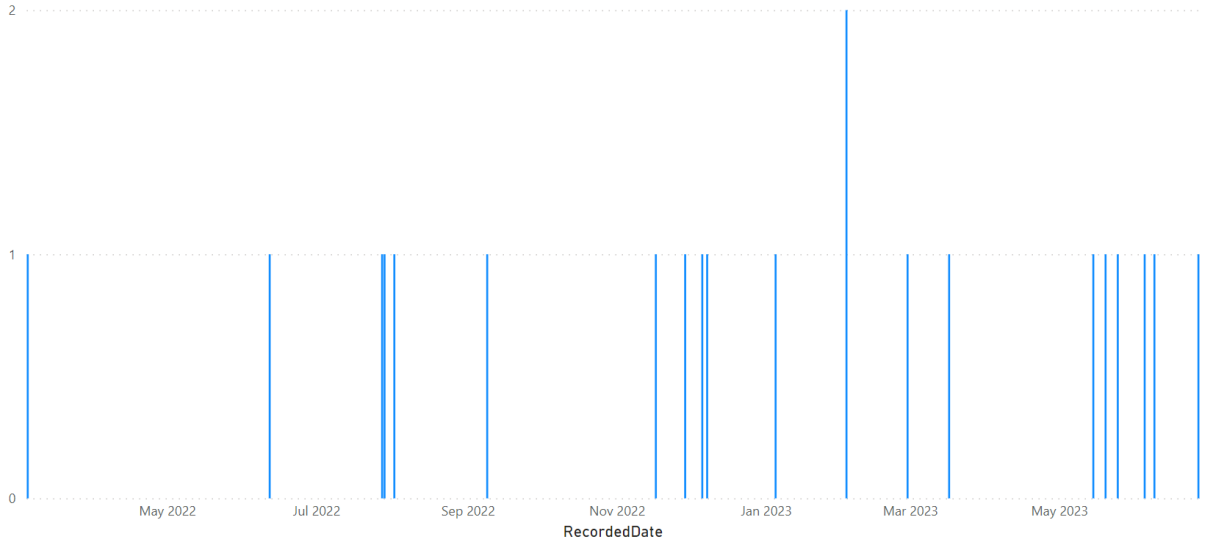
The thematic analysis was undertaken using Microsoft Copilot and has been used to provide a summary of themes per Service per year based on the patient feedback received.

Service Changes

There have been no service changes for Radiology within the review period and so the data set has been presented as a whole.

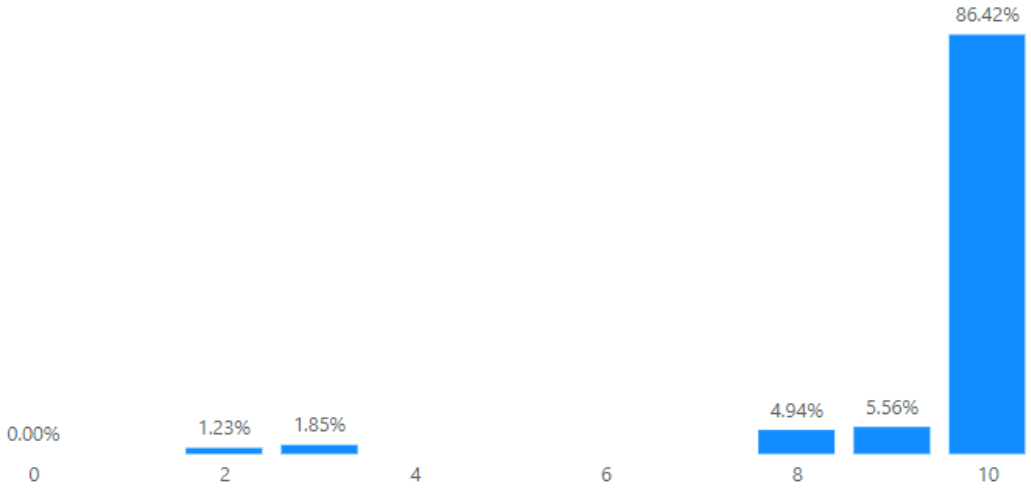
Patient Experience

All Wales Experience – Health Board Survey (1st April 2021 to 31st July 2023)



			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2021
			0	0	0	0	0	0	0	0	0	0
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2022
0	0	1	0	0	1	2	1	1	0	2	2	10
Jan	Feb	Mar	Apr	May	Jun	Jul						2023
1	3	1	0	3	3	0						11

Using a scale of 0-10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?



Themes – 2022

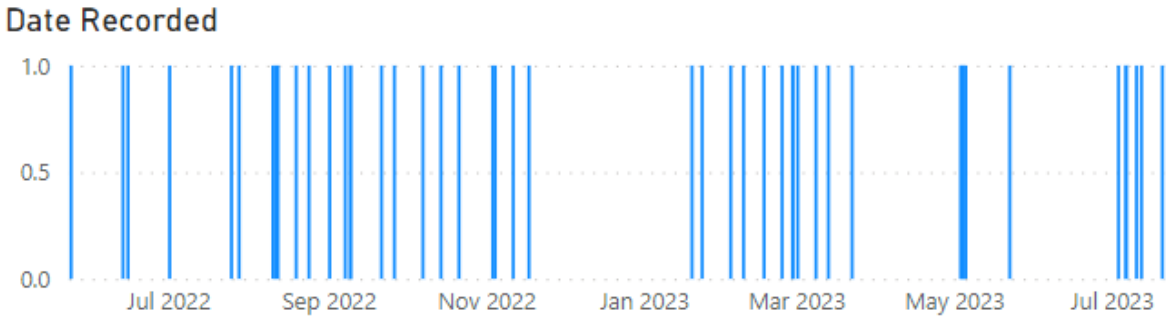
The themes arising relate to the staff and the way the procedures were undertaken. Patients speak very highly of staff members kindness, caring and effort to protect patient dignity while remaining professional. Negative experiences relate to appointment cancellations and some patients not being aware of what would happen during the procedure or staff not introducing themselves or their purpose during the procedure.

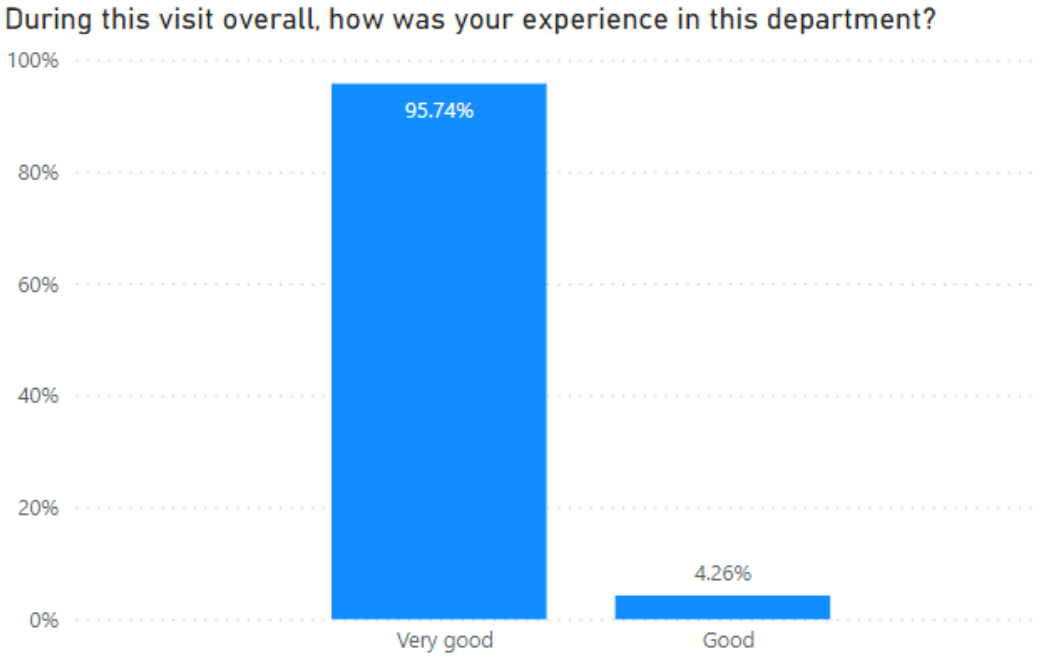
Themes - 2023

The themes arising relate to the staff and the way the procedures were undertaken. Patients speak very highly of staff members kindness, caring and effort to protect patient dignity while remaining professional. Negative experiences relate to appointment cancellations and some patients not being aware of what would happen during the procedure or staff not introducing themselves or their purpose during the procedure.

Patient Experience

Friends and Family Test (1st April 2021 to 31st July 2023)





Themes – 2022

The themes arising were all positive, focusing on the kind, caring and friendly staff who provided comfort to patients while providing high quality care and good communication throughout the procedure.

Themes - 2023

The themes arising were all positive, focusing on the kind, caring and friendly staff who provided comfort to patients while providing high quality care and good communication throughout the procedure.

Patient Experience
Compliments (1st April 2021 to 31st July 2023)

Recorded Date	Count
Jan 23	1
May 23	1

3 Sentiments that relate to Compliment

Sentiment	Count
Listening, Understanding, Communication	1
Understanding, Calm, Communication	1

3 Health Board Values that relate to Compliment

Value	Count
Dignity, Respect, Caring	1
Respect, Caring, Kindness	1

Themes – 2023

Themes arising are that staff were helpful and supportive of people with disabilities, providing person centred care and treating them with dignity to make them feel comfortable throughout procedures.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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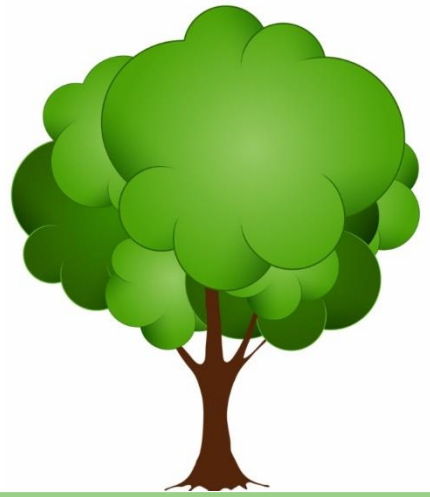
Workforce Data

Clinical Services Plan : Activity Modelling Workstream

RADIOLOGY



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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Glossary of terms

Term/Acronym	Definition
ESR	Electronic Staff Record – This is the National recording system within the NHS that houses all staff information. The majority of the workforce information contained within this report will have been extracted from the reporting functionality within the system.
WTE	Whole Time Equivalent – For the medical workforce 1WTE equates to 10 sessions or above. For all other staff working in the NHS under AfC terms and conditions 1WTE equates to a full time position of 37.5 hour working week.
AfC	Agenda for Change is the current NHS grading and pay system for NHS staff across Wales, with the exception of doctors, dentists, apprentices and some very senior managers.
Cost code	The Health Board Budget is structured to take into account all areas that incur a cost and is therefore broken down into different directorate areas. The cost code is the lowest level of organisational hierarchy which would denote the department/service/ward e.g. Ward 1
Staff group	There are 9 staff groups to which workforce will belong, dependent on their role. These are: Additional Professional Technical & Scientific; Additional Clinical Services; Administrative & Clerical; Allied Health Professionals; Estates & Ancillary; Healthcare Scientists; Medical & Dental; Nursing & Midwifery Registered and Students
TRAC	NHS Recruitment system
SLE	Single Lead Employment model – Since 2019, all Junior doctors are now under an SLE contract and co-located within NHS Wales Shared Services Partnership (NWSSP) ESR data to allow doctors to rotate across health boards easily.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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Workforce Data Methodology overview

As part of the Activity Modelling workstream of the Clinical Services Plan the Strategic Workforce Planning team has provided the following report to assist the Workforce picture for the issues paper.

For the 9 Service areas noted, it is agreed that the Workforce data supplied will be based on the staffing consisted within the defined cost codes provided for each area. Where needed, additional information will be discussed with Service Managers as part of the current Task & Finish groups for each service.

As the scope of the project is to look at potential configuration changes for specific services, the workforce supporting the wider pathway will not be included within the data.

The data will focus on the clinical roles within the services i.e. Medical and Nursing workforce, but where available all professional group data from the cost codes will be presented.

To ensure any interdependencies are highlighted, any known workforce risks for the service will be included.

On the following pages the supplied cost codes for the service area are noted along with the intended outputs from each data set.

Due to the complexity of the workforce breakdown of some cost codes which can cover a number of service areas, where we may have not been able to disaggregate the specific workforce aligned to the service. Where these issues are raised within the data, this has been noted within the information provided.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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University Health Board

Workforce Data Sources and outputs

Workforce Area	Data Source	Output
Current Workforce	ESR Staff In Post for: 31st July 2023	Table/Graph denoting current Budget, Actual and Vacancies for each of the service areas based on cost codes supplied. This will be by Professional group and where possible by role and location (this will be determined by data availability for each area). Where possible this will also include details of any Temporary Workforce utilised.
Workforce Risks	Risk Register / Datix: 31st August 2023	Information on Current Service specific Workforce risks and any known interdependent service risks associated.
Historic Workforce Trend	ESR Staff in Post for 1st April 2018, 1st April 2019, 1st April 2020, 1st April 2021, 1st April 2022, 1st April 2023	Table/Graph denoting current Budget, Actual and Vacancies for each of the 9 service areas based on cost codes supplied for the period April 2018 to 2023. This will be by Professional group and where possible by role and location (this will be determined by data availability for each area).
Starters & Leavers	ESR Staff Movements Yearly data for 1st April to 31st March for each year	Table/Graph denoting number of Starters and Leavers across each of the service areas. As above, where possible additional information will be provided for role and location however we are aware for leavers some of this data is not available within ESR.
Recruitment Issues	TRAC / Recruitment Team	Information in table or narrative format detailing any known targeted campaign activity for each of the service areas across the time period 2018 – 2023. Additional data were available on volume of vacancies advertised in the last 12 months for each service.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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Radiology Workforce Overview
31st July 2023

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Radiology Workforce : Staff in post data from cost codes as of 31st July 2023

Staff Group	Role	Location /Site						Grand Total
		Bronglais General Hospital	Glangwili General Hospital	Prince Philip Hospital	Withybush General Hospital	Cardigan Integrated Care Centre	South Pembs Hospital	
Add Prof Scientific and Technic	Technician		1.6					1.6
	Add Prof Scientific and Technic Total		**1.6**					**1.6**
Additional Clinical Services	Assistant	6.9	14.5	7.0	9.8	1.0		39.2
	Assistant or Associate Practitioner	2.8		3.0				5.8
	Technician				1.6			1.6
	Additional Clinical Services Total	**9.7**	**14.5**	**10.0**	**11.4**	**1.0**		**46.6**
Administrative and Clerical	Clerical Worker	2.8	6.8	1.0	6.0		0.9	17.4
	Manager	1.0	1.6					2.6
	Medical Secretary		2.5	2.6	1.0			6.1
	Officer	1.0			1.0			2.0
	Personal Assistant				1.0			1.0
	Receptionist			3.0				3.0
	Secretary	1.7						1.7
	Administrative and Clerical Total	**6.5**	**10.8**	**6.6**	**9.0**		**0.9**	**33.8**
Allied Health Professionals	Radiographer - Diagnostic	16.4	35.3	29.7	22.2	1.0		104.6
	Radiographer - Diagnostic Advanced Practitioner		1.4					1.4
	Radiographer - Diagnostic, Consultant	1.0						1.0
	Radiographer - Diagnostic, Manager	3.0		1.0	4.2			8.2
	Radiographer - Diagnostic, Specialist Practitioner	2.4		3.4	1.0			6.8
	Superintendent Sonographer		1.0	0.8				1.8
	Senior Sonographer		0.9					0.9
	Reporting Sonographer		2.9	0.8	2.8			6.6
	Sonographer	2.7						2.7
	Allied Health Professionals Total	**25.5**	**41.5**	**35.7**	**30.2**	**1.0**		**133.9**
Estates and Ancillary	Porter				2.7			2.7
	Estates and Ancillary Total				**2.7**			**2.7**
Healthcare Scientists	Sonographer		0.4					0.4
	Healthcare Scientists Total		**0.4**					**0.4**
Medical and Dental	Consultant	3.8	4.0	5.0	2.5			15.3
	Specialist		1.0					1.0
	Medical and Dental Total	**3.8**	**5.0**	**5.0**	**2.5**			**16.3**
Nursing and Midwifery Registered	Midwife Sonographer	0.2	1.0		1.0			0.2
	Specialist Nurse		2.0					2.0
	Staff Nurse	1.0		4.0	1.6			6.6
	Nursing and Midwifery Registered Total	**1.2**	**3.0**	**4.0**	**2.6**			**10.8**
	Total	**46.7**	**76.8**	**61.3**	**58.3**	**2.0**	**0.9**	**246.0**

The table shows the breakdown of the staff group, role and location of the workforce across the Radiology service as of 31st July 2023.

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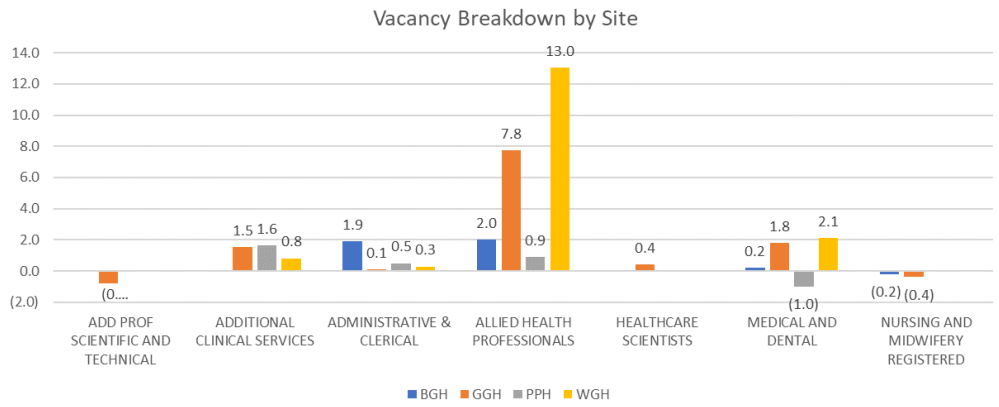
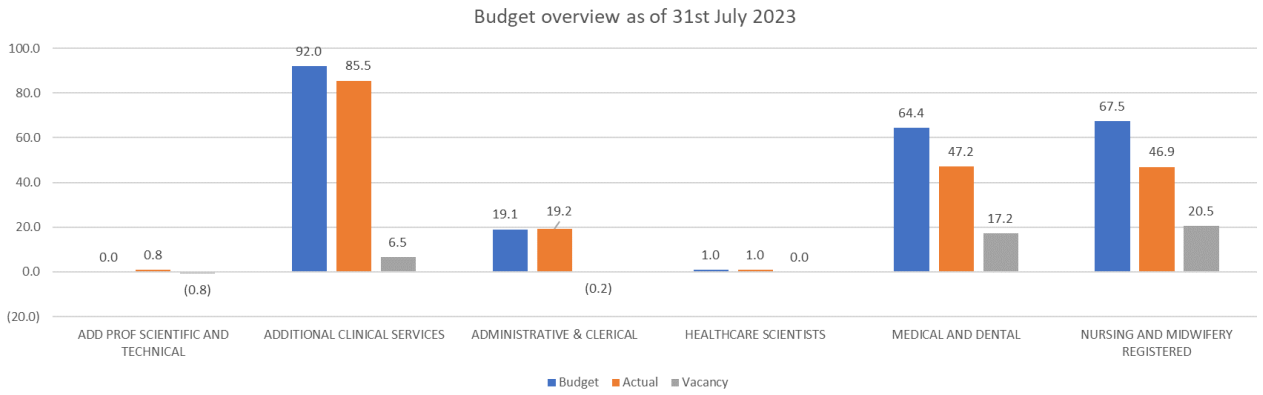
Radiology Workforce continued (as of 31st July 2023)

	All Site Totals			Vacancy Breakdown By Site					
Staff Group	Budget	Actual	Vacancy	BGH	GGH	PPH	WGH	Cardigan ICC	Health Board wide
ADD PROF SCIENTIFIC AND TECHNICAL	0.8	1.6	(0.8)		(0.8)				
ADDITIONAL CLINICAL SERVICES	51.0	46.0	5.0		1.5	1.6	0.8	1.0	
ADMINISTRATIVE & CLERICAL	36.7	33.8	2.8	1.9	0.1	0.5	0.3		
ALLIED HEALTH PROFESSIONALS	160.5	133.8	26.7	2.0	7.8	0.9	13.0		3.0
ESTATES AND ANCILLIARY	2.7	2.7	(0.0)						
HEALTHCARE SCIENTISTS	0.8	0.4	0.4		0.4				
MEDICAL AND DENTAL	19.4	16.3	3.1	0.2	1.8	(1.0)	2.1		
NURSING AND MIDWIFERY REGISTERED	9.2	9.8	(0.6)	(0.2)	(0.4)				
Grand Total	281.0	244.4	36.5	3.9	10.4	2.0	16.3	1.0	3.0





The table and graph show the current Budget, Actual workforce in post, and the vacancies within the Radiology service. As of 31st July 2023 there was a total of 36.5WTE vacancies within the service, the majority of these vacancies can be seen in Withybush Hospital.

As expected the highest vacancies are within the Allied Health Professional workforce with 26.7WTE, the majority are across GGH and WGH (7.8WTE and 13WTE). Additional clinical services, Medical & Dental and Admin and clerical have smaller vacancies which are spread across the health board geography.

During this period an average of 6WTE agency Radiologists and a minimum of 15WTE agency Radiographers and Sonographers were being utilised on average across radiology services. For Nursing and Additional clinical services roles an additional 2.22WTE a week of additional temporary staffing was utilised. 1.54WTE through Bank usage with the remainder from contracted agency. This equates to a minimum of 23.22WTE additional temporary workforce being utilised to fill the vacancy gap.

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Radiology Workforce continued: additional external activity

EverlightRadiology

Everlight Radiology is an external company that provide an after hours reporting service to the Health Board through tele-radiology. Images are taken at the hospital site and then transmitted to Everlight to enable specialist radiologist to undertake the reporting and diagnosis element when an on site consultant radiologists is not available. This service is generally utilised between the hours of 5pm and 9am on weekdays and may be used across the weekends from 5pm Friday to 9am on Monday. The majority of the activity takes place between 5pm – 11.30pm.

During 2022/23 Everlight undertook 37,375 tele radiology reports for the Health Board, demonstrating the challenges faced in the service to manage growing demand. This relates to reporting activity only during this period. Further focus is needed to understand what the true workforce gap is in the Radiologist workforce, as Everlight data does not reflect the current job plans of substantive staff, therefore actual reporting capacity of our Radiologists requires further consideration.

However, based on previous (and current) Everlight usage it is evident that there is a workforce gap in our Radiologist workforce, and it is anticipated that a number of additional Consultant radiologists would be required to meet demand, to address the additional reporting activity that is being outsourced to Everlight. The ambition is to reduce the reliance on using Everlight, which is being actively prioritised and reviewed by the service.

There is an ongoing requirement for demand and capacity work to be prioritised, to understand true demand at present, as well as to explore future service provision and workforce requirements (for all roles) to meet the needs of the local population. Targeted efforts to explore job plans for substantive consultant and locum consultants (acknowledging that their job plans differ) is necessary, which will also enable further consideration of opportunities to support locums to undertake their CESR application, to hopefully become substantive staff. This will help to develop the workforce using more sustainable options. Some of this work is currently underway to reduce the reliance on Everlight through recruitment of Locum Consultant Radiologists who are due to commence in post from April 2024.

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Workforce Risks continued

Service Risk Linked to 1649	Directorate	Risk Statement	Workforce Themes	Workforce Control Mesaures in place	Current Risk Score	Previous Risk Score	Movement (↓, ↑ & ↔)	RAG Rating	Staff Group/ Groups affected
111	USC: Radiology	There is a risk of avoidable delay in diagnosis and treatment of patients, leading to a poorer quality of care. Increases in diagnostic waiting time breaches and cancer pathway breaches. This is caused by unavailability of consultants in specialised areas (MSK Paeds and Interventional). Under establishment per population heads and when compared with the neighbouring HB in Wales. This will lead to an impact/affect on the failure to treat patients, clinical deterioration and death. Lack of availability to cover MDT meetings. Increased costs for external reporting. Inpatients may have increased length of stay due to delay in reported studies being available. Increased turnaround time for reports. Financial impacts due to high cost of external reporting and agency staff Risk location, Health Board wide.	**Hard to fill Consultant vacancies. Locum usage**	Arrangements in place for additional reporting by existing radiology team (In lieu of Locum). Unreported studies sent to third party tele-radiology company (Everlight). Recruitment campaign commenced to target radiologists with special interest. Communication with both Swansea Bay and the National Imaging Academy for additional support with joint appointments and trainee radiologist placements. Continued communication with Swansea Bay around joint appointments. Reporting radiographers working to capacity , worklists redone to accommodate. Reporting radiographers trained for appropriate studies. Use of some locums and low cost agency to fill some gaps. Establishment of Clinical interface group with primary and secondary care leads to continuously review pathways and attempt to reduce demand. Employing final years registrars to complete reporting at weekends. Continued encouragement and discussion of local trainees to retain in HDHB.	**15**	**15**	↔		**Medical**
114	**USC: Radiology**	"There is a risk delay in diagnosis, not achieving 8 week diagnostic waits, increased inpatient Length of Stay (LOS) and inability to achieve cancer pathway targets. This is caused by increased demand for CT, MRI, Ultrasound and nuclear medicine which exceeds current capacity and staffing to deliver. Establishment of radiology staff and radiologists have not increased with demand. Inability to recruit to vacancies in both disciplines. This will lead to an impact/affect on delayed access to all imaging resulting in Negative impact on patient health and treatment plans. Increased stress and pressure for radiology staff. Risk location, Health Board wide."	**Demand & Capacity, wellbeing, vacancies, hard to fill vacancies**	"Monthly monitoring of activity, demand. Patients / staff moved to available capacity . Weekly review of all patients on Cancer Pathway. Prioritisation of referrals based on clinical risk and discharge dependant investigations. Regular monitoring of waits. Staff working additional hours to meet demand.	**15**	**15**	↔		**Diagnostics, AHPs**

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Workforce Risks continued

Service Risk Linked to 1649	Directorate	Risk Statement	Workforce Themes	Workforce Control Mesaures in place	Current Risk Score	Previous Risk Score	Movement (↓, ↑ & ↔)	RAG Rating	Staff Group/ Groups affected
1223	**USC: Radiology**	"There is a risk of patients not receiving Radiology procedures out of hours across the Health Board, affecting CT and General Radiography This is caused by on call being a voluntary rota and additional to basic working hours, exacerbated by staff shortages due to vacancies and illness and long-term sickness - particularly at WGH and GGH. Increased activity during on call shifts. This will lead to an impact/affect on timely and safe patient care and diagnosis, and commencement of required treatment. Also has an impact on staff morale. Reputational damage to the Health Board, and a potential negative impact on RTT times. Risk location, Health Board wide.	**Vacancies, recruitment, sickness, wellbeing, morale, agency, demand & capacity, locums**	"Services can be provided at alternative sites where possible, therefore patients can be diverted when critical On call rotas done in advance to determine where shortfalls may arise, at which point alternative arrangements are considered to plug the gap Continued recruitment cycle and sourcing agency staff - reviewed on a monthly basis Additional Elective Recovery Planning (ERP) lists in place over the weekends to try and manage backlog of work Cross-site working of staff where possible when there are workforce gaps identified Continual review of staffing capacity, streamlining opportunities and locum staff availability, cross-site cover Engagement with the Society of Radiographers to explore potential staffing models"	**12**	**12**	**↔**		**Diagnostics, AHPs**
1341	**USC: Radiology**	"There is a risk of the loss of radiology services at community hospitals in Pembrokeshire This is caused by the need to centralise Radiology services at WGH by withdrawing X Ray services at both Tenby Cottage Community Hospital and South Pembrokeshire Community Hospital in order to provide a safer service as a result of critical staff shortages. Reason for staff shortages at WGH include: •Long term sickness absence •Long standing recruitment issues and retirement. •Underestimation of projected increase in workload and workforce review. •The OOH system •Historical part time and term friendly contracts. •No planned backfill for radiographers leaving the general area prior to them going to other modalities. This will lead to an impact/affect on •The inability to deliver of X-ray services in the community hospitals •Cause additional fragility to the out of hours on call system •Potential for loss of services at WGH if staff absence increases, or we are not successful via recruiting. Risk location, Pembrokeshire, Withybush General Hospital.	**Recruitment and retirement, long term sickness rate & management, agency use - Medacs, loss of serivce is staff shortages increase**	"*Centralising services in Withybush to improve working conditions for radiographers and increase safety of service, therefore keeping essential services running. *Seek assistance via Medacs for additional staff - currently permanent advert out for general radiography staff. *Review of service provision to identify potential gaps or service failures in good time to reduce further risk"	**12**	**12**	**↔**		

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Workforce Risks

The following Workforce themed risks appeared on Datix (as of 31st August 2023).

Service Risk Linked to 1649	Directorate	Risk Statement	Workforce Themes	Workforce Control Mesaures in place	Current Risk Score	Previous Risk Score	Movement (↓, ↑ & ↔)	RAG Rating	Staff Group/ Groups affected
1349	**USC: Radiology**	There is a risk of service failing to deliver the ultrasound service at WGH. This is caused by a lack of appropriately trained obstetric staff, with no additional capacity on site to absorb displaced patient slots. The obstetric ultrasound examination unit operating at reduced capacity due to: *Lack of robust plan to replace sonographers who have now retired. *National shortage of radiographers within the general area. *Staff working arrangements changing, with several now going part time *Increased obstetric demand - specifically for 3rd trimester scans in line with the WAG targets of reducing still birth rates. This will lead to an impact/affect on increasing routine ultrasound waiting lists (which is already breaching 40 weeks in some cases), adverse peri-natal outcomes, failure to provide routine obstetric screening nuchal translucency (NT), and anomaly scans, failure to provide growth scans (the HB is not working in line with Growth Assessment Protocol (GAP) grow guidelines), non-adherence to RCOG and NICE guidelines, increased stress for staff creating a negative working culture, increased risk of staff developing Repetitive Strain Injury (RSI) and reduction in confidence from stakeholders. Additional impacts include failure to provide SDEC with same-day diagnostics, and DVT diagnostics. Risk location, Withybush General Hospital.	**Staff vacancies, workforce model, morale, wellbeing**	*Continual recruitment campaigns *Ability to request assistance from other sites when peak staff shortages experienced at WGH *Review of current workforce issues by senior management, and SBARs drafted for relevant Bronze and Silver * Met with recruitment to improve advertising of posts. * Outpatient referrals are being sent to other sites. * Some weekend working in place during Apr22 where there are gaps in service during the week. * In addition to the Site Lead Superintendent Radiographer, it has been agreed that sonographers from other sites will provide cover when possible, and a locum for 2 months has been agreed. * Waiting lists monitored and prioritised * Ultrasound Control Group	**20**	**20**	**↔**		**Diagnostics**

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Workforce Risks continued

Service Risk Linked to 1649	Directorate	Risk Statement	Workforce Themes	Workforce Control Mesaures in place	Current Risk Score	Previous Risk Score	Movement (↓, ↑ & ↔)	RAG Rating	Staff Group/ Groups affected
1399	**USC: Radiology**	"There is a risk of IRMER non-compliance This is caused by a lack of dedicated Quality Lead, a lack of dedicated document control systems within the service, and staffing pressures. Current document control systems in place are not capable of the level of document control that is required to ensure compliance with IRMER standards. This will lead to an impact/affect on Radiology services in the Health Board, as risk of non-compliance could lead to services being stopped, therefore directly impacting on wider services in the Health Board, including (but not limited to) General Surgery, Cancer, Trauma and Stroke. Current staff are unable to take on additional work required in order to meet standards due to operational and workforce pressures. The Health Board will also be unable to achieve accreditation by Quality Standards in Imaging without a dedicated individual or document control system in place within the Directorate to drive quality standards and ensure adherence to requirements. Risk location, Health Board wide.	**Vacancies - staffing pressures, wellbeing of current staff, demand & capacity, IMTP mentioned in risk actions**	"1. Monthly site lead meetings and regular communication on quality issues 2. All Wales Radiology Quality Forum (informal group) which is attended by site leads 3. Radiology QSE meetings, standing agenda item on Quality which encompasses IRMER requirements 4. Use of shared drives and document sharing facilities on Teams "	**20**	**20**	↔		**Diagnostics, AHPs**
1547	**USC: Radiology**	"There is a risk of the inability to provide a quality and timely service across the Radiology directorate, and a detrimental impact on staff morale and welfare This is caused by under-established workforce within the Directorate of radiographers and radiologists, in addition to recruitment challenges, particularly within specialist areas This will lead to an impact/affect on quality of patient care, as there are delays in the diagnosis and subsequent treatment, and a negative impact on waiting lists therefore affecting performance against ministerial directives. An additional impact of the risk is the requirement for staff to work overtime to cover service demands, resulting in staff burnout and fatigue. Risk location, Health Board wide."	**Vacancies for radiographers and radiologists, wellbeing of current staff due to demand & capacity, GYO approach, locums & agency used**	Agency radiographers Additional reporting lists offered to locum consultants on weekends Outsourcing reporting to maximum capacity via Everlight Employing locum consultants Existing radiographers working additional lists via overtime / on weekends Prioritising reporting of USC / Multi-Disciplinary Team cases and urgent cases, and follow up appointments Support from site lead radiographers to assist with staff welfare Regular team communications on sites via team meetings Use of Resource meeting on a monthly basis with Finance to review and prioritise spend Continued recruitment activity Grow Your Ownâcheme whereby NQTs being identified for training in specialised areas to reduce dependence on locum	**15**	**15**	↔		**Diagnostics, AHPs**

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Workforce Risks continued

Service Risk Linked to 1649	Directorate	Risk Statement	Workforce Themes	Workforce Control Mesaures in place	Current Risk Score	Previous Risk Score	Movement (↓, ↑ & ↔)	RAG Rating	Staff Group/ Groups affected
1658	**USC: Radiology**	There is a risk of Wanchese repetitive strain injury (RSI) to sonographers across the Health Board. This is caused by a national shortage in sonographers. The small numbers of available sonographers has presented challenges in the ability to train additional sonography staff within the Health Board. The global increase in patient BMI has also had an effect on musculoskeletal (MSK) injuries amongst sonographers. Additionally, there have been changes in policy/patient pathways which has meant an increase in both obstetric and urgent ultrasound demand. This will lead to an impact/affect on increased numbers of sonography staff taking time off work due to sickness, and could result in some departments experiencing either a significant or complete loss of service. In addition, further clinical pressures are presented in terms of fitting additional examinations during sonographer lists, with demand exceeding current capacity. A loss of service would also have a significant impact and risk on patient care. If left untreated and not properly managed, sonographers may suffer career changing injuries. The Health Board has a duty of care to balance the risk between further staff injury/worsening of injury and service loss. There is also a detrimental effect on staff morale, as a reduced workforce causes inflexibility in terms of sonographers being able to take recommended breaks. There have been restrictions to vary the types of examinations and workload, along with the inability to take leave when requested. In addition, some sonographers are required to work solely in high impact areas such as obstetrics. Risk location, Health Board wide.	**Shortage of Sonographers - increased health risks and long-term sickness**	Vary examination lists where possible in order to reduce RSI, as some scans are harder on the wrist/shoulder than others. Increase all obstetric examination times to 30 mins which will further impact scanning capacity. Obstetrics are particularly challenging to scan from an RSI perspective. Ensuring there are reporting breaks within scan lists to minimise injury. Weekly Multi-Disciplinary Team meeting (Ultrasound Control Group) headed by General Manager of Radiology, to actively address the Ultrasound challenges across the Health Board and Plan. In sourcing currently being investigated by Head of Radiology.	**20**				**HCS**

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Workforce Risks continued

Service Risk Linked to 1649	Directorate	Risk Statement	Workforce Themes	Workforce Control Mesaures in place	Current Risk Score	Previous Risk Score	Movement (↓, ↑ & ↔)	RAG Rating	Staff Group/ Groups affected
1659	**USC: Radiology**	There is a risk of Wanchese being unable to undertake obstetric scanning at Bronglais General Hospital This is caused by ageing equipment, which is resulting in sub-optimal image quality being produced. The equipment requires to be replaced after 5 years of use - this item was purchased in April 2018, and therefore is now exceeding its recommended life expectancy. This will lead to an impact/affect on the ability to maintain ultrasound obstetric service at Bronglais General Hospital. Patients would need to be relocated to alternative acute sites across the Health Board, adding to existing pressures on sonography services being experienced at Glangwili General Hospital, Withybush General Hospital and Prince Philip Hospital. In addition, there is an impact to the patient and foetus with imaging not being to the required standard, resulting in the potential of incorrect diagnosis being made. This results in additional stress and a negative impact on staff welfare to sonographers undertaking obstetric scans. Risk location, Bronglais General Hospital.	**Not workforce related but issue affecting workforce**	Ultrasound Control Group in place since April 2023 Equipment noted on Equipment Replacement List	**20**				**HCS**

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Radiology Workforce Overview
Historic picture
April 2018 – April 2023

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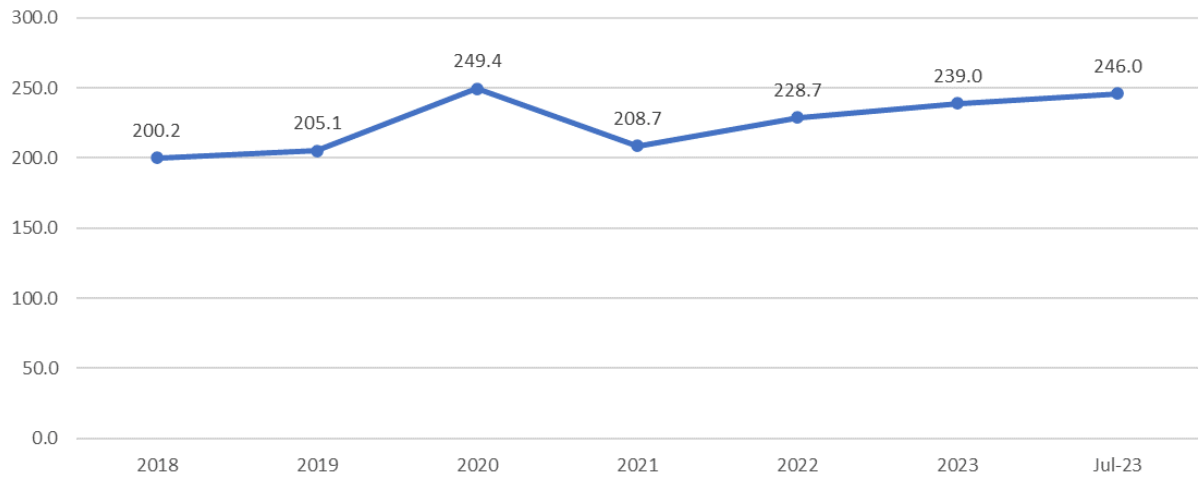
Historic Workforce

The data below shows a historic picture of the ESR Staff in post for cost codes as at 1st April each year.

Radiology Cost codes	2018	2019	2020	2021	2022	2023	Jul-23
Add Prof Scientific and Technic	1.6	1.6	1.6	1.8	1.6	1.6	1.6
Additional Clinical Services	26.2	28.2	46.1	32.3	39.1	42.5	46.6
Administrative and Clerical	29.2	30.1	33.8	30.5	35.5	34.0	33.8
Allied Health Professionals	121.3	121.4	136.8	118.4	123.4	132.6	133.9
Estates and Ancillary	2.7	2.7	2.7	2.7	1.7	2.7	2.7
Healthcare Scientists			0.4			0.4	0.4
Medical and Dental	11.0	12.6	16.3	13.0	16.0	14.5	16.3
Nursing and Midwifery Registered	8.2	8.6	11.6	10.0	11.4	10.8	10.8
TOTAL WTE	**200.2**	**205.1**	**249.4**	**208.7**	**228.7**	**239.0**	**246.0**



A significant growth in workforce can be seen in 2020 of 44.3WTE as additional workforce was recruited to help meet the increased demand during the Covid-19 pandemic. The subsequent decrease to the service in 2021 of 40.7WTE could be as a result of fixed term contracts coming to an end and additional retirements post Covid-19.

Since 2021 the workforce has increased steadily to try and meet the challenges of the increase in demand on the service. As at 31st July 2023 the total workforce across Radiology services was 246WTE.

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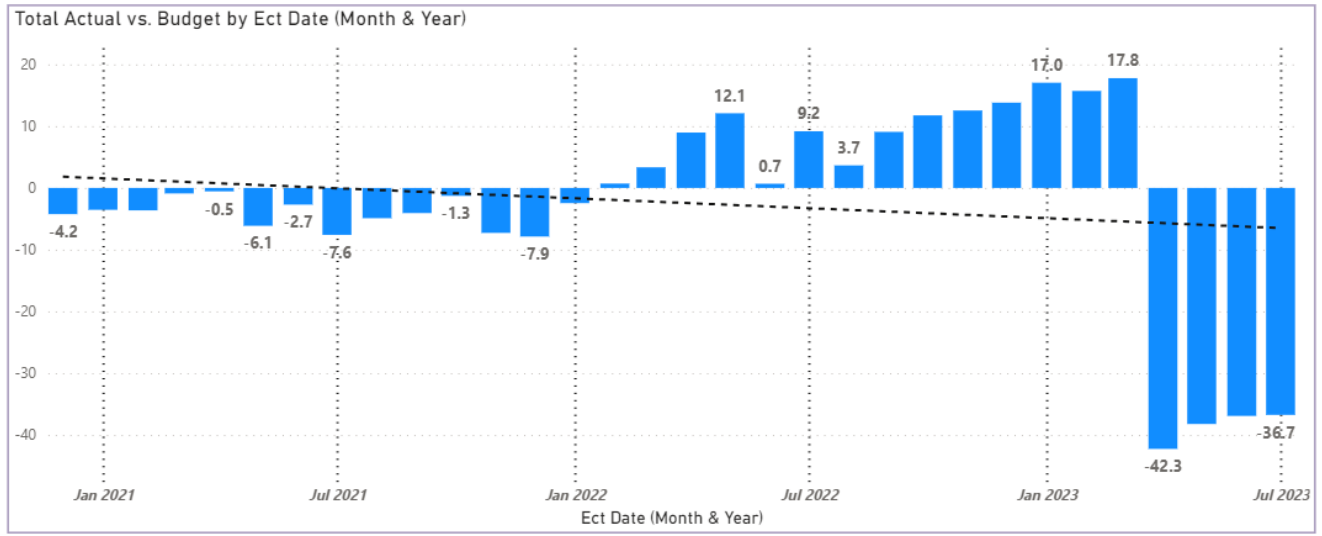
Historic Workforce continued

The data below shows a historic picture of the vacancies across the radiology service between December 2020 and July 2023.

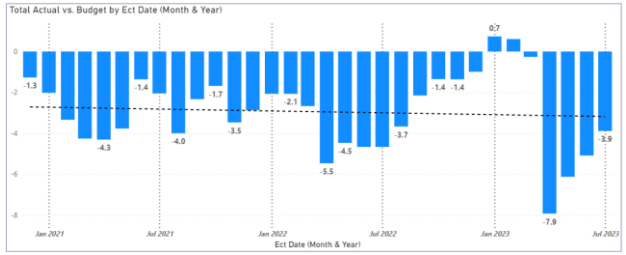


The vacancy graph (left) depicts the vacancy increase and decrease across the timeline since December 2020. The highest number of vacancies can be seen in April 2023 with 42.3WTE. The graphs below show the vacancies by site for the same time period.
As can be seen all sites had significant increases in their vacancies during April 2023. This is as a result of an increase in budget for radiology to support cost pressures and create much needed vacancies in the service to address the demand.

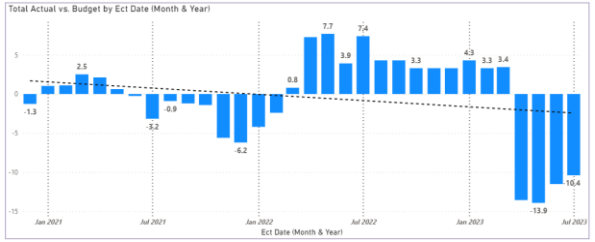
GGH and WGH vacancies have remained the most static during the period December 2020 to March 2023, with GGH running slightly over budget for the majority of 2022 and WGH running slightly under budget with an average vacancy of 2.2WTE across the period. This consistent vacancy gap may indicate potentially hard to fill posts.

PPH, until April 2023 were consistently over budget whilst BGH has held consistent vacancies averaging at 3WTE. This increased substantially to 7.9WTE in April 2023 however this has decreased to 3.9WTE as of July 2023.

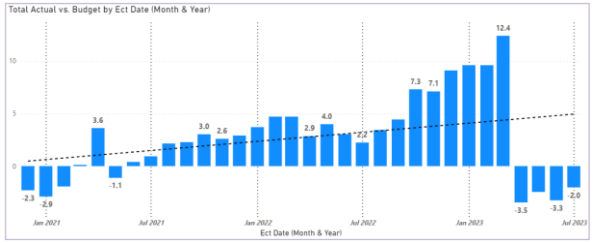
BGH Vacancy timeline



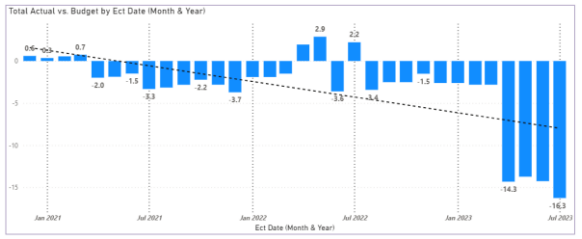
GGH Vacancy timeline



PPH Vacancy timeline



WGH Vacancy timeline



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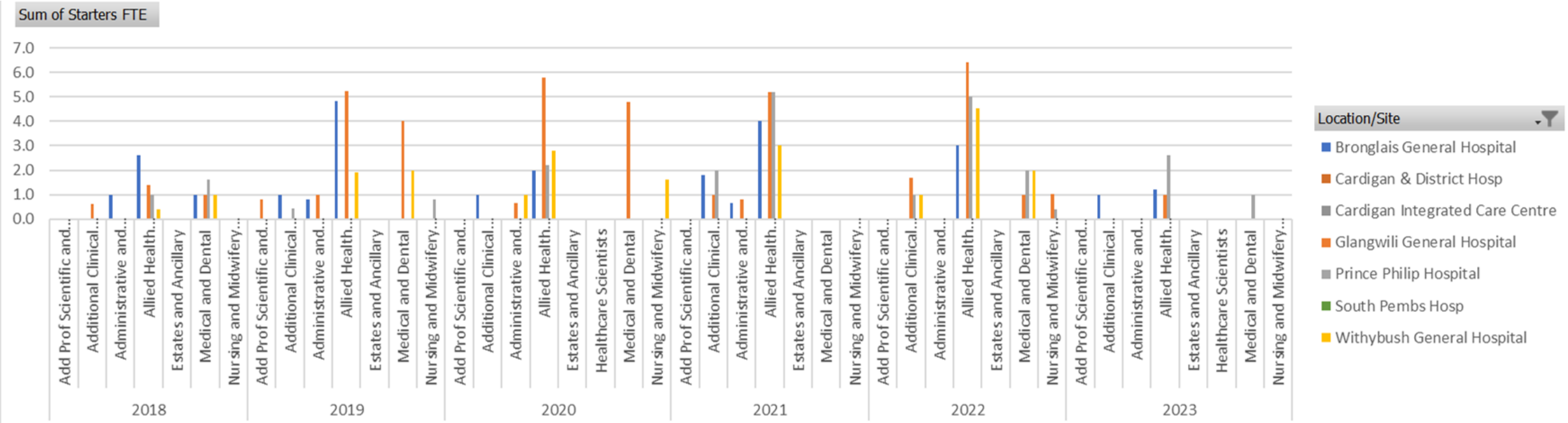
Starters



	2018	2019	2020	2021	2022	2023
Starters	11.6	22.8	21.8	23.7	29.1	6.8

The largest increase in new starters was seen in 2022 in Allied Health Professionals with 18.9WTE. The highest increase of staff across the five year period with 29.1WTE starting in the year, the majority in Glangwili hospital (10.1WTE).

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SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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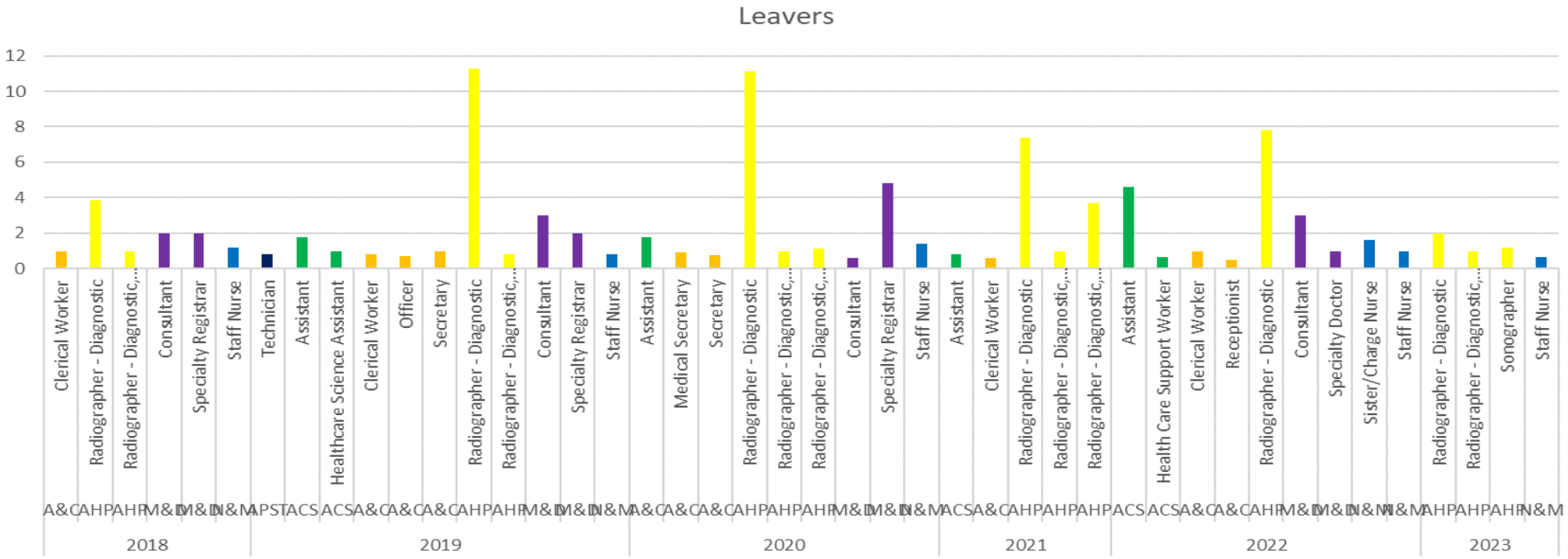
Leavers



Leavers	2018	2019	2020	2021	2022	2023
Add Prof Scientific and Technic		0.8				
Additional Clinical Services		2.8		0.8	5.3	
Administrative and Clerical	1	2.5	3.5	0.6	1.5	
Allied Health Professionals	4.9	12.1	13.2	12.1	7.8	4.2
Medical and Dental	4	5	5.4		4	
Nursing and Midwifery Registered	1.2	0.8	1.4		2.6	0.7
Total	**11.1**	**24**	**23.5**	**13.5**	**21.2**	**4.9**

The majority of leavers across Radiology have been within the Allied Health Professional staff group (denoted in yellow). The highest number of leavers were in 2019 & 2020 with 24WTE and 23.5WTE leaving respectively each year.

This corelates with the increase seen across 2019 and 2020 in starters (22.8WTE & 21.8WTE) within Allied Health Professionals across the same time period, however the service lost more staff than it gained in total during this period.

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University Health Board

Recruitment

Targeted Campaigns across the period 2018 – 2023:

No targeted recruitment campaigns were noted during the period for Radiology however online enhancements were placed in the British Medical Journal for all the locum posts advertised below.

Vacancy /Recruitment overview:

Vacancy Information (last 12 months)	Role	Outcome
100-MED-GGH-189	Consultant Radiologist	2 WTE advertised - 1 started in post
100-MED-WGH-121-L	Locum Consultant General Radiology Non Vascular Intervention interest	1 WTE - 1 offer made but withdrew due to change of circumstances
100-MED-WGH-115-L	Locum Consultant Radiologist with an interest in Breast Radiology	1 WTE - 1 candidate rejected after interview
100-MED-PPH-085-L	Locum Consultant Radiologist with an interest in Head & Neck Radiology	1 WTE - 1 application withdrawn and another did not show at interview
100-MED-WGH-115-L1	Locum Consultant Radiologist with an interest in Breast Radiology	1 WTE - 3 applications received, 1 offer made but candidate withdrew due to change of circumstances
100-MED-WGH-121-L1	Locum Consultant General Radiology Non Vascular Intervention interest	1 WTE - 0 applications received
100-MED-PPH-085-L1	Locum Consultant Radiologist with an interest in Head & Neck Radiology	1 WTE - 2 rejected, 1 offer made but withdrew
100-MED-GGH-287-L	Locum Consultant in Radiology - Cross Sectional Imaging	4 WTE advertised - 5 applications to be interviewed

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Recruitment continued

Headhunting:

Role	Outcome
Locum Consultant with interest in breast radiology	30 candidates headhunted via LinkedIn. 4 responses interested in coming to wales. 1 CV sent to service and interview was arranged 5th May 2023. Doctor was unsuccesful at consultant level but offered lower grade to work up to consultant level - chased doctor for an update but lost contact with us.
Locum Consultant Radiologist with an interest in Head & Neck Radiology	10 doctors headhunted via Linkedin - No interest
Locum Consultant General Radiology with an interest in Non Vascular Intervention	5 doctors headhunted - No interest. Very difficult to headhunt for intervention.

Hywel Dda University Health Board
Equality Impact Assessment (EqIA)

Please note:

Equality Impact Assessments (EqIA) are used to support the scrutiny process of procedures / proposals / projects by identifying the impacts of key areas of action before any final decisions or recommendations are made.

It is recognised that certain proposals or decisions will require a wider consideration of potential impacts, particularly those relating to service change or potential major investment. For large scale projects and strategic decisions please consult the Health Board's Equality and Health Impact Assessment Guidance Document and associated forms.

The completed Equality Impact Assessment (EqIA) must be:

- Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval.
- Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.

For in-house advice and assistance with Assessing for Impact, please contact:

Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Form 1: Overview

1.	**What are you Equality Impact assessing?**	Radiology Services throughout the Hywel Dda University Health Board.
2.	**Brief Aims and Description**	To consider the impact of the Radiology Service within Hywel Dda University Health Board.
3.	**Who is involved in undertaking this EqIA?**	Radiology Site Leads and Head of Radiology.
4.	**Is the Policy related to other policies/areas of work?**	Part of the overall Clinical Service Plan and the Healthier Mid and West Wales Strategy. Diagnostics: Recovery and Renewal: Report of the Independent Review of Diagnostics Services for NHS England DIAGNOSTICS: RECOVERY AND RENEWAL – Report of the Independent Review of Diagnostic Services for NHS England – October 2020 Imagine Statement of Intent imaging-statement-of-intent.pdf (gov.wales)

		NHS Wales Executive: Strategy for Developing a Radiology Workforce Model for Wales heiw.nhs.wales/files/strategy-for-developing-a-radiology-workforce-model-for-wales/
5.	**Who will be affected by the strategy / policy / plan / procedure / service?** (Consider staff as well as the population that the project / change may affect to different degrees)	All Health Board staff. All patients who use the Service, along with relatives, friends, carers and all other visitors.
6.	**What might help/hinder the success of the Policy?**	Continued engagement and support from Radiology Service Staff. The Service is currently working as a Health Board Radiology Service rather than by individual sites. The Service currently has some staffing deficits.

Form 2: Human Rights

Human Rights: The Human Rights Act contains 15 Articles (or rights), all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below. Depending on the Policy you are considering, you may find the examples below helpful in relation to the Articles.		
Consider, is the Policy relevant to:	**Yes**	**No**
Article 2: The right to life **Example**: The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control	x	
Article 3: The right not to be tortured or treated in an inhuman or degrading way **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; Issues of patient restraint and control	x	
Article 5: The right to liberty **Example**: Issues of patient choice, control, empowerment and independence; issues of patient restraint and control	x	
Article 6: The right to a fair trial **Example**: issues of patient choice, control, empowerment and independence	x	

Article 8: The right to respect for private and family life, home and correspondence; Issues of patient restraint and control **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life	x	
Article 11: The right to freedom of thought, conscience and religion **Example**: The protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers	x	

<table>
<tr><th>How will the strategy, policy, plan, procedure and/or service impact on:</th><th>Positive</th><th>Negative</th><th>No impact</th><th>Potential positive and / or negative impacts

Please include unintended consequences, opportunities or gaps. This section should also include evidence to support your view e.g. staff or population data.</th><th>Opportunities for improvement / mitigation

If not complete by the time the project / decision/ strategy / policy or plan goes live, these should also be included within the action plan.</th></tr>
<tr><td>Age
Is it likely to affect older and younger people in different ways or affect one age group and not another?</td><td></td><td>X</td><td></td><td>Population:
<table>
<tr><th>Year (data was collected)</th><td colspan="8">2021</td></tr>
<tr><th>County</th><td colspan="2">Carmarthenshire</td><td colspan="2">Ceredigion</td><td colspan="2">Pembrokeshire</td><td colspan="2">Total</td></tr>
<tr><th>Measure</th><td>value</td><td>percent</td><td>value</td><td>percent</td><td>value</td><td>percent</td><td>value</td><td>percent</td></tr>
<tr><th>Age</th><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Total: All usual residents</td><td>187,895</td><td>100</td><td>71,468</td><td>100</td><td>123,366</td><td>100</td><td>382,729</td><td>100.0</td></tr>
<tr><td>Aged 4 years and under</td><td>9,057</td><td>4.8</td><td>2,706</td><td>3.8</td><td>5,586</td><td>4.5</td><td>17,349</td><td>4.4</td></tr>
<tr><td>Aged 5 to 9 years</td><td>10,274</td><td>5.5</td><td>3,288</td><td>4.6</td><td>6,731</td><td>5.5</td><td>20,293</td><td>5.2</td></tr>
<tr><td>Aged 10 to 15 years</td><td>13,080</td><td>7</td><td>4,087</td><td>5.7</td><td>8,494</td><td>6.9</td><td>25,661</td><td>6.5</td></tr>
<tr><td>Aged 16 to 19 years</td><td>7,799</td><td>4.2</td><td>4,129</td><td>5.8</td><td>4,890</td><td>4</td><td>16,818</td><td>4.7</td></tr>
<tr><td>Aged 20 to 24 years</td><td>8,821</td><td>4.7</td><td>6,366</td><td>8.9</td><td>5,621</td><td>4.6</td><td>20,808</td><td>6.1</td></tr>
<tr><td>Aged 25 to 34 years</td><td>20,692</td><td>11</td><td>7,106</td><td>9.9</td><td>12,907</td><td>10.5</td><td>40,705</td><td>10.5</td></tr>
<tr><td>Aged 35 to 49 years</td><td>31,801</td><td>16.9</td><td>10,145</td><td>14.2</td><td>19,459</td><td>15.8</td><td>61,405</td><td>15.6</td></tr>
<tr><td>Aged 50 to 64 years</td><td>40,905</td><td>21.8</td><td>15,256</td><td>21.3</td><td>27,335</td><td>22.2</td><td>83,496</td><td>21.8</td></tr>
<tr><td>Aged 65 to 74 years</td><td>24,605</td><td>13.1</td><td>9,942</td><td>13.9</td><td>17,444</td><td>14.1</td><td>51,991</td><td>13.7</td></tr>
<tr><td>Aged 75 to 84 years</td><td>15,246</td><td>8.1</td><td>6,095</td><td>8.5</td><td>10,855</td><td>8.8</td><td>32,196</td><td>8.5</td></tr>
</table></td><td></td></tr>
</table>

Aged 85 years and over	5,615	3	2,348	3.3	4,044	3.3	12,007	3.2		

A significant proportion of the Health Board population are over 50 years old. The Health Board population is an ageing population and this is projected to continue in the immediate future.

Patients:

Radiology patient cohort age breakdown:

	2019			**2020**			**2021**		
	Carms	**Ceredigion**	**Pembs**	**Carms**	**Ceredigion**	**Pembs**	**Carms**	**Ceredigion**	**Pembs**
Age									
<=4	869	223	369	1027	278	401	824	203	285
5-9	957	244	378	826	218	353	782	221	375
10-15	1986	497	780	1440	458	667	1450	389	649
16-19	1197	417	555	947	327	454	926	268	393
20-24	1788	717	736	1407	579	689	1349	489	507
25-34	4254	1220	1780	3559	943	1670	3293	807	1264
35-49	6530	1747	2672	5216	1448	2332	4805	1169	1814
50-64	9874	2592	4195	7381	2197	3303	6268	1758	2645
65-74	7530	1992	3325	4928	1494	2286	4183	1213	1720
75-84	5407	1602	2594	3497	1063	1589	3096	896	1268
>=85	2263	751	1182	1601	578	812	1400	423	591
Total	**42655**	**12002**	**18566**	**31829**	**9583**	**14556**	**28376**	**7836**	**11511**

	2022			**2023**			**Grand Total**

	Carms	Ceredigion	Pembs	Carms	Ceredigion	Pembs	
Age							
<=4	455	83	125	211	52	75	5480
5-9	625	187	221	362	124	166	6039
10-15	1151	364	461	654	201	263	11410
16-19	736	185	329	395	103	159	7391
20-24	1002	289	407	572	161	193	10885
25-34	2553	546	905	1434	276	412	24916
35-49	3689	904	1343	1967	469	747	36852
50-64	4896	1319	2077	2731	761	1065	53062
65-74	3379	904	1254	1861	481	697	37247
75-84	2635	686	986	1340	377	468	27504
>=85	1028	292	406	584	151	181	12243
Total	**22149**	**5759**	**8514**	**12111**	**3156**	**4426**	**233029**

Age range	HB population	Radiology Attendances
Under 16	16%	9%
16-50	37%	32%
over 50	43%	59%

Radiology has a higher proportion of their patients in the over 50 range.

Staff:

Age										
25 and under	*26-30*	*31-35*	*36-40*	*41-45*	*46-50*	*51-55*	*56-60*	*61-65*	*66 and over*	*Grand Total*
17	*28*	*44*	*51*	*33*	*42*	*41*	*34*	*30*	*13*	*333*
5%	*8%*	*13%*	*15%*	*10%*	*13%*	*12%*	*10%*	*9%*	*4%*	*100%*

				The radiology staff have a large percentage of staff who are over 55 – 35. Radiology equipment has become easier to use (less heavy and difficult) which means staff are able to remain in posts at an older age. There are also opportunities to work in none patient facing roles (management and reporting) **Positive Impacts** Some sites already offer evening and weekend appointments – this is preferable to working age patients and for older patient who might rely on relatives to transport them. Radiology services are mostly offered on all four sites so patient do not have to travel long distance for most radiology examinations. **Negative Impacts** Paediatrics – Paed MRI and CT doesn't take place across all sites, only at GGH as general anaesthetic or play specialist needed. Data exists to show numbers of patients and their postcodes. Elderly – movement of Services negatively impacts the older population as travelling between sites can be more difficult. They are likely to not have their own transport. Removal of Services from Withybush – this has meant that patients have had to travel further – Breast PPH, Paediatrics GGH, Working age patients – services based around office hours of 9-5 and do not offer evening or weekend appointments. Younger and older patients that more commonly have travel and mobility issues will be negatively affected. Those without private transport will need to rely on public transport or lifts from family/friends.	**Mitigation** Extension of paediatric MRI and CT to BGH. Patients offered choice of location e.g., near place of work rather than home. Extension of working hours to include appointments outside of these times Hospitals sit on bus routes for those without private transport.

				Those using Radiology services will often do so in line with another Service and would therefore need to travel across hospital sites from another Service ward/location. Those with mobility issues need to navigate around the sites ensuring suitable routes are used. For example, wheelchair access, ramps, no stairs, accessible doorways, hallways. Drop off areas are available across health board sites to reduce the need to walk across car parks and site grounds.	Pensioners will benefit from free bus travel Ensure there is clear signage around sites to direct patients towards stairs, lifts, relevant departments. Porter service available to transfer patients between hospital areas Wheelchairs are widely available at hospital entrances to be used by patients who have difficulty walking. All sites will have accessible toilets either directly in the service area or nearby.
Disability		**x**		Population:	

Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes				Patients and Staff: No Service data is captured inform Service position. Service uses different system to other Services so more difficult to capture this data. Service will record where patients have specific needs for any future visits. **<u>Positive Impacts</u>** All health board staff undertake equalities training as part of mandatory competency training. All health board staff undertake equality training (including Paul Ridd Learning Disability Awareness, Safeguarding, Equality, Diversity and Human Rights, Autism Awareness and Mental Capacity Act) relating specifically to disabilities as part of mandatory competency training. Disability champions exist across each department site. All Radiology rooms are on the ground floor of all sites which increases ease of access for patients. **<u>Negative Impacts</u>** Only one site (BGH) can scan patients with pacemakers (typically more elderly). Data exists for patients from Pembrokeshire that have gone to Llanelli etc and why (due to dated scanners). Some remote sites have dated equipment so those with disabilities will often need to travel to the larger sites for appointments.	**Action** – monitor training completion through PDR and ESR monitoring. **<u>Mitigation</u>** Extension of service to other sites

	Carmarthenshire	Ceredigion	Pembrokeshire	Total
Disabled under the Equality Act: Day-to-day activities limited a lot	21255	6686	12522	40463
Disabled under the Equality Act: Day-to-day activities limited a little	21897	8951	14651	45499
	43152	15637	27173	

				All the recent imaging equipment installations have included improvements to waiting rooms and patient change areas to improve patient experience. All the new CT and Xray rooms have a wall mural and the CT scanners have light boxes with calming images installed into the ceiling to help relax the patients. All radiology departments are in the main hospital and near to car parks. Those using Radiology services will often do so in line with another Service and would therefore need to travel across hospital sites from another Service ward/location. Those with mobility issues need to navigate around the sites ensuring suitable routes are used. For example, wheelchair access, ramps, no stairs, accessible doorways, hallways. Drop off areas are available across health board sites to reduce the need to walk across car parks and site grounds. Patients with disability can have issues with: • Locating the building/service within the building • Accessing the area physically – ramps, steps, accessible toilet, accessible rooms, wide doors, bariatric chairs/trolleys • Accessing accessible transport • Difficulty walking long distances Older people are disproportionately affected by the conditions noted above and make up the majority of patients within the service. Even though all health board sites adhere to meeting minimum standards in terms of disabled facilities, concerns in relation to parking have been raised about both Glangwili and Amman Valley hospitals.	All hospital sites adhere to minimum accessibility standards. Ensure there is clear signage around sites to direct patients towards stairs, lifts, relevant departments. Wheelchairs are widely available at hospital entrances to be used by patients who have difficulty walking. Porter service available to transfer patients between hospital areas Hospital transport has cars and ambulances to support patients with different

<table>
<tr><td></td><td></td><td></td><td></td><td></td><td>types of mobility concerns.</td></tr>
<tr><td>Gender Reassignment
Consider the potential impact on individuals who either:

•Have undergone, intend to undergo or are currently undergoing gender reassignment.
•Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth.</td><td></td><td>X</td><td></td><td>Population:

<table>
<tr><td>Year (data was collected)</td><td colspan="8">2021</td></tr>
<tr><td>County</td><td colspan="2">Carmarthenshire</td><td colspan="2">Ceredigion</td><td colspan="2">Pembrokeshire</td><td colspan="2">Total</td></tr>
<tr><td>Measure</td><td>value</td><td>percent</td><td>value</td><td>percent</td><td>value</td><td>percent</td><td>value</td><td>percent</td></tr>
<tr><td>Gender</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>All persons</td><td>187,897</td><td>100</td><td>71,475</td><td>100</td><td>123,360</td><td>100</td><td>382,732</td><td>100.0</td></tr>
<tr><td>Male</td><td>91,685</td><td>48.8</td><td>34,963</td><td>48.9</td><td>60,071</td><td>48.7</td><td>186,719</td><td>48.8</td></tr>
<tr><td>Female</td><td>96,212</td><td>51.2</td><td>36,512</td><td>51.1</td><td>63,289</td><td>51.3</td><td>196,013</td><td>51.2</td></tr>
<tr><td>Gender identity the same as sex registered at birth</td><td>144,924</td><td>93.2</td><td>55,874</td><td>91</td><td>95,794</td><td>93.4</td><td>296,592</td><td>92.5</td></tr>
<tr><td>Gender identity different from sex registered at birth but no specific identity given</td><td>210</td><td>0.1</td><td>84</td><td>0.1</td><td>121</td><td>0.1</td><td>415</td><td>0.1</td></tr>
<tr><td>Trans woman</td><td>93</td><td>0.1</td><td>73</td><td>0.1</td><td>58</td><td>0.1</td><td>224</td><td>0.1</td></tr>
<tr><td>Trans man</td><td>90</td><td>0.1</td><td>62</td><td>0.1</td><td>66</td><td>0.1</td><td>218</td><td>0.1</td></tr>
<tr><td>Non-binary</td><td>60</td><td>0</td><td>143</td><td>0.2</td><td>40</td><td>0</td><td>243</td><td>0.1</td></tr>
<tr><td>All other gender identities</td><td>38</td><td>0</td><td>66</td><td>0.1</td><td>32</td><td>0</td><td>136</td><td>0.0</td></tr>
</table>

Patients and Staff:

No Service data is captured inform Service position

<u>Positive Impacts</u>

All health board staff undertake equalities training as part of mandatory competency training.

There are all Wales discussions with the Radiology managers throughout Wales about how this is communicated to patients – posters, information leaflets.</td><td><u>Mitigation</u>

A clear strategy would be helpful – being discussed on an all-Wales basis at present</td></tr>
</table>

				Negative Impacts There is an impact due to radiation dose – it is important for us to be aware of an individual's gender at birth so we can risk assess the possibility of pregnancy. This may mean that patients have to declare their sex at birth. There is little data on this.	To ensure this data is captured confidentially this is carried out privately in the examination room.
Marriage and Civil Partnership This also covers those who are not married or in a civil partnership.			**x**	**Population:** **Year (data was collected)** 2021 **County** Carmarthenshire / Ceredigion / Pembrokeshire / Total **Measure** value / percent **Marital Status** Total: All usual residents aged 16 and over: 155,488 (100) / 61,389 (100) / 102,551 (100) / 319,428 (100.0) Never married and never registered a civil partnership: 50,384 (32.4) / 23,766 (38.7) / 32,566 (31.8) / 106,716 (34.3) Married or in a registered civil partnership: 73,529 (47.3) / 26,468 (43.1) / 48,487 (47.3) / 148,484 (45.9) Married: 73,191 (47.1) / 26,292 (42.8) / 48,264 (47.1) / 147,747 (45.7) In a registered civil partnership: 338 (0.2) / 176 (0.3) / 223 (0.2) / 737 (0.2) Separated, but still legally married or still legally in a civil partnership: 3,157 (2) / 1,029 (1.7) / 2,210 (2.2) / 6,396 (2.0) Divorced or civil partnership dissolved: 16,309 (10.5) / 5,681 (9.3) / 10,912 (10.6) / 32,902 (10.1) Widowed or surviving civil partnership partner: 12,109 (7.8) / 4,445 (7.2) / 8,376 (8.2) / 24,930 (7.7) There are no identified impacts on Marital Status affecting access to the Radiology Service. This will be continuously reviewed. This will be reviewed after any potential recommended changes.	

<table>
<tr>
<td>Pregnancy and Maternity
Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.</td>
<td></td>
<td>X</td>
<td></td>
<td>In 2021, there were 29,007 births registered across Wales.
Maternity and birth statistics: 2021 | GOV.WALES

Patients and Staff:

In Hywel Dda, 4% of staff were reported to have maternity/adoption leave. It is unlikely that pregnancy and maternity will impact on the service, other than by potentially decreasing the number of staff available to cover the service.

No Service data is captured inform Service position. This will be reviewed in line with any proposed changes in the future.

<u>Positive Impacts</u>

Maternity patients are scanned on all sites for routine antenatal scanning.

<u>Negative Impacts</u>

Twin pregnancies are scanned at GGH, at times due to staffing patient have to be moved to other sites. Many patients are seen in WGH then transferred to GGH for imaging for obstetrics due to the lack of consultant led services in WGH. This results in additional travelling for those that are pregnant with twins resulting in additional travel costs and time.</td>
<td><u>Mitigation</u>

Create more structured obstetric clinics to mitigate patient travel.</td>
</tr>
<tr>
<td>Race/Ethnicity or Nationality
People of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, gypsies/travellers, asylum seekers and migrant workers.</td>
<td></td>
<td></td>
<td></td>
<td>Population:

<table>
<tr><td>Year (data was collected)</td><td colspan="8">2021</td></tr>
<tr><td>County</td><td colspan="2">Carmarthenshire</td><td colspan="2">Ceredigion</td><td colspan="2">Pembrokeshire</td><td colspan="2">Totals</td></tr>
<tr><td>Measure</td><td>value</td><td>percent</td><td>value</td><td>percent</td><td>value</td><td>percent</td><td>value</td><td>percent</td></tr>
<tr><td>Ethnicity</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Total: All usual residents</td><td>187,898</td><td>100</td><td>71,473</td><td>100</td><td>123,359</td><td>100</td><td>382,730</td><td>100</td></tr>
<tr><td>Asian, Asian British or Asian Welsh</td><td>2,321</td><td>1.2</td><td>1,096</td><td>1.5</td><td>1,159</td><td>0.9</td><td>4,576</td><td>1.2</td></tr>
<tr><td>Black, Black British, Black Welsh, Caribbean or African</td><td>455</td><td>0.2</td><td>366</td><td>0.5</td><td>244</td><td>0.2</td><td>1,065</td><td>0.3</td></tr>
</table>
</td>
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</table>

Mixed or Multiple ethnic groups	1,756	0.9	867	1.2	1,162	0.9	3,785	1
White	182,652	97.2	68,776	96.2	120,375	97.6	371,803	97
Gypsy or Traveller	450	0.2	55	0.08	585	0.5	1,090	0.3
Other ethnic group	714	0.4	368	0.5	419	0.3	1,501	0.4

Patients and Staff:

No Service data is captured inform Service position.

Positive Impacts

All health board staff undertake equalities training as part of mandatory competency training.

All health board staff undertake equality training as part of mandatory competency training.

Recognised translation services are used throughout the Health Board.

Negative Impacts

Language barriers is a difficulty to overcome. Often not aware until patient presents if English/Welsh is not their first language.

Action – monitor training completion through PDR and ESR monitoring.

Mitigation

Create a method where radiology are aware of these issues pre appointment (referrers to supply info on request form). Translation services can be pre organised to support patients.

Religion or Belief (or non-belief)
The term 'religion' includes a religious or philosophical belief.

Population:

Year (data was collected)	Hywel Dda University Health Board Census Data - 2021							
County	Carmarthenshire		Ceredigion		Pembrokeshire		Totals	
Measure	value	percent	value	percent	value	percent	value	percent
Religion								
Total: All usual residents	187,899	100	71,476	100	123,363	100	382,738	100.0
No religion	83,409	44.4	30,749	43	52,998	43	167,156	43.5
Christian	89,378	47.6	33,409	46.7	60,174	48.8	182,961	47.7
Buddhist	557	0.3	378	0.5	462	0.4	1,397	0.4
Hindu	419	0.2	158	0.2	161	0.1	738	0.2
Jewish	103	0.1	75	0.1	58	0	236	0.1
Muslim	1,026	0.5	515	0.7	587	0.5	2,128	0.6
Sikh	177	0.1	35	0	32	0	244	0.0
Other religion	1,127	0.6	677	0.9	746	0.6	2,550	0.7
Not answered	11,703	6.2	5,480	7.7	8,145	6.6	25,328	6.8

Patients and Staff:

No Service data is captured inform Service position.

Positive Impacts

All health board staff undertake equality training (including Equality, Diversity and Human Rights) relating as part of mandatory competency training.

				<u>Negative Impacts</u> A non-English or Welsh speaker may be unable to communicate to staff. The service are currently unaware if certain drugs that are delivered orally contain animal products that would be suitable for particular groups. All patients are asked if they are allergic to particular substances which will capture products a patient cannot be administered.	**Action** – monitor training completion through PDR and ESR monitoring. The Health Board has access to a translation service for patients who are unable to communicate in English or Welsh, and Health Board leaflets are available in different languages.

					The specialist pharmacy service can support when managing situations where a patient is known to be unable to be administered specific drugs
Sex Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other?				**Population:**	

Year (data was collected)	2021							
County	Carmarthenshire		Ceredigion		Pembrokeshire		Total	
Measure	value	percent	value	percent	value	percent	value	percent
Gender								
All persons	187,897	100	71,475	100	123,360	100	382,732	100.0
Male	91,685	48.8	34,963	48.9	60,071	48.7	186,719	48.8
Female	96,212	51.2	36,512	51.1	63,289	51.3	196,013	51.2
Gender identity the same as sex registered at birth	144,924	93.2	55,874	91	95,794	93.4	296,592	92.5
Gender identity different from sex registered at birth but no specific identity given	210	0.1	84	0.1	121	0.1	415	0.1
Trans woman	93	0.1	73	0.1	58	0.1	224	0.1

Trans man	90	0.1	62	0.1	66	0.1	218	0.1
Non-binary	60	0	143	0.2	40	0	243	0.1
All other gender identities	38	0	66	0.1	32	0	136	0.0

Patients:

	2019			2020			2021		
	Carms	**Ceredigion**	**Pembs**	**Carms**	**Ceredigion**	**Pembs**	**Carms**	**Ceredigion**	**Pembs**
Sex									
Female	23678	6790	10580	17260	5205	7945	15318	4196	6086
Male	18977	5212	7986	14569	4378	6611	13058	3640	5425
Total	**42655**	**12002**	**18566**	**31829**	**9583**	**14556**	**28376**	**7836**	**11511**

	2022			2023			Total
	Carms	**Ceredigion**	**Pembs**	**Carms**	**Ceredigion**	**Pembs**	
Sex							
Female	11891	3087	4463	6518	1673	2203	126893
Male	10258	2672	4051	5593	1483	2223	106136
Total	**22149**	**5759**	**8514**	**12111**	**3156**	**4426**	**233029**

Radiology patients - 54% are female compared to 51% population.

Staff:

Gender		
Female	Male	Grand Total
232	101	333
70%	30%	100%

Positive Impacts

The proportion of male staff has increased which means that we are usually able to provide patients with a choice of gender for the staff performing their examination. We are able to offer chaperones of either sex to patients.

Negative Impacts

The majority of sonographers are female and dependant on examination we may not be able to provide a choice of gender for patients on some occasions. Currently the majority of Service users are female which aligns with the gender split of Service staff.

Sexual Orientation
Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.

Population:

Year (data was collected)	Hywel Dda University Health Board Census Data - 2021							
County	Carmarthenshire		Ceredigion		Pembrokeshire		Totals	
Measure	value	percent	value	percent	value	percent	value	percent
Sexual Orientation								

Total: All usual residents aged 16 years and over	155,486	100	61,391	100	102,551	100	319,428	100.0
Straight or Heterosexual	139,511	89.7	51,998	84.7	92,094	89.8	283,603	88.1
Gay or Lesbian	1,845	1.2	941	1.5	1,093	1.1	3,879	1.3
Bisexual	1,500	1	1,617	2.6	1,050	1	4,167	1.5
Pansexual	202	0.1	225	0.4	149	0.1	576	0.2
Asexual	79	0.1	140	0.2	52	0.1	271	0.1
Queer	23	0	49	0.1	12	0	84	0.0
All other sexual orientations	19	0	16	0	7	0	42	0.0

There are no identified impacts on Sexual Orientation affecting access to the Radiology Service. This will be continuously reviewed.

Armed Forces

Consider members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in

Population:

	Carmarthenshire	Ceredigion	Pembrokeshire	Totals
Previously served in the UK regular armed forces	5610	1851	4654	**12115**
Previously served in UK reserve armed forces	1334	537	930	**2801**
Previously served in both regular and reserve UK armed forces	336	137	248	**721**
	7280	**2525**	**5832**	**15637**

Patients and Staff:

<table>
<tr>
<td>maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.’

For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see:
Armed-Forces-Covenant-duty-statutory-guidance</td>
<td></td><td></td><td></td>
<td>No Service data is captured inform Service position.

<u>Positive Impacts</u>

Some armed forces individuals are eligible for priority treatment, provided they adhere to the specific criteria as noted within the Welsh Government Armed Forces Covenant Armed Forces Covenant: annual report 2021 [HTML] | GOV.WALES

If their injury or illness is attributable to their military service, then they are eligible for priority treatment.

If they were on a waiting list in another Health Board or even in England and they get posted (moved) to our Health Board area, then they are entitled to join the Health Board waiting list at the same point as when they left the previous location e.g. they had been waiting for an operation for two years and they join the waiting list here at the same point as someone who has been waiting two years and don’t join at the end of the queue.

<u>Negative Impacts</u>

Due to longer waiting lists, armed forces and their families may struggle to be seen and must re-join waiting lists at other locations. Armed forces covenant needs to be upheld. Many military spouses reliant on public transport to get around.</td>
<td><u>Mitigation</u>

Be aware of potential travel issues and offer nearest appointments to home.</td>
</tr>
<tr>
<td>Socio-economic Deprivation
Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered.</td>
<td></td><td></td><td></td>
<td>
<table>
<tr><td>Year (data was collected)</td><td colspan="8">Hywel Dda University Health Board Census Data - 2021</td></tr>
<tr><td>County</td><td colspan="2">Carmarthenshire</td><td colspan="2">Ceredigion</td><td colspan="2">Pembrokeshire</td><td colspan="2">Totals</td></tr>
<tr><td>Measure</td><td>value</td><td>percent</td><td>value</td><td>percent</td><td>value</td><td>percent</td><td>value</td><td>percent</td></tr>
<tr><td>Economic Factor</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Total: All usual residents aged 16 years and over</td><td>155,487</td><td>100</td><td>61,392</td><td>100</td><td>102,551</td><td>100</td><td>319,430</td><td>100.0</td></tr>
<tr><td>Economically active (excluding full-time students)</td><td>83,262</td><td>53.5</td><td>29,845</td><td>48.6</td><td>54,182</td><td>52.8</td><td>167,289</td><td>51.6</td></tr>
<tr><td>In employment</td><td>79,927</td><td>51.4</td><td>28,718</td><td>46.8</td><td>51,697</td><td>50.4</td><td>160,342</td><td>49.5</td></tr>
<tr><td>Unemployed</td><td>3,335</td><td>2.1</td><td>1,127</td><td>1.8</td><td>2,485</td><td>2.4</td><td>6,947</td><td>2.1</td></tr>
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For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resource please see: **https://gov.wales/more-equal-wales-socio-economic-duty**

Economically active and a full-time student	2,612	1.7	2,119	3.5	1,352	1.3	6,083	2.2
In employment	2,025	1.3	1,401	2.3	1,068	1	4,494	1.5
Unemployed	587	0.4	718	1.2	284	0.3	1,589	0.6
Economically inactive	69,613	44.8	29,428	47.9	47,017	45.8	146,058	46.2
Retired	43,170	27.8	16,997	27.7	30,306	29.6	90,473	28.4
Student	6,422	4.1	6,150	10	3,544	3.5	16,116	5.9
Looking after home or family	6,296	4	2,119	3.5	4,755	4.6	13,170	4.0
Long-term sick or disabled	9,710	6.2	2,730	4.4	5,632	5.5	18,072	5.4
Other	4,015	2.6	1,432	2.3	2,780	2.7	8,227	2.5

Population:

Patients and Staff:

No Service data is captured inform Service position.

Positive Impacts

More community sites in South Pembrokeshire which will support lower income population.

Negative Impacts

Travel costs to go between sites when certain services aren't available locally. Issues around travel will also exist for visitors.

Nuclear medicine scans only available in Withybush.

Hywel Dda University Health Board covers a very large geographical area, which may impact service users and staff when trying to access certain parts of the service that might only be delivered from sites which are not local.

Mitigation

Telephone follow up clinics can be utilised allowing patients to access the follow up service via telephone. Therefore, allowing the patients to access the appointments in the comfort of their own home.

Hospital Transport is provided to a certain

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<td>criterion of patients.

Patients can make a claim travel from the general office in the hospital.

·Staff can claim travel expenses when working away from their usual base</td>
</tr>
<tr>
<td>Welsh Language
Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language.</td>
<td></td>
<td></td>
<td></td>
<td>Patients:

No service user data available.

Staff:
<table>
<tr><th colspan="8">Welsh Language (NB: Welsh Language figs do not include bank or locum staff)</th></tr>
<tr><th>0 - No Skills / Dim Sgiliau</th><th>1 - Entry/ Mynediad</th><th>2 - Foundation / Sylfaen</th><th>3 - Intermediate / Canolradd</th><th>4 - Higher / Uwch</th><th>5 - Proficiency / Hyfedredd</th><th>Not recorded on ESR</th><th>Grand Total</th></tr>
<tr><td>121</td><td>73</td><td>19</td><td>32</td><td>20</td><td>25</td><td>8</td><td>298</td></tr>
<tr><td>41%</td><td>24%</td><td>6%</td><td>11%</td><td>7%</td><td>8%</td><td>3%</td><td>100%</td></tr>
</table>
41% of Radiology staff have no Welsh language skills.</td>
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				Positive Impacts Recognised Welsh translation services used for material. The Health Board adopted the Welsh Language Standards in 2019 across all directorates including Mental Health & Learning Disabilities Services. Follow on from this a Welsh Language Services report is produced annually. In March 2021 the Bilingual Skills Policy was introduced across the health board. The main aims of the policy are as follows: · To increase the use of Welsh within the workplace. · To enable everyone who receives or uses our services to do so through the medium of Welsh or English, according to personal choice, and to encourage other users and providers to use and promote the Welsh Language within the health sector. · To ensure staff are able to enact their right to receive services through the medium of Welsh within our internal administrative systems. The Health Board is supportive of any staff who would like to learn of improve their Welsh Speaking ability. **Negative Impacts** % of Welsh speaking staff across sites is low. There are less Welsh speakers in Pembrokeshire and there has been difficulty finding language champions.	**Mitigation** Health board approved translation services are available.

Form 4: Examine the Information Gathered So Far

1.	**Do you have adequate information to make a fully informed decision on any potential impact?**	Yes
2.	**Should you proceed with the Policy whilst the EqIA is ongoing?**	Yes
3.	**Does the information collected relate to all protected characteristics?**	Yes
4.	**What additional information (if any) is required?**	None
5.	**How are you going to collect the additional information needed? State which representative bodies you will be liaising with in order to achieve this (if applicable).**	N/A

Form 5: Assessment of Scale of Impact

This section requires you to assign a score to the evidence gathered and potential impact identified above. Once this score has been assigned the Decision column will assist in identifying the areas of highest risk, which will allow appropriate prioritisation of any mitigating action required.

Protected Characteristic	Evidence: Existing Information to suggest some groups affected. (See Scoring Chart A below)	Potential Impact: Nature, profile, scale, cost, numbers affected, significance. Insert one overall score (See Scoring Chart B below)	Decision: Multiply 'evidence' score by 'potential impact' score. (See Scoring Chart C below)
Age	**3**	**2**	**6**
Disability	**1**	**-1**	**-1**
Gender Reassignment	**1**	**0**	**0**
Marriage and Civil Partnership	**1**	**0**	**0**
Pregnancy and Maternity	**1**	**-2**	**-2**
Race/Ethnicity or Nationality	**1**	**0**	**0**
Religion or Belief	**1**	**0**	**0**
Sex	**3**	**0**	**0**
Sexual Orientation	**1**	**0**	**0**
Armed Forces	**1**	**-1**	**-1**
Socio-Economic Deprivation	**1**	**-1**	**-1**
Welsh Language	**3**	**-1**	**-3**

Scoring Chart A: Evidence Available	
3	Existing data/research
2	Anecdotal/awareness data only
1	No evidence or suggestion

Scoring Chart B: Potential Impact	
-3	High negative
-2	Medium negative
-1	Low negative
0	No impact
+1	Low positive
+2	Medium positive
+3	High positive

Scoring Chart C: Impact	
-6 to -9	High Impact (H)
-3 to -5	Medium Impact (M)
-1 to -2	Low Impact (L)
0	No Impact (N)
1 to 9	Positive Impact (P)

Form 6 Outcome

You are advised to use the template below to detail the outcome and any actions that are planned following the completion of EqIA. You should include any remedial changes that have been made to reduce or eliminate the effects of potential or actual negative impact, as well as any arrangements to collect data or undertake further research.

Will the Policy be adopted?	Yes
If No please give reasons and any alternative action(s) agreed.	
Have any changes been made to the policy/ plan / proposal / project as a result of conducting this EqIA?	N/A

What monitoring data will be collected around the impact of the plan / policy / procedure once adopted? How will this be collected?	N/A
When will the monitoring data be analysed? Who will be responsible for the analysis and subsequent update of the impact assessment as appropriate?	N/A
Where positive impact has been identified for one or more groups please explain how this will be maximised?	N/A
Where the potential for negative impact on one of more group has been identified please explain what mitigating action has been planned to address this. **If negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan / project / proposal regardless, please provide suitable justification.**	N/A

Form 7 Action Plan

Actions (required to address any potential negative impact identified or any gaps in data)	**Assigned to**	**Target Review Date**	**Completion Date**	**Comments / Update**
Monitor staff completion of equalities training through ESR compliance records	Gail Roberts-Davies	June 2024		
Review where it is assumed there is no impact foreseen for protected characteristics.	Gail Roberts-Davies	June 2024		
Review what Services are being offered across sites	Gail Roberts-Davies	June 2024		
Review link with Anaesthetics with regards to any potential extension of Paediatrics to Bronglais Hospital	Gail Roberts-Davies	June 2024		
Review appointment times being offered outside of 9-5 working hours	Gail Roberts-Davies	June 2024		
Review all Wales gender reassignment strategy and where this impacts Radiology in particular	Gail Roberts-Davies	June 2024		
Review links with maternity department	Gail Roberts-Davies	June 2024		
Review use of “Requests” section included in pre appointment form	Gail Roberts-Davies	June 2024		

EqIA Completed by:	**Name**	Sarah Procter
	Title	Deputy Head Of Radiology

	Team / Division	Radiology
	Contact details	01253 229623
	Date	7/3/24
EqIA Authorised by:	**Name**	Gail Roberts-Davies
	Title	Head of Radiology
	Team / Division	Radiology
	Contact details	01554 899088
	Date	7/3/24
Seen by Diversity & Inclusion Team:	**Name**	Eiddan Harries
	Title	Diversity and Inclusion Manager
	Team	Strategic Partnership Diversity & Inclusion
	Contact details	Eiddan.harries@wales.nhs.uk
	Date	07.03.2024