Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	30 May 2024
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Corporate Risk Register
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Professor Philip Kloer, Interim Chief Executive
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Wilson, Director of Corporate Governance Charlotte Wilmshurst, Assistant Director of Assurance and Risk

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

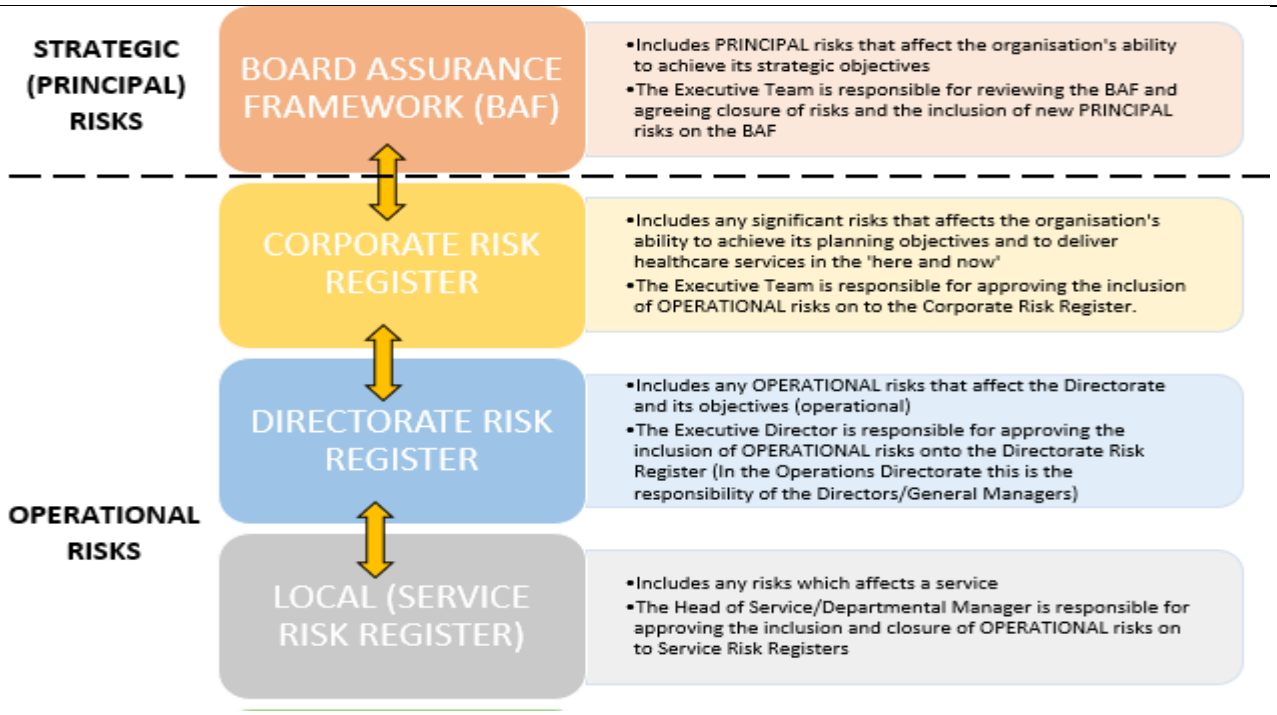
Cefndir / Background

Risk management is a key component of the governance framework, and should underpin organisational strategy, decision-making and the allocation of resources; as such the organisation is required to have effective risk management arrangements in place. The Board should receive sufficient and timely assurance information on the management of risk to enable it to exercise good oversight.

The Executive Directors, via monthly Executive Team meetings, are responsible for reviewing and discussing their corporate risks, and agreeing any new risks and the escalation/de-escalation of operational risks that are on directorate risk registers.

It is the role of the Executive Directors to review controls and ensure appropriate action plans are in place, which might include the development of corporate risk management strategies to manage risk(s). Effective management of these risks enables the organisation to improve its chances of success and reduce the likelihood of failure.

The CRR includes significant risks that affect the organisation's ability to deliver healthcare in the 'here and now' and its ability to achieve its planning objectives (linked to directorate objectives). This is how the CRR interacts with the principal risks on the Board Assurance Framework (BAF), and the operational risks that are on Directorate and Service risk registers.



Asesiad / Assessment

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

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

The following changes have taken place since the CRR was previously presented to the Board in January 2024:

Total Number of Risks as at January 2024	19	
New/Escalated	6	*See note 1*
De-escalated/Closed	2	*See note 2*
Increase in risk score ↑	1	*See note 3*
Reduction in risk score ↓	3	*See note 4*
No change in risk score →	13	
Total Number of Risks as at May 2024	23	

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

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

Due to the sensitive nature of the following risks, the detail is being reported to In-Committee Board, to facilitate discussion and provide assurance:

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

Details on the 21 remaining corporate risks are included in Appendix 2. The following risks are currently under review as a result of discussions at the Executive Team meeting held on 8 May 2024:

- 1328 - Risk of harm to staff, patients and critical assets due to insufficient physical security measures.
- 1649 – Risk of insufficiently skilled workforce to deliver services in Annual Plan 2023/24 due to limited labour market;
- 1821 - Risk to the welfare of Health Board staff due to current demands;
- 1822 - Risk to the welfare of senior management due to current demands; and
- 1810 - Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS).

The 23 corporate risks are detailed on the below heat map:

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 5
CATASTROPHIC 5		1699 (↓)	813 (→) 1745 (→)	1027 (→) 1531 (↑) 1664 (→) 1843 (NEW)	1810 (NEW)
MAJOR 4		1548 (↓)	1350 (→) 1433 (→)	1352 (→) 1649 (→) 684 (→) 1708 (→) 1812 (NEW)	797 (→) 1032 (→) 1328 (→)
MODERATE 3		1335 (↓)	1821 (NEW)	1822 (NEW)	1842 (NEW)
MINOR 2					
NEGLIGIBLE 1					

Note 1 – New Risks

Since the previous report in January 2024, 6 new risks have been added to the CRR:

Risk	Lead Director	New / Escalated	Current Risk Score (Likelihood x Impact)	Rationale for Current Risk Score
1843 - Risk of Health Board not meeting statutory requirement to break even 24/25 due to significant deficit position *(approved at Executive Team May 2024)*	Director of Finance	New	**4x5=20**	The annual plan for 2024/25 is unacceptable to the Board and to Welsh Government (WG). The Board have been involved in the discussions and decisions in the development of the plan through our Committees, Board Seminar sessions, and Public Board meetings. The Board, at its meeting on the 28 March 2024, endorsed the annual plan, recognising the forecast financial outturn remains unacceptable and in breach of the Health Board's statutory requirement to achieve financial balance. Without further support, the Health Board will require further cash-backed support as the extent of the cash allocation will be insufficient to pay our liabilities as they fall due in February and March 2025. Through our planning process, operational plans to address the recurrent financial savings gap and operational variation have not provided sufficient assurance to mitigate the current financial trajectory. Actual delivery also falls short of submitted plans, adding further assurance concerns.
1812 - Risk of non-compliance with Medical Examiners (Wales) regulations due to the failure to fully resource internal processes. *(approved by Chair's Action in February 2024*	Interim Executive Medical Director	New	**4x4=16**	New processes are in place for mortality reviews, in line with the All-Wales Learning from Mortality Framework, supported by the Clinical Lead for Mortality and Mortality Review and Improvement Facilitator. However, these are not fully embedded across all acute sites due to the issues with scanning capacity. The risk score of 16 reflects additional resource

and ratified at Executive Risk Group in March 2024)				requirements for the successful rollout at Glangwili General Hospital (GGH) ahead of the statutory introduction of the Medical Examiner Service. The risk score remains at 16 in April 2024, as while we have a definitive statutory date of 9 September 2024, scanners are not in place and may not be recruited into position by the statutory date. Recent absences of scanning staff have also made the service provision even more fragile. There is an increased risk by running two different processes on one site, causing confusion due to the variation. In addition, we have a very fragile service in relation to clinical screeners, with only three in place to screen all the letters that are returned from the Medical Examiner Service to the Health Board. Withybush General Hospital (WGH) has experienced some fragility due to long term absences within the team. There is currently insufficient scanning capacity to enable the scanning and sending of case notes to the Medical Examiner Service to enable the full roll-out to GGH wards. GGH scanning staff are currently scanning all of Prince Philip Hospital (PPH) case notes and a proportion of GGH (all Medical Wards and 1 Surgical). In addition, there is a lack of sufficient clinician capacity across all disciplines to screen Medical Examiner Service letters, with a current backlog of 90, with 65 cases coming through on average each month, causing a backlog which has the potential for urgent concerns highlighted by the Medical Examiner not being addressed.

1842 - Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 24/25 due to demand exceeding capacity *(approved at Executive Team May 2024)*	Director of Operations	New	**5x3=15**	The combined impact of a mismatch between demand and current / forecast capacity in key specialties, workforce limitations and limitations on the amount of recovery funding agreed by the Board all pose a risk to full achievement of ministerial planned care recovery targets. The Annual Plan, approved by the Board in March 2024 highlighted delivery risks in Orthopaedics and Ophthalmology, and the additional recovery resource agreed by the Board is below the level required to ensure full delivery of the ministerial milestones. Whilst delivery plans for 2024/25 reflect positive progress in increasing outpatient activity and treatment capacity, underpinned by planned improvements in workforce availability and operational productivity and efficiency, the Annual Plan signalled expected delivery gaps in both specialties. Both specialties have been prioritised for active exploration of regional solutions, in partnership with Swansea Bay University Health Board (SBUHB), to expand available capacity and address forecast shortfalls against anticipated demand. Health Board performance in respect of planned care delivery milestones is also a key feature of its escalation to Targeted Intervention status. The current risk score is assessed to be lower than the inherent risk score due to the significant progress achieved in the past 12 months in improving waiting times, and current performance compares positively with other Health Boards. However, as the delivery

				commitments outlined in the Annual Plan do not support full achievement of the planned care delivery targets in these 2 specialties, the target risk score is yet to be achieved. Furthermore, revised delivery expectations advised by WG since submission of the Health Board's Annual Plan have brought forward the expected target dates for achievement of the 104-week Total Pathway maximum wait from March 2025 to December 2024. Delivery plans across all other specialties are being reviewed to assess the implications for achievement of a maximum 104-week Total Pathway wait by this expedited target date.
1810 – Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with Quality Assurance of Aseptic Preparation Services (QAAPS). *(approved by Chair's Action in February 2024 and ratified at Executive Risk Group in March 2024)*	Director of Primary Care, Community & Long Term Care	New	**3x5=15**	The facilities of the WGH Aseptic unit are currently non-compliant with regulatory standards. The unit is subject to external audit by the National Pharmacy Quality Assurance Lead and the facilities were identified as being a high risk to patient safety in 2019. An audit performed in February 2023 confirmed the facilities were a high risk, and the unit at risk of forced closure. A pharmacy Aseptic unit based at GGH was forced to close in December 2018 as the facilities were deemed a risk to patient safety. Short term control measures have been implemented by the Health Board to reduce the risk of immediate forced closure (see control measures). However, as the unit and equipment are beyond their useful expected life, there will come a time where the control measures will no longer be sufficient to allow the safe running of the unit. If the unit was forced to close, the Health Board would be entirely reliant on outsourcing cancer therapy from commercial suppliers. Some

					cancer treatments cannot be outsourced due to their short shelf life. There were 345 reported service and quality-related incidents (e.g., delayed or failed deliveries) linked to outsourcing from commercial suppliers between September 2022 and August 2023 at Hywel Dda. Without a functioning Aseptic unit, the Health Board could not offer over 500 cancer treatments each year, and further treatments would be delayed/cancelled due to supplier service failures. The most recent audit, conducted on the 20 and 23rd February 2024 with the final report received on 7 March 2024, confirmed that the control measures employed are mitigating the risk, therefore the current risk score has been adjusted from 20 to 15 to reflect the reduction in the likelihood of the risk of forced closure materialising, provided that these control measures remain effective. A business case for the demountable unit at WGH was submitted to WG in February 2023. The business case also requested funding to convert the current Aseptic unit into drug storage facilities. Based on budget cost estimates of £2.89m the submission was for review and scrutiny by WG to provide assurance to the Health Board before resourcing, and underwriting the financial risk, of progressing a detailed design for tendering. In September 2023, WG requested submission of a fully tendered business justification case, which is currently being drafted by the Health Board.

				As part of the Transforming Access to Medicines (TrAMS) project programme, a regional manufacturing hub will be built in South-West Wales that will prepare cancer therapy for Hywel Dda patients. The hub was originally estimated to open in 2028, however there have been delays to the project plan and the opening date is currently unknown. There is therefore a high risk that the current Aseptic unit at WGH will be forced to close before the South-West TrAMS manufacturing hub is operational. In this case, there would be no means of obtaining certain cancer therapy for Hywel Dda patients to be administered within the Health Board locality.
1822 - Risk to the welfare of senior management due to current demands *(approved by Executive Risk Group in March 2024)*	Director of Workforce & OD / Interim Deputy CEO	New	**4x3=12**	There is a general sense from key personnel that the work requirements are exceeding capacity to respond. These requirements cut across a number of work areas including ARCH Regional programme (A Regional Collaboration for Health), Clinical Services Plan projects, Recovery and Savings Plans. Engagement with senior operational and corporate personnel are noted, we see the manifestations of this risk in a number of meetings held at a corporate level such as Improving Together, Core Delivery Group, Clinical Services Plans and related sub-groups. There are also potential increases in "incidents" and a general inability to review key actions, e.g "risk registers". It has been noted that risks are circa 4 months out of date which would align to the start of the recovery work in July 2023. Further monitoring across critical workforce service areas and performance indicators will be

				needed to underpin and assess this risk score; specifically, a growth in demand on: a) Staff Wellbeing & Occupational Health Services; b) Employee Relations cases; and c) dashboard performance for turnover and sickness. In addition, the "ask" for further savings may exacerbate the current situation.
1821 - Risk to the welfare of Health Board staff due to current demands *(approved by Executive Risk Group in March 2024)*	Director of Workforce & OD / Interim Deputy CEO	New	**3x3=9**	The Health Board is monitoring a number of areas and metrics to monitor this risk such as turnover, absence etc. Careful consideration is being taken at different organisational levels to mitigate this risk.

Note 2 – De-escalated / Closed Risks

Since the previous report to Board in January 2024, 2 risks have been closed:

Risk	**Lead Director**	**Closed / De-escalated**	**Reason**
1642 - Risk of Health Board not meeting statutory requirement to break even 23/24 due to significant deficit position	Director of Finance	Closed	The risk has now been closed, with new risk 1843 - risk of the Health Board not being able to meet the statutory requirement of breaking even 2024/25 being approved for the current financial year, as agreed by the Executive Team at its meeting held on 8 May 2024.
1657 - Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 23/24 due to demand exceeding capacity	Director of Operations	Closed	The risk has now been closed, with new risk 1842 - risk to delivery of Ministerial Priorities in relation to delivery of planned care recovery ambitions through 2024/25, as agreed by the Executive Team at its meeting held on 8 May 2024.

Note 3 – Increase in Current Risk Score

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

Risk	Risk Owner	Previous Risk Score: Jan 2024 (Likelihood x Impact)	Risk Score: May 2024 (Likelihood x Impact)	Date risk reviewed	Rationale for Current Risk Score
1531 - Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Director of Operations	**3x5=15**	**4x5=20 (↑)**	11/04/24	The current risk score was increased in April 2024. In addition to the risk at WGH, the GGH surgical consultant on call rota is also in a fragile position. Since July 2023, due to a retire and return, without on call commitments in their job plan, the 1:8 rota at WGH became 1:7 with agreed internal cover for the 1 gap. Since February 2024, the rota has become a 1:6 due to a further vacancy, following a promotion within the team. This is a fixed term arrangement for 12 months, and a locum upper Gastro-Intestinal (GI) consultant post to cover this vacancy is currently being reviewed and due to be advertised in April 2024. There is a further gap on the rota which affects 1:8 weekends only, due to medical reasons. The GGH rota is currently running as a 1:5 which is not sustainable. There is also currently unplanned sickness in the team at GGH, causing further pressure on remaining consultants and has impacted elective activity. The recommended solution to the rota fragilities on both sites is to is to consider combining the two rotas and move the general surgery emergency service to one location. The fragilities at WGH remain the same, with high cost Medacs locums supporting the consultant and Speciality & Specialist (SAS) Doctors level on call rotas. There are only 2 substantive consultants on the 1:4 consultant on-call rota.

Note 4 – Reduction in Current Risk Score

Since the previous report to Board in January 2024, the score of 3 risks has reduced:

Risk	Risk Owner	Previous Risk Score: Jan 2024 (Likelihood x Impact)	Risk Score: May 2024 (Likelihood x Impact)	Date risk reviewed	Rationale for Current Risk Score
1699 - Risk of loss of service capacity at WGH due to surveys and remedial work relating to Reinforced Autoclaved Aerated Concrete (RAAC)	Director of Operations	**4x5=20**	**2x5=10 (↓)**	29/04/24	The major internal incident was stood down on 19 January 2024, reflecting the re-opening of 4 of the 6 affected wards. Updates are continually provided to Executive Team via the Control Group. Initial detailed surveys and required remedial actions have been undertaken and completed on all affected wards as at April 2024. These wards are now subject to re-survey, with work commencing in April 2024 on Ward 9. A programme of works is in place to ensure that all re-surveys are completed by the end of 2024. Visual surveys in Outpatients A identified significant RAAC related issues (P1 planks). Detailed surveys were completed on 10 November with remedial works to follow and scheduled to return to service at end of October 2024. Alternative locations for outpatient provision have been coordinated and scoped by Scheduled Care directorate. A schedule for detailed survey programme and remedial work for ground floor areas has been developed, with the programme due to complete by 31 March 2025. Remedial works will follow a detailed survey in the physiotherapy area, resulting in a need to decant from February - October 2024. Given these developments, the likelihood score of this risk has been reduced from 4 to 2 in April 2024, resulting in a reduction in the current risk score from 20 to 10. It is noted that the outcomes of re-surveys may impact future inpatient capacity, with the risk to be reviewed and updated accordingly.

1548 - Risk to the Health Board maintaining service provision due to industrial action	Executive Director of Public Health	**5x3=15**	**2x4=8 (↓)**	16/04/24	The current risk score has been reduced as the British Medical Association (BMA) have announced that they will pause industrial action for all 3 groups (Consultants, SAS and Junior Doctors) as negotiations with WG have re-commenced. Meetings are currently underway to confirm the timelines for negotiations but it is anticipated that no further industrial action will be announced until mid-May at the earliest should the negotiations break down (the mandate for action remains valid). Currently no other Trade Unions have registered a dispute with WG as pay talks for Agenda For Change (A4C) staff are not likely to commence until May 2024. The BMA have declined an offer of 5% uplift (1.5% uplift for Junior Doctors including SAS Doctors) for 2023/24 to basic pay. Ballot notices were received by employers (both Hywel Dda University Health Board and NHS Wales Shared Services Partnership (NWSSP) detailing that the ballot to members would run until 18 December 2023. This applies to Junior Doctors only. Confirmation was received that the BMA reached the 50% threshold required to mandate action for the period 8 January - 17 June 2024. Mitigation and contingency measures, together with command-and-control structures put in place during periods of previous action by Trade Unions resulted in a co-ordinated response to minimise impact as far as possible, and this has been re-established. Three rounds of industrial action have now been held from: 15-18 January; 21-24 February and 25-29 March 2024. The ballot relating to the SAS Doctors and Consultants closed on 4 March 2024 when the BMA confirmed the threshold required to mandate industrial action had been reached. Date for industrial action for the SAS/Consultants was confirmed as 7am on 16 April-7am on 18 April 2024. This was stood down.

1335 - Risk to the ability to access paper patient records in a timely manner due to existing records management infrastructure	Director of Operations	**3x3=9**	**2x3=6 (↓)**	15/04/24	Currently across the Health Board there is a considerable variance in both practice and process, operationally when utilising and dealing with the various types of records in use throughout directorates, services and departments. The current records management methodology results in a non-standardised approach to delivering effective records management arrangements. With a lack of agreed criteria in terms of managing the record during its life cycle from creation, during retention and to disposable. There is a requirement for an investment in a modern-day solution and an alteration to culture and attitude that will embrace change and the technology associated with a digital health record (DHR) to manage the risk. The Health Board has selected its electronic document management system (EDMS) supplier, and work has commenced on scanning legacy documents into a development environment.

Argymhelliad / Recommendation

The Board is asked to **CONSIDER** whether it has sufficient assurance that corporate risks are being assessed, managed and reviewed appropriately/effectively through the risk management arrangements in place, noting that these have been reviewed by Board level Committees

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Included within the body of the report.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply

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

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

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

Enw Da: **Reputational:**	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Gyfrinachedd: **Privacy:**	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.
Cydraddoldeb: **Equality:**	No direct impacts from report however impacts of each risk are outlined in risk description of individual risks.

Risk Ref	Risk (for more detail see individual risk entries)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score May-24	Trend	Target Risk Score	Risk on page no...
1843	Risk of Health Board not meeting statutory requirement to break even 24/25 due to significant deficit position	Thomas, Huw	Finance inc. claims	6	N/A	4×5=20	New risk	3×4=12	6
1027	Risk to delivery of timely urgent and emergency care due to demand exceeding current capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	4×5=20	→	3×4=12	9
1032	Risk of timely diagnosis and treatment of MH&LD clients due to demand and capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	5×4=20	→	3×4=12	14
797	Risk to the ability to deliver ultrasound services due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	5×4=20	→	3×4=12	21
1664	Risk to ophthalmology service delivery due to a national shortage Consultant Ophthalmologists and the inability to recruit	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	4×5=20	→	2×5=10	26
1531	Risk of being unable to safely support the Consultant on-call rota at WGH & GGH due to workforce pressures	Carruthers, Andrew	Safety - Patient, Staff or Public	6	3×5=15	4×5=20	↑	1×5=5	32
1649	Risk of insufficiently skilled workforce to deliver services in Annual Plan 23/24 due to limited labour market	Gostling, Lisa	Workforce/OD	8	4×4=16	4×4=16	→	3×4=12	36
684	Risk to the timely investment and replacement of Radiology equipment and supporting infrastructure	Carruthers, Andrew	Service/Business interruption/disruption	6	4×4=16	4×4=16	→	2×4=8	44
1708	Risk of increasing fragility in primary care contractor services due to recruitment challenges	Paterson, Jill	Service/Business interruption/disruption	6	4×4=16	4×4=16	→	2×4=8	50
1812	Risk of non-compliance with Medical Examiners (Wales) regulations due to the failure to fully resource internal processes	Henwood, Mr Mark	Quality/Complaints/Audit	8	N/A	4×4=16	New risk	2×2=4	53
1842	Risk to delivery of Ministerial Priorities relating to planned care recovery ambitions 24/25 due to demand exceeding capacity	Carruthers, Andrew	Safety - Patient, Staff or Public	6	N/A	5×3=15	New risk	3×4=12	57
1745	Risk of not being able to safely deliver services due to ageing estate and infrastructure across the Health Board	Carruthers, Andrew	Safety - Patient, Staff or Public	6	3×5=15	3×5=15	→	2×5=10	60
1810	Risk to delivering effective and timely cancer service due to Aseptic Unit facilities being non-compliant with QAAPS.	Paterson, Jill	Safety - Patient, Staff or Public	6	N/A	3×5=15	New risk	1×5=5	63
813	Risk of non-compliance with the Regulatory Reform (Fire Safety) Order 2005 due to ageing infrastructure	Carruthers, Andrew	Statutory duty/inspections	8	3×5=15	3×5=15	→	1×5=5	67
1822	Risk to the welfare of senior management due to current demands	Gostling, Lisa	Workforce/OD	8	N/A	4×3=12	New risk	3×3=9	73
1350	Risk of not meeting the 75% SCP waiting times target for 2022 - 2026 due to diagnostics capacity and delays at tertiary centre	Carruthers, Andrew	Quality/Complaints/Audit	8	3×4=12	3×4=12	→	2×4=8	76
1433	Risk to the ability to maintain routine and emergency services in the event of a severe pandemic	Gjini, Ardiana	Service/Business interruption/disruption	6	3×4=12	3×4=12	→	2×4=8	80
1699	Risk of loss of service capacity at WGH due to surveys and remedial work relating to RAAC	Carruthers, Andrew	Service/Business interruption/disruption	6	4×5=20	2×5=10	↓	2×5=10	82
1821	Risk to the welfare of Health Board staff due to current demands	Gostling, Lisa	Workforce/OD	8	N/A	3×3=9	New risk	3×2=6	86
1548	Risk to the Health Board maintaining service provision due to industrial action	Gjini, Ardiana	Safety - Patient, Staff or Public	6	5×3=15	2×4=8	↓	2×3=6	88
1335	Risk to the ability to access paper patient records in a timely manner due to existing records management infrastructure	Carruthers, Andrew	Quality/Complaints/Audit	8	3×3=9	2×3=6	↓	2×3=6	91

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

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

RISK SCORING MATRIX

Likelihood x Impact = Risk Score					
Likelihood	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	**This will probably never happen/recur (except in very exceptional circumstances).**	**Do not expect it to happen/recur but it is possible that it may do so.**	**It might happen or recur occasionally.**	**It might happen or recur occasionally.**	**It will undoubtedly happen/recur, possibly frequently.**
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
	* time-framed descriptors of frequency				
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	**(0-5%*)**	**(5-25%*)**	**(25-75%*)**	**(75-95%*)**	**(>95%*)**
	*used to assign a probability score for risks related to time-limited or one off projects or business objectives.				
Risk Impact Domains	**Negligible - 1**	**Minor - 2**	**Moderate - 3**	**Major - 4**	**Catastrophic - 5**
Safety of Patients, Staff or Public	**Minimal injury requiring no/minimal intervention or treatment.**	**Minor injury or illness, requiring minor intervention.**	**Moderate injury requiring professional intervention.**	**Major injury leading to long-term incapacity/disability.**	**Incident leading to death.**
	No time off work.	**Requiring time off work for >3 days**	**Requiring time off work for 4-14 days.**	**Requiring time off work for >14 days.**	**Multiple permanent injuries or irreversible health effects.**
		Increase in length of hospital stay by 1-3 days.	**Increase in length of hospital stay by 4-15 days.**	**Increase in length of hospital stay by >15 days.**	**An event which impacts on a large number of patients.**
			Agency reportable incident.	**Mismanagement of patient care with long-term effects.**	
			An event which impacts on a small number of patients.		
Quality, Complaints or Audit	**Peripheral element of treatment or service suboptimal.**	**Overall treatment or service suboptimal.**	**Treatment or service has significantly reduced effectiveness.**	**Non-compliance with national standards with significant risk to patients if unresolved.**	**Totally unacceptable level or quality of treatment/service.**
	Informal complaint/inquiry.	**Formal complaint.**	**Formal complaint -**	**Multiple complaints/ independent review.**	**Gross failure of patient safety if findings not acted on.**
		Local resolution.	**Escalation.**	**Low achievement of performance/delivery requirements.**	**Inquest/ombudsman inquiry.**
		Single failure to meet internal standards.	**Repeated failure to meet internal standards.**	**Critical report.**	**Gross failure to meet national standards/performance requirements.**
		Minor implications for patient safety if unresolved.	**Major patient safety implications if findings are not acted on.**		
		Reduced performance if unresolved.			

Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.
			Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
		Reduced performance levels if unresolved.	Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty.	Prosecution.
				Improvement notices.	Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
				Critical report.	Severely critical report.
Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage
					Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
Health Equity	Minimal or no impact on our attempts to improve health equity	Minor impact on our attempts to improve health equity or low level of certainty on the impact we are having on health equity	Moderate impact on our attempts to improve health equity or a lack of sufficient information that would demonstrate this. Indications that we are not having a positive impact on health improvement or health equity	Major impact on our attempts to improve health equity. Validated data suggesting that we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity.

RISK MATRIX

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

RISK ASSESSMENT - FREQUENCY OF REVIEW

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

Date Risk Identified:	Apr-24	**Executive Director Owner:**	Thomas, Huw	**Date of Review:**	May-24
Strategic Objective:	6. Sustainable use of resources	**Lead Committee:**	Sustainable Resources Committee	**Date of Next Review:**	Jun-24

Risk ID:	**1843**	**Risk Description:**	There is a risk that the Health Board deficit is unaffordable and unacceptable for Welsh Government. This is caused by the financial plan for 2024/25 setting a £64m deficit plan against a WG control total of £44.8m. This is the result of: 1. Continued significant growth in expenditure across our unscheduled care services; 2. Staffing pressures and reliance on locum and agency staff to fill gaps; 3. Continued pressure across services and sites as demand exceeds capacity, compromising patient flow and elective pathways; 4. The embedded impact of recent inflationary pressures on the costs of goods, drugs and services from providers. 5. Capacity and capability amongst budget holders and service leads to adequately engage with the financial agenda. The recovery of the financial position has been hampered by insufficient assurance over the identification and operational delivery of the required level of savings; and by insufficient controls in place on the operational drivers of expenditure, most significantly in the management of beds and rostering controls. Given the scale of the deficit transformational change is required at a pan Health Board level in addition to ensuring there is a robust control environment at a Directorate level. The savings schemes put forward by Directorates to date do not capture this scale of change and financial impact required. This could lead to an impact/affect on 1. An inability to meet the Ministerial priority of operating within our budget; 2. An inability to develop an approvable Integrated Medium Term Plan; 3. A likely impact that the Health Board has insufficient cash available to make payments to suppliers in February and March 2025; 4. A likely impact on the delivery of WG performance measures and consequential impact on patients having to wait longer for care or treatment; 5. A potential impact the Health Board will be escalated further from Targeted Intervention to Special Measures.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Finance inc. claims
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	*New risk*

Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
The annual plan for 2024/25 is unacceptable to the Board and to Welsh Government. The Board have been involved in the discussions and decisions in the development of the plan through our Committees, Board Seminar sessions, and Public Board meetings. The Board, at its meeting on the 28 March 2024 endorsed the annual plan, recognising the forecast financial outturn remains unacceptable and in breach of the Health Board's statutory requirement to achieve financial balance. Without further support, the Health Board will require further cash-backed support as the extent of the cash allocation will be insufficient to pay our liabilities as they fall due in February and March 2025. Through our planning process, operational plans to address the recurrent financial savings gap and operational variation have not provided sufficient assurance to mitigate the current financial trajectory. Actual delivery also falls short of submitted plans, adding further assurance concerns.	Given the historic challenges relating to operational controls of the drivers of our expenditure, and the operational delivery of savings schemes; it is unlikely that the risk tolerance or target will be achieved in year. Further work is needed to provide assurance that this risk target is achievable over the medium term.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
1.Timely financial reporting to Directorates, Sustainable Resources Committee, Board and Welsh Government on the finances to inform central and local scrutiny, feedback and decision-making. 2.Oversight arrangements in place at Board level and through the Executive Team structure, including through: a.Core Delivery Group b.Directorate Improving Together meetings c.The Executive Team Escalation framework. 3.Exploration of a number of funding streams, including: Local Health Board funding arrangements; Funding arrangements through the Regional Partnership Board and Local Authority partners. Funding from WG's own sources or from HM Treasury via WG. 4.Opportunities Framework refreshed with the expectation that identified areas of waste will present deliverable cost reductions/formal savings schemes. Linked to Planning Objectives workplan, which will be shaped by the Health Board's strategy, “A Healthier Mid and West Wales", and align to the design assumptions set out in that. 5.Accountability agreements in relation to the Opening Directorate Budgets will be issued to the Executive Team in March 2024. 6.Delivery of our Planning Objectives and the subsequent financial	The control of the operational drivers of financial risk has been a significant historic gap in control. This has included: 1. The effective management of rostering; 2. The effective management of beds; 3. Effective contract management arrangements; 4. Oversight arrangements over commissioned services. The delivery of savings plans through the effective and timely oversight of projects and the resulting corrective actions and decisions required.	The implementation of a rostering system across medical staff, and the extension of rostering to other staff groups.	Hill, Carly	30/09/2024	23/04/24 - initial meeting to discuss the rostering system implementation. 24/04/24 - identification of project management support for roll-out 09/05/24 - Resourcing Team to meet Allocate to discuss key stakeholders, pre-requisites for the project and potential kick off dates. 16/05/24 - next meeting of project group to identify what work can be undertaking while waiting for the hiring process and the identification of operational team early adopters to launch the rostering system 24/06/24 - Paper to LNC on the implementation of electronic rostering system.

6.Delivery of our Planning Objectives and the subsequent financial benefits.	Operational adoption of the Welsh Patient Administration System (WPAS) Bed Module and its incorporation into daily site management meetings.	Carruthers, Andrew	31/10/2024	Progress to be provided at next risk review
	Implementation of a new contract management approach to ensure that services are provided in line with purchasing intentions.	Thomas, Huw	30/09/2024	Progress to be provided at next risk review
	Implementation of new oversight arrangements across commissioned services.	Davies, Lee	30/09/2024	Progress to be provided at next risk review

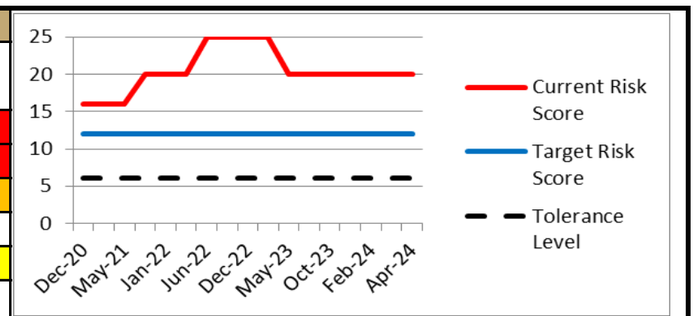
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level		
Performance against operational plans and targets through Performance KPIs In-month financial monitoring	Performance against plan monitored through Improving Together Meetings.	1st			
	Sustainable Resources Committee oversight of current performance	2nd			
	Transformation & Financial Report to Board & SRC	2nd			
	WG scrutiny through monthly monitoring returns	3rd			
	WG scrutiny through revised monthly Monitoring Returns (specific supplementary templates) and through Finance Delivery Unit	3rd			
	Audit Wales Structured Assessment process	3rd			

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

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Apr-24
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	May-24

Risk ID:	**1027**	**Risk Description:**	There is a risk to the consistent delivery of timely and high quality urgent and emergency care. This is caused by significant fragility across the urgent and emergency care (UEC) system (acute, primary care (including out of hours), community and social care services), related to workforce compromise and increasing levels of demand and acuity. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increased incidents of a serious nature relating to ambulance handover delays and overcrowding at Emergency Departments and delayed ambulance response to community emergency calls, increasing pressure of adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.
Does this risk link to any Directorate (operational) risks?			1649, 1406, 1548, 1210, 750, 205, 86, 820, 232, 1298, 1281, 906, 1380, 1116, 878, 839, 1167, 1223, 111, 114, 199, 523, 136, 200, 1115, 1078, 572, 1295, 1231, 966, 967, 565, 852, 1295, 1435, 1377, 1083, 180, 1424, 1417, 1309, 291, 118, 925, 119, 1245, 695

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



Rationale for CURRENT Risk Score:

Levels of urgent and emergency pathway capacity pressures continue at significantly escalated levels. This is driven by post pandemic demand and the broader impacts of COVID-19. Workforce deficits, handover delays, 4- and 12-hour performance, bed occupancy rates and significant pressures on wider community and social care capacity are all demonstrating significantly worrying trends. The indirect legacy of the pandemic has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. The situation remains at high levels of risk escalation across our acute sites on a daily basis.

Notwithstanding these challenges, whilst positive progress has been achieved during 2023 in reducing peak levels of pressure with notable improvements achieved in key urgent and emergency care (UEC) pathway metrics relating to ambulance handover and emergency departments (ED) waiting times; this has not been sustained through the winter 2023/24 period, with a significant re-emergence of system-wide capacity pressures. Notwithstanding continuing progress in delivering the Health Boards TUEC objectives, there has been a notable increase in the volume of patients with lengths of stay (LOS) in excess of 21 days across all hospital locations during this period.

With specific reference to Withybush Hospital, UEC performance has been significantly impacted since the Summer of 2023 due to the extent to which the RAAC infrastructure improvement project has reduced capacity.

The completion of improvement works in closed wards areas has enabled the return of previously closed capacity at the hospital and it is anticipated this will support performance, quality and patient experience improvements from April 2024.

Whilst experience during the post-Easter period suggests capacity pressures have eased and ambulance handover performance is showing early signs of improvement, the risk score remains unchanged as at April 2024, pending further review.

Rationale for TARGET Risk Score:

There is a significant challenge across the Urgent and Emergency Care system. The combined impact of the multi-faceted pressures which underpin this risk have led to an incremental increase in the overall level of pressure as reflected in deteriorating delays for ambulance handover, access to urgent and emergency care and delayed discharges. The extent to which these combined pressures impact upon the timeliness and quality of care provided is related to the overall availability of staffing resources on a daily / weekly basis, which in turn is influenced by increasing levels of staff sickness/absence.

Plans for improvement during 2024/25 are reflected in the HB's Annual Plan, approved by the Board in March 2024.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage unscheduled care risks on daily basis including multiple daily multi-site calls in times of escalation which include efficient handover from WAST into ED. # Reviews of patients admitted to surged areas to ensure patient acuity and dependency is monitored and controlled. # Surge beds continue as per escalation and risk assessment of site demand and acuity (where staffing allows). A daily review of the use of surge beds via patient flow meetings to facilitate step down of beds. # Discharge lounge takes patients who are being discharged. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites. # Regular advice on discharge planning and complex care management is provided to ward based staff through Community Discharge Liaison teams, Social services and the Long Term Care Team support. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Escalation plans for acute and community hospitals (within limits of staffing availability). # Winter Plans developed to manage whole system pressures. # Joint workplan with Welsh Ambulance Services NHS Trust. # 111 implemented across Hywel Dda. # Transformation fund bids in relation to crisis response being implemented across the Health Board. # Ability to deploy Health Board staff where workforce compromise is immediately threatening to continuation of care for residents. # Care Home Risk & Escalation Policy to be applied to support failing care homes as required	# Fragility of Care Home Sector exacerbated by COVID related issues such as financial viability, staffing deficits, recruitment and retention of workforce. # Significant paucity of domiciliary care/social care availability due to recruitment and retention of staff # Nurse staffing availability to ensure safe levels of care as a consequence vacancies. # Inability to offload ambulances to release them back for use within community. # Increased pressures at ED as a result of WAST ambulance response policy resulting in very poorly patients self-presenting. # Better understanding of ED presentations to ensure development of alternative pathways in primary care / community to prevent ED attendance # Effective and timely communication to the public at times of pressure but also of safe alternatives to hospital admission / ED presentation that will contribute to changing public mind set	Develop plans to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	~~31/03/2024~~ 30/06/2024	Please refer to risk 1649 on the corporate risk register which provides detail on actions to address insufficient workforce to support delivery of essential services.

homes as required. # Domiciliary Care Risk and Escalation Policy approved by Integrated Executive Group and implemented across Health Board # Integrated whole system, urgent and emergency care plan agreed. # Establishment of a Discharge to Assess (D2A) Group which reports to the Unscheduled Care group. # Establishment of a D2A Escalation Transfer panel which provides senior oversight of delays, assesses risk of the delay to the patient and organisation in terms of flow compromise # To optimise step down bed capacity in the community across care homes and community hospitals # SRO in place to lead agreed Urgent and Emergency Care (UEC) programme # Supernumery HCSWs aligned to the acute response teams to support failing community care capacity # Support for complex discharge caseload management tool (SharePoint) appointed # SDEC models continuously reviewed and refined to maximise impact on admission avoidance. # Alternative models of medical oversight i.e service level agreement with local GPs and HB salaried community GPs. # Service provision in the community for people pending ambulance conveyance, and where conveyance is not possible to manage ambulance handover delays. # Increased bedding capacity in community hospitals. # UEC live performance dashboard in place. # Local streaming hub. # Direct referral into SDEC in WGH, GGH and PPH. # Operational joint meeting with WAST to identify and taking forward key action to help address conveyance. # Clinical Streaming Hub includes APP Navigator working with Physicians to triage and stream patients pending conveyance to more appropriate pathway in the community (In Hours).	contribute to changing public mind set / expectation and culture in terms of use of NHS resource and 'Home First' # Education and training for best practice in frailty management mandated to effect culture of 'unsafe to admit' for our very / severely frail # Supporting staff to be able to better manage family dispute relating to expectation eg home of choice, transfer pathways to short term placement in care home pending home care availability # Development of a 'tool' that supports staff to assess risk across the whole system to support decision making when discharge appears to be 'risky' to the individual patient. This includes decision making for 'further rehabilitation required in the acute environment' (why not at home?), further blood analysis to confirm medically fit to discharge, home care not available but family happy to take in the interim. # For all patients with LOS > 21 days the need for escalation and 'senior think tank' # If there is a paucity of home care to the extent that we are unable to provide > 28 hours per week (calls four times per day) - why are we advocating this level of commissioning? # Clarity regarding roles and responsibilities for discharge planning and coordination # The availability of live data at Cluster, County and Site level with sufficient analytical support # the ability to risk stratify for people at moderate to high risk of admission in the community to implement proactive anticipatory care plans to support avoidance of exacerbation / decompensation and hence increased risk of hospital admission # Optimising our bedded facilities in the community i.e we should aim for 'step up' from community and from 'front door' hospitals (within 72 hours) rather than as a 'step down'	Incorporate and deliver actions that will address control gaps into the Health Board's UEC Plan.	Carruthers, Andrew	31/03/2025	The Annual Recovery Plan for 2023/24 outlines the UEC improvement actions being progressed during the current financial year in support of this longer-term objective. These are overseen and monitored by the TUEC steering group, chaired by the Director of Operations, with progress reported regularly to Board Committees.
		To develop a plan with Local Authority partners that sets out a model for integrated community health and care provision for older adults and adults living with frailty	Paterson, Jill	30/11/2023	Work is underway across the three counties.

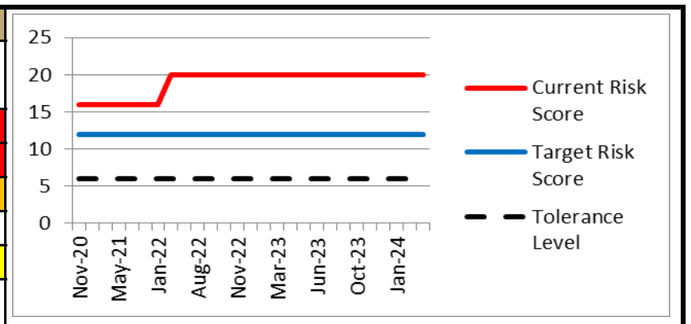
		hours, rather than as a 'step down' from acute hospitals after long length of stay. LOS should be no more than 10 days # Bespoke recruitment targeted at critical posts that will deliver improvements in UEC eg ANPs, APPs, PAs etc. and accept risk to permanently fund such posts i.e should not be temporarily funded. # Frailty screening by staff in ED and reporting into WPAS to support risk stratification of patient cohorts who should spend no more than 10 days in hospital. Majority should be turned around in 12 hours and < 72 hours. # Frailty screening and reporting into WPAS of inpatients who either have formal care in place on admission or whose level of frailty on admission suggests a need for care and support on discharge. This will support risk stratification to support discharge planning and coordination. # Consideration of workforce development for existing staff but also bespoke opportunities for non clinical roles that releases clinical time for 'clinicians to only do what they can do' # Reduce service duplication across sites # Inconsistent clinical provision for the Out of Hours (OOH) Service # Development of 24/7 urgent primary care service that integrates urgent primary care service in the day and GP OOH and provides timely information, advice and assistance to patients and clinicians to provide safe alternatives to hospital admissions.				

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Performance indicators. A suite of unscheduled care metrics have been developed to measure the system performance.	Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st				None identified.				
	Daily performance data overseen by service management	1st								
	Delivery Plans overseen by Unscheduled Care Improvement Programme	2nd								
	Bi-annual reports to SDODC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	IPAR Performance Report to SDODC & Board	2nd								
	WAST IA Report Handover of Care	3rd								
	11 x Delivery Unit Reviews into Unscheduled Care	3rd								
	Delivery Unit Report on Complex Discharge	3rd								

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Apr-24
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	May-24

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

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



Rationale for CURRENT Risk Score:

The service is experiencing significant waiting times as a result of increasing demand levels which are exceeding pre-pandemic levels, compounding the backlog due to Covid restrictions. Due to increasing Did Not Attend (DNA) rates, ongoing recruitment challenges and increasing demand there is an impact on the services' ability to see the same volume of service users as they were previously able to. Some posts continue to be funded on fixed term basis which can make staff retention challenging along with having to train new incoming staff.

As of March 2024, there are 3,067 CYP on the waiting lists, with 2,605 waiting longer than 26 weeks.
Average wait has increased from 74 weeks to 92 weeks.
For Autism Spectrum Disorder (ASD), a meeting took place with the Delivery Unit to establish trajectories, along with the commissioned service which since have been agreed in March 2023. The DU were unable to provide trajectories, therefore Health Board has agreed to a 1% monthly improvement trajectory. For psychological services a trajectory is now in place for 1% per month.

This risk was reviewed on the 21/12/2023 - on the basis on improved CAMHS Part 1 position and a deterioration in ASD/ADHD, this risk score remains the same.

Rationale for TARGET Risk Score:

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

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

While trajectory plans are in place as of March 2024, there is recognition that the Health Board will not achieve WG targets.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Use of IT/virtual platforms such as Attend Anywhere when appropriate. Clinical prioritisation regarding assessment and treatment of service users by engaging in a dynamic process of reviewing waiting lists in line with any other referrals that may be received in respect of that service user. Additional funding received in 2023/24 for ND services Services are in contact with individuals to provide information regarding mainstream/Tier 0 support, wellbeing at home and guidance should their situation deteriorate. Process in place to ensure individuals on waiting lists are being contacted periodically through the wait for assessment/treatment to monitor any alteration in presentation. Autism Advice Hubs and pre-assessment workshops in place for Childrens Neurodevelopmental Service Monthly meetings with Women and Children's Service to strengthen interdepartmental working. ND Service Delivery Manager appointed and in place. Continual review of vacancies via MHLD QSE meetings resulting in the consideration of alternative staffing models when recruitment drives do not materialise.	Although dedicated premises have been sourced for ASD services, there is limited clinical space and Estate issues remain a challenge as identified in the risk narrative. Information not currently included on Health Board website and QR codes due to IT difficulties Additional funding received in 2022/23 for ND service on fixed term annual basis until 2025 Current resource does not provide sufficient capacity to meet demand Unable to recruit in to Clinical psychology in adult ASD service	Keeping in touch processes to be in place (Adult Inpatient and Learning Disabilities Services).	Bassett-Gravelle, Ms Lisa	Completed	Psychology In May 2023, 52 (40.00%) patients out of 130 were waiting less than 26 weeks to start psychological therapy in the Learning Disabilities Psychology Service. 78 (60%) were waiting more than 26 weeks. This is a month on month improvement since January 2023 and the position is likely to further improve due to Psychologists returning from maternity leave and recruitment. All new referrals are screened by the Community Teams and priority given where possible. Waiting lists review has been undertaken and keeping in touch letters in easy read have been sent out to all on the waiting list. We have recruited 8b psychologist who commences in August 2023. OT Urgent referrals taking priority. • Continue to prioritise referrals and support workforce modelling as part of service improvement work

Workforce Management Group has been established which meets monthly. Trajectories have been identified for IPTS and Children's ND and there are systems in place to monitor waiting lists at service level, through performance-management meetings, IPAR and Directorate and service level review meetings. Monthly meetings with Estates to look at accessing/leasing/enhancing the current MH estates with a view to increase MH estate footprint. Work underway across all services who have waiting times, be they intervention or assessment. Use of HB Third Party Contractor has begun and keeping in touch letters sent to those waiting appointments with the Integrated Autism Service and Children's ND service. ND specific HB internet and intranet pages in development to give guidance and support whilst neuro-divergent individuals and parent carers are waiting. Keeping in touch letters developed and sent to those on ASD waiting lists on a 3-4 monthly basis and monitored by individual service leads. Service Leads secured opportunities for outsourcing for ASD services and Psychological Therapies. Commissioned external provider for ASD services across all ages, similar contract out to tender for Psychological Therapies. 'Grow your own' scheme is coming into place with funding provided in academic year 23/24 for 3 places on the Clinical Psychologist programme (3 year programme). Quarterly meetings with the NHS Executive, Welsh Government and Service Leads at the Health Board SMS functionality in place for ND and IPTS to improve attendance and decrease instances of DNA All posts recruited in to Children's ASD service					underway. • Additional up-skilling B4 techs • Reviewing universal offers of support/workshops for families and carers particularly around sensory processing referrals. • Reviewing use of caseload weighting tools and enhanced professional lead oversight of caseloads • Limited clinical support from AMH B7 in Pembs CTLD. • Additional 1.0WTE B6 OT post to cover Carmarthenshire, and 1.0WTE OT B6 post within WEIT being proposed as part of SIP. Physio LD Service Manager EOC will attend peer meetings in the absence of a professional lead. EOC has advised the Physiotherapist that she will be validating and monitoring the waiting list reporting to the Information Dept on a monthly basis until they have a Prof Lead in place. Services developing a professional lead physio for LD JD. All LD Therapies Service Manager EOC has advised the to adopt Psychology's approach of formally writing to each individual on the WL over 6/12 as part of the regular Waiting list review cycles.

			Identify alternative venues/space to hold clinics(CAMHS & Psychological therapies).	Lodwick, Angela	Completed	Challenges continue in access to Estates to undertake assessments across the three counties. Remains ongoing working with Estates and submitting capital bids to WG for monies to fund works within allocated buildings to make them fit for purpose. SBAR being developed to repurpose the use of Tudor House. RAAC issue is extenuating the estates position with some areas within Pembrokeshire/Ceredigion not being available to undertake assessments/interventions. Ongoing estates issues, movement of Directorate Management team from Ty Gwili to provide additional clinical space. Neuro / IAS moving to Ty Gwili for clinical space by March 2024. Other moves taking place throughout the service and additional funding and areas being explored. Moves have been completed from Ty Gwili to Tudor House to identify clinical space for Neuro in Ty Gwili. Continuing to pay for space within Nurture Centre for DBT and PMH/SiR teams for additional family sessions. Remain looking into additional funding and exploring areas.

Identify alternative venues/space to hold clinics (Integrated Psychological Services).	Homfray, Andrew	~~31/07/2023~~ ~~31/11/2023~~ 31/08/2024	As many groups as possible are being set up to utilise online facilities and third sector venues to support any face to face meetings, ensuring that costs are managed appropriately. Phase 1 of groups completed in February 2024, targeting waiting lists. Phase 2 of group implementation to implement a tiered approach to intervention to commence April 2024 following further staff training, with full implementation expected by August 2024.
Identify alternative venues/space to hold clinics(Commissioning /CDAT).	Richards, Matthew	Completed	New North Dock premises are being progressed by APB to deliver new base in Llanelli with accessible clinic space. Currently going through planning and concerns about potential delays due to public objections. Due to a revision of the risk narrative, this action is no longer relevant and therefore noted as complete.
Directorate to transfer all service data collection processes to WPAS.	Amner, Karen	Completed	Delays to the Dementia Wellbeing Service, Integrated Autism Service, Perinatal, Memory Assessment Service migration delayed due to capacity within the Digital team to test and develop system at required pace. As at October 2023, all data for the relevant services noted on the risk have been transferred, therefore to close action.
Review workforce skill mix in light of any potential new funding received from WG for Neurodevelopmental services.	vaughan, Catherine	Completed	Workforce reviewed and skill mix within team expanded to ensure a multidisciplinary approach in order to deliver an integrated multi disciplinary service in respect of the fixed term funding for 2023/24 received on behalf of the Regional Partnership board(RPB). Skill mix introduced but unable to recruit in to some posts due to delay in funding received via RPB and fixed term nature

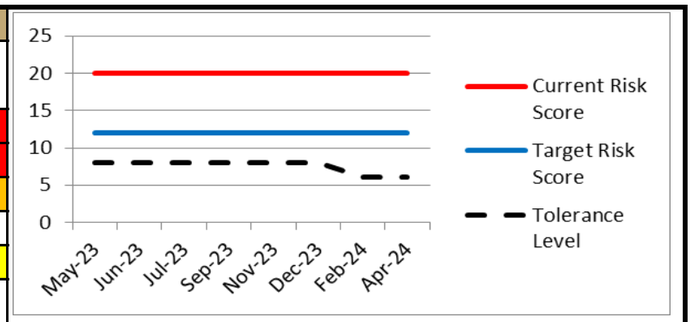
	Monitor the use of SIFT monies for service development. The Director of Finance has given an undertaking that this will be funded as discussed and agreed at a Directorate Improving Together Session in April.	Carroll, Mrs Liz	Completed	During the budget setting process in Month 7, the £575k for procurement for EMDR and ASD was not factored into the Directorate position despite this having been agreed following agreement at Public Board in September 2022. This was raised by the Finance Business Partner during the budget setting process with Finance colleagues. This leaves a deficit in this years budget. To be reviewed in the DITS meeting on the 27th October 2023. This outsourcing has been absorbed by the Directorate.
	As a result of Reinforced Autoclaved Aerated Concrete (RAAC) found at Withybush General Hospital site and the internal major incident that has been declared, some areas previously used by the Directorate have now been withdrawn. The Directorate attend the Outpatients RAAC Subgroup (Bronze) where the impact on the Directorate and potential solutions are being worked through in collaboration with the wider Health Board. Linked to Estates Risk 1711.	Carroll, Mrs Liz	~~29/03/2024~~ 30/06/2024	08.11.23 - Bronze RAAC Sub Group have identified no impact for MHLD services due to relocating or virtual clinics.
	Development of a MH/LD essential training framework to reflect training needs across MH/LD services based on a systematic TNA that can be reviewed at regular intervals and monitored for compliance.	Temple-Purcell, Rebecca	~~30/11/2023~~ 31/12/2024	In progress, working with Workforce to develop a training needs and analysis tool. MH&LD to act as a pilot for this pending further roll out across the HB.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Welsh Government performance indicators along with internal monitoring arrangements will be used to ensure the actions are having the desires effect or whether there is more that needs to be done.	Management monitoring of referrals	1st			Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC (Oct21) MHLD progress update on Planning Objective 5G - Board (Mar22) Papers have been presented at the Quality Safety and Experience Assurance Committee with a further update paper provided for the December 2021 meeting outlining control measures to manage the waiting times that the Directorate have at present. A paper was presented at Board Seminar in June 2022 to provide assurance on current waiting times and control measures.	System to improve analysis of patient experience	Outcome measures to be in place to measure effectiveness/quality of services provided (CAMHS & Psychological therapies).	Lodwick, Angela	Completed	S-CAMHS is implementing nationally agreed Welsh Government Outcome Measures - staff have received training as part of the Welsh Government Initiative. Gold Based Outcomes, SDQ and YP Core. Katie O'Shea has implemented this and all staff have received training and aware of expectations.
	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd					Outcome measures to be in place to measure effectiveness/quality of services provided(Adult Inpatient and Learning Disabilities Services).	Bassett-Gravelle, Ms Lisa	Completed	Due to staffing issues it has been difficult for the Business Manager to take further with the SALT team due to pressures within services. Business Manager is liaising with Sarah Mackintosh from Carmarthenshire People First with questions to go onto an easy read format. Meeting with Carmarthenshire People first on 17th April 2023 to go through the questions for the easy read format. Once easy read format has been completed Business Manager will take to Q&S Team to add a QR Code to give the service user the choice of both options. 15/06/2023 both easy read and electronic forms completed, meeting with CTLD managers taking place to roll out the new forms.
	MH&LD QSE Group overseeing patient outcomes	2nd					Outcome measures to be in place to measure effectiveness/quality of services provided(Commissioning /CDAT).	Richards, Matthew	Completed	CDAT outcomes measures are gathered using TOP assessment for all service users and reported via quarterly KPI's to APB and WG. Commissioning outcomes measures are being reviewed and recent work with NCCU will support this. Possibly pilot an outcome framework with NCCU as a temaplate for national approach. Due to the reframing of the narrative of this risk, CDAT is now out of scope therefore action completed
	Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC	2nd								
	W-PAS Internal Audit (reasonable assurance)	3rd								
	An update was requested by the Chair and provided for the August Quality, Safety, Assurance Committee.									

Date Risk Identified:	Nov-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Apr-24
Strategic Objective:		**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	Jun-24

Risk ID:	**797**	**Risk Description:**	There is a risk of being unable to provide a full range of ultrasound services including antenatal across the Health Board. This is caused by the retirement and resignation of current sonography staff, low availability of sonographers UK wide, and the inability to recruit to due national shortages of qualified staff, and the inability release existing workforce to train and develop to meet current service demands. This could lead to an impact/affect on delays in diagnosis which could result in detrimental outcomes for patients, inability to meet diagnostic targets and cancer pathway targets, and an inability to hold clinics to meet demand in ante natal screening services within required timescales. In addition, there is an impact on staff health and wellbeing in terms of the volume of patients examined within a shift/overtime, which could lead to increased incidents of repetitive strain injuries (RSI), along with increased incidents of staff stress and burnout. This could ultimately lead to increased errors when performing the dynamic diagnostic test.
Does this risk link to any Directorate (operational) risks?		1557, 1349, 1658	

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



Rationale for CURRENT Risk Score:

Despite best efforts, the service remains fragile. There are still vacancies which remain unfilled, but there has been an improvement in recruitment due to the financial picture across Wales and the cessation of use of agency staff above AFC pay rates. Even if all vacancies were recruited to, the Health Board would still not have the capacity to meet current demand (as at end March 2024 there were 917 patients waiting 8 weeks plus for non-obstetric ultrasound (Dec 2023: 1547, February 2024:1288), with the reduction a result from the use of insourcing and a small amount of overtime by substantive staff utilising end of year recovery monies).

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

Modality leads have been recruited at Withybush (2023) and Bronglais (2024) which is positive and will ensure that undertake governance and audit requirements.

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

3 of the 4 vacancies as advertised in July 2023 were successfully appointed to (with agency staff), though this has not resulted in additional capacity to the service as roles have been given to previous locum staff.

Rationale for TARGET Risk Score:

The actions below will not in themselves reduce this risk significantly. Demand and capacity and the current establishment review is being undertaken by the Ultrasound control group via a needs assessment and is due to be complete by July 2024. It is likely that these reviews will lead to a need for further investment and additional funding to establish a sustainable service model to include a robust perpetual training programme, that will enable the Health Board to met expected diagnostic waiting times targets.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Process in place for the movement of staff across the Health Board to maintain capacity where possible. Ultrasound Control Group reconvened in Jan 2024 after having not met since July 2023 due to operational pressures. Meetings take place on a monthly basis. The PPH modality lead has been filled (Feb 2024)	Inability to release existing staff to train and develop to undertake sonography and growth scans. Inability to recruit and retain staff. While process in place regarding the movement in staff, due to current staffing levels and pressures this is not being implemented, however the teams across sites are collaborating and look at all possibilities when gaps in rota arise and are foreseen.	Develop a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.	Jones, Keith	~~31/12/2022~~ ~~31/10/2023~~ ~~31/01/2024~~ 30/06/2024	Discussions have taken place with Head of Maternity Services. Protocols and training being developed. Implementation date to be agreed. A meeting was scheduled for 20th June 2023 with CVUHB in order to assist with the development of a training plan but there was no midwifery representation available on the day. Midwifery services approached Powys for assistance with training midwives sonographers, and appointed 2 midwives to join the ultrasound Course for January intake 2024. However, Powys are unable to support training in the same original capacity and the certainty around midwife training in January is currently unknown. Ultrasound Control Group was arranged for 7th December, but re-arranged for January 4th 2024 due to availability. "midwife sonographers have started training, however support from Radiology will not be able to be enacted until the Sonographer Clinical Educator is in post due to the current training commitments within Radiology.

			Train members of staff to become sonographers, the number of which dependant on capacity to take training.	Roberts-Davies, Gail	~~31/03/2020~~ ~~31/12/2022~~ ~~01/02/2023~~ ~~30/09/2024~~ 31/01/2026	As at November 2023, we are currently training 3 members of staff (2 at GGH and 1 at PPH) along with 2 Midwife Sonographers who are currently undertaking clinical training in Powys. Clinical Educator role has been developed and recruited to with the successful candidate due to commence employment on 01/06/2024. This will allow us to expand Ultrasound training an all sites and advertise existing vacancies in ultrasound as training positions under Annex 21 rules.
			Work with the workforce planning team to build a sustainable workforce plan for ultrasound services.	Roberts-Davies, Gail	~~31/10/2023~~ ~~31/03/2024~~ 31/07/2024	Fortnightly workforce planning meetings in place with colleagues from Radiology and Workforce in attendance. Stakeholder mapping exercise being undertaken as at December 2023. Work is ongoing in this area and is currently concerned with the Clinical Services Plan issues paper along with the Radiology Annual plan (Jan/Feb 2024) and the Ultrasound needs assessment.

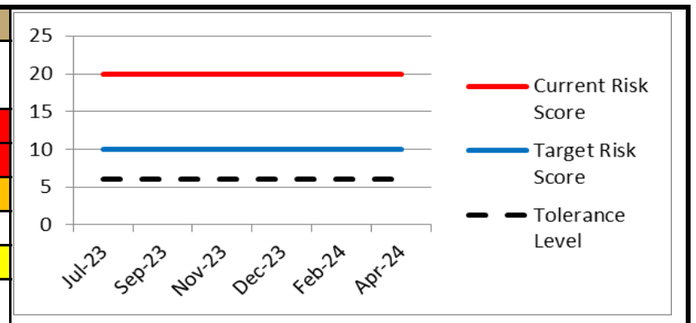
	Seek support to undertake a demand and capacity (D&C) review and detailed establishment review of the radiology service.	Jones, Keith	~~30/06/2022~~ ~~30/11/2022~~ ~~31/03/2023~~ ~~30/08/2023~~ ~~31/01/2024~~ 31/05/2024	Initial contact made with workforce planning team re: establishment review work. This has been discussed in the Radiology Use of Resources Meeting. A Radiology dashboard is in place which provides activity and demand. A new dashboard was published in Jan 2024 which is aligned to ARCH development. As of November 2023 there have been some significant staff changes on various sites with the loss and gain of sonographer hours. D&C needs further review and is being linked into Workforce planning. Workforce planning work is taking place and as of Jan 2024 and concerned with the clinical services plan and annual plans. An ultrasound needs assessment is currently being undertaken via the Ultrasound Control Group and is due to be completed by July 2024.
	To consider possible insourcing options to support the service	Roberts-Davies, Gail	~~31/03/2024~~ 31/07/2024	Head of Radiology has liaised with contacts in NWSSP Procurement. The tender submissions have been received and evaluation of responses to undertaken in November 2023. In December 2023, confirmation received of allocation of recovery funding for the ultrasound insourcing contract approved to the end of the current financial year. As of Feb 2024, insourcing contract started utilising EOY recovery funding during Feb & March 2024. Continued use during 24-25 financial year subject to recovery funding.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Non-Obs ultrasound - currently over 40 weeks Radiology Dashboard IPAR Reports WG Cancer PTL, reported monthly	Management review of sonography and SCP diagnostic waiting times	1st			Sonography Report to Acute Bronze and Operation Planning and Delivery Programme meeting					
	Monthly review of USC performance undertaken monthly (36% of USC carried out in 7 days, 56% carried out in 14 days at Dec. 2023), included in the IPAR & reported to WG	1st								
	Performance monitored at Directorate Improving Together Sessions	2nd								
	Performance monitored via IPAR, overseen SDODC & Board	2nd								

Date Risk Identified:	May-23	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Apr-24
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	May-24

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

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



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
Increased demand and reduced capacity continues to be a challenge. Balancing Eye Care Measures for patients most at risk with Ministerial Measures for longest waiting patients presents a conflicting priority to the service with limited capacity. The service has provided additional AMD sessions on a weekend, however these additional sessions have not been enough to meet the demand across all counties in the Health Board (HB). Patient delays continue across the HB. AMD continues to be prioritised impacting on the provision of general clinics, having an impact on the wider ophthalmology service and patient experience. The current non-medical workforce establishment is not aligned to service needs. Additional staffing for Wet AMD was incorporated into IMTP but no funding was allocated. The service as at February 2024 has 6,383 patients (Nov 23: 5,713) that have been 100% delayed for their follow up appointment. The total new patient referrals is at 7,088 (Nov 23: 5492) of which 713 (Nov 23: 403) are breaching 52 weeks (the longest wait from this cohort is 84 weeks (Nov 23: 67 weeks)). 4,040 patients are awaiting an Ophthalmic operation (Nov 23: 3,785) of which 46 (Nov 23: 24) are breaching 104 weeks (the longest wait from this cohort is 130 weeks). The current impact has been scored as 5 because patients suffering irreversible sight loss or damage is a reality and the current Likelihood has been scored 4 as Ophthalmology is a fragile service. It is unlikely that we will be able to achieve the Board tolerance score of 6 without a regionally agreed solution.	It is unlikely that the service will be able to reduce the impact score of this risk as the consequences to the patient remains high, however due to recent re-structuring of the management team within Ophthalmology it is hoped that this will provide opportunities to review and improve service delivery with an initial focus on meeting eye care measure targets for the most high risk cohort of patients. The recent addition of a substantive WTE Consultant will help to address the longest waits. A Regional Consultant post has been recruited in Swansea Bay to provide an additional 10 sessions a week in HDUHB, however noting that 7 of these sessions relate to clinical delivery. With the above additional workforce and focused management of the waiting lists, HDUHB will potentially help to reduce the likelihood score on this risk.

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

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

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

			Plan for Cataracts pathway to be implemented through ARCH.	Barreiro, Marta	~~30/06/2022~~ ~~30/09/2023~~ ~~30/11/2023~~ ~~31/03/2024~~ 30/06/2024	Locum Consultant secured to assist with delivery of Cataracts surgery/Substantive Consultant with specialism in plastics secured who can also undertake cataract surgery. Review of Demand and Capacity now undertaken to inform service recovery. The ARCH pathway as of December 2023 has ceased, with plans devised and approved. GIRFT review for cataracts is ongoing, with recommendations raised noted on the Audit and Inspection tracker and progress updates obtained. Action is linked to the ability to restructure service between AVH and Pembrokeshire, which is currently impacted by RAAC.
			Implement virtual review clinics for patients undergoing Hydroxychloroquine (HCQ) treatment.	Coppack, Victoria	~~30/09/2022~~ ~~31/10/2023~~ ~~30/11/2023~~ ~~31/03/2024~~ 30/06/2024	Validation of HCQ patient commenced in November 2023. Longest wait HCQ patients have been identified for tech review. Virtual review process to be discussed with Clinical lead. Clinic spaces to be secured for patient review. This is an interim measure whilst community hub is being developed.

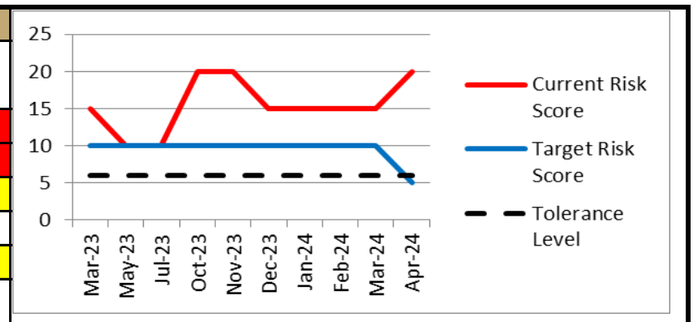
	Clinical validation rota to be established within the service to ensure validation of high risk patients and longest waits is undertaken to prioritise patient reviews and safety net patients	Coppack, Victoria	~~30/09/2023~~ ~~31/12/2023~~ 30/04/2023	Validation ongoing and R1/longest wait patients booked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

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Eye care measures monthly report.	WPAS	1st			Ophthalmology 'Deep Dive' paper to ARAC (Dec 2023)					
GIRFT review Cataracts.	GIRFT action plan cataracts	1st								
GIRFT review Glaucoma.	GIRFT action plan Glaucoma	1st								
Watchtower review of ministerial measures	WPAS, scheduled care performance indicators	1st								

Date Risk Identified:	Nov-22	**Executive Director Owner:**	Carruthers, Andrew
Strategic Objective:		**Lead Committee:**	Quality, Safety and Experience Committee
Date of Review:	Apr-24		
Date of Next Review:	May-24		

Risk ID:	**1531**	**Risk Description:**	There is a risk of being unable to provide a safe and sustainable general surgery consultant on-call rota at WGH and GGH. This is caused by One vacancy and one substantive consultant who is no longer taking part in the on call rota, due to health issues, on the General Surgery Consultant rota at WGH (1:5). This is now running as a 1:4 rota with one Medacs and one NHS Locum filling the gaps. One vacancy, one retire and return consultant and one consultant who has reduced their on calls on the General Surgery Consultant rota at GGH (1:8). GGH is now running as a 1:5.5 which is not sustainable. This could lead to an impact/affect on the ability to provide an emergency general surgery service at WGH and GGH affecting patient experience, causing clinical delays and poor outcomes for patients. The wellbeing of remaining consultants who are already working to full capacity is also affected and there is an increased expenditure on agency locum consultants.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	1×5=5
Tolerable Risk:	6
Trend:	↔



Rationale for CURRENT Risk Score:

The risk score has been increased. In addition to the risk at WGH, the GGH surgical consultant on call rota is also in a fragile position. Since July 2023, due to a retire and return, without on call commitments in their job plan, the 1:8 rota became 1:7 with agreed internal cover for the 1 gap. Since February 2024, the rota has become a 1:6 due to a further vacancy, following a promotion within the team. This is a fixed term arrangement for 12 months and a locum upper GI consultant post to cover this vacancy is currently being reviewed and will be advertised in April 2024. There is a further gap on the rota which affects 1:8 weekends only, this is due to medical reasons. The GGH rota is currently running as a 1:5.5 which is not sustainable. There is also currently unplanned sickness in the team at GGH, which is likely to be for 6 weeks. This has caused further pressure on remaining consultants and has impacted elective activity. The recommended solution to the rota fragilities on both sites is to consider combining the two rotas and move the general surgery emergency service to one location. The fragilities at WGH remain the same, with high cost Medacs locums supporting the consultant and SAS level on call rotas. There are only 2 substantive consultants on the 1:4 consultant on call rota.

Rationale for TARGET Risk Score:

The target risk score is based on the agreement of amalgamating the GGH and WGH rotas to one site. This has been suggested by the senior consultant leads for general surgery. It is believed that making this change to the service would reduce the likelihood of rota collapse and reduce the risk of not being able to provide a safe and sustainable emergency general surgery service to patients in the south of the health board. Under this plan, a 1:10 or 1:12 rota would be in place at GGH. There is a belief that this would provide a more sustainable service and make recruitment more attractive when comparing to other health board's across Wales. This has been included in the scheduled care annual plan and an updated SBAR with these recommendations is to be presented in CDG.

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 WGH General Surgery consultant on call rota currently runs as a 1:4. There are currently 4 consultants on the rota, 2 substantive, 1 NHS locum and 1 Medacs locum who joined the team on 06/11/2023. An NHS locum consultant post was advertised and appointed to on the 20/11/2023 as an exit strategy for the Medacs locum. The successful candidate withdrew on 29/11/2023. A job description for an emergency general surgeon is currently being developed. The 2.5 gaps on the 1:8 General Surgery consultant on call rota at GGH is currently being covered by internal staff on a locum basis. A job description for a consultant Upper GI surgeon, to join the GGH rota is being updated and the job will be advertised before the end of April. Current staff from WGH and GGH continue to provide backfill to maintain the rota. Continuously liaising with the rota coordinator at WGH for potential gaps on the rota. Proactive sickness management Escalation to clinical leads Medacs locum has been briefed on clinical pathways and procedures within Hywel Dda Health Board and expectations have been made clear by the surgical team. Engagement with WGH Medical Staff Committee and public on changes to services An interim 1:3 model with day consultant cover being provided by WGH consultants and night consultant cover being provided by BGH or GGH on a rota, came to an end on 03/11/2023. Board approval was received for a 1:4 24/7 surgical consultant on call rota to commence from 03/11/2023. The rota consists of 2 substantive consultants, 1 NHS locum, 1 Medacs locum. In response to the fragility of the rotas and the recruitment difficulties	The 1:4 model at WGH, which commenced on 03/11/2023 continues to be fragile, with only 2 substantive consultants on the rota. The 4th slot on the WGH rota is being filled by a Medacs locum which incurs additional costs. There are also risks of the locum leaving at short notice, causing the rota to collapse. An NHS locum consultant post was advertised and appointed to on the 20/11/2023 as an exit strategy for the Medacs locum. The successful candidate withdrew on 29/11/2023. To maintain the current rota model, we will now be reliant on the Medacs locum for a longer period. The locum consultant who started on 04/09/2023 was an associate specialist and part of the SAS level rota at WGH. This has now left a gap on the SAS level rota. This is currently being covered by a Medacs locum. We advertised and appointed a specialty doctor but the successful candidate withdrew on 13/11/2023. The post went back out to advert and we appointed on 01/12/2023. This person withdrew on 07/02/2024. The post is going back to advert in April 2024. Previous difficulties in recruitment into the consultant and specialty doctor post. A job description for a consultant emergency general surgeon is currently being developed	Recruitment of 1 Consultant upper GI surgeon for GGH. Agreement to recruit 1 consultant emergency general surgeon for WGH or 1 consultant general surgeon for GGH.	Lewis, Caroline	~~20/11/2023~~ 01/06/2024	One NHS locum has been recruited to WGH and has been in post since 04/09/2023. Following previous withdrawals and a further vacancy in GGH. The plan for recruitment has changed with a consultant upper GI surgeon post to be advertised for GGH in April 2024. A job description for a consultant emergency general surgeon is being devised for WGH, if rotas are amalgamated, a consultant general or upper GI surgeon could be appointed to the new rota.
		To introduce a contingency model of day time consultant on-call rota in WGH with support from GGH and BGH consultant cover out of hours.	Lewis, Caroline	Completed	Report discussed at Acute Leadership Group, Executive Team and Operational Planning and Delivery Programme (OPDP) meetings. A 1:3 rota was agreed and will commence from 01May23.

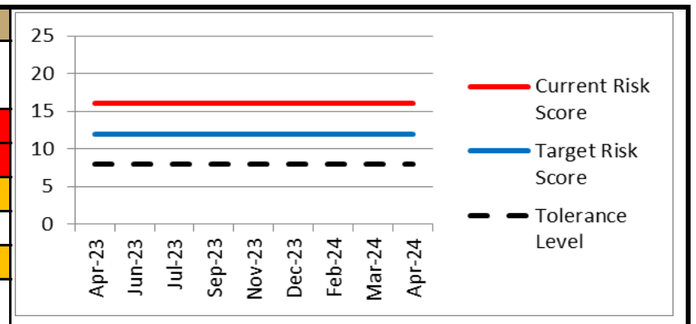
	In response to the fragility of the rotas and the recruitment difficulties that have been faced. A plan for relocating emergency surgical on call from WGH has been submitted as part of the directorates annual plan. In April 2024, an updated SBAR was populated to go to board with the recommendation of amalgamating the two on call rotas to 1 site to either a 1:12 or a 1:10. There is a belief that these changes provide a more sustainable service and would make recruitment more attractive, when comparing to other health boards across Wales who provide emergency general surgery cover in this way.	surgeon is currently being developed with the hope of going out to advert. An increase in consultants at GGH, working additional on call locum weeks is resulting in a reduction in elective activity in OPD, endoscopy and theatre. This will have a negative impact on RTT and SCP targets. The fragility of the GGH rota and it's impact on elective activity has become evident this month with further short notice sickness in the team, causing a further reduction in activity. Concerns raised about a transfer, which is being managed by an IMG process. Vacancies remain due to inability to appoint permanent Consultants to WGH. Risk of short notice sickness, with limited options of sourcing internal cover for this. Capacity to support 3 consultant on call rotas internally across the 3 sites (BGH/GGH/WGH) has reduced significantly with a gap of 2.5 on the GGH on call consultant rota and the BGH on call consultant rota already being a 1:4. This makes the opportunities for internal support more unlikely. A prolonged unsustainable service could impact on the training of surgical doctors and could increase the number of HEIW vacant posts in August 2024. Concerns from WGH physicians on the wider implications on the emergency service model at WGH.	Review the longer term sustainability of general surgery on-call rotas across Hywel dda (recommendation from Getting it Right First Time (GIRFT) review in Jan23)	Lewis, Caroline	~~31/12/2023~~ 30/04/2024	The senior consultant leads for general surgery have suggested that the WGH and GGH on call rotas are amalgamated to one site. This would provide an increase of consultants on the rota to either a 1:10 (the 3 WGH consultants and the 7 GGH consultants) or a 1:12 (the 3 WGH consultants, 7 GGH consultants and 2 newly recruited posts). This recommendation is in line with the GIRFT report. An SBAR has been devised by the service to be presented at CDG in April 2024.
		Robust plans to be developed for transfer and repatriation of patients	Lewis, Caroline	Completed	SOP has been developed and discussed with clinicians.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
	WGH Medical Staff Committee established to develop models of sustainability	1st			Management team have presented an SBAR to Acute Leadership Group (Feb23) SBAR to Executive Team and OPDP to agree 1:3 rota (Mar23) General Surgery Report to Board (Mar23) Management team to present updated SBAR to Acute Leadership Group (Oct23) Management team to present updated SBAR to Acute Leadership Group (Nov23) Management team to present updated SBAR to Corporate Directorate Group (Apr24)	Assurance to Board on communication and repatriation arrangements	Produce update report to Board in May23 to include details on communications with clinicians and the public, details of repatriation arrangements and accommodation and support for families, the patient experience and the governance arrangements for onward scrutiny	Lewis, Caroline	Completed	on 10/05/2023, an update was provided to Ben Rogers of the clinical services programme for the draft SBAR clinical services update which is what was taken to board.
	Reported to monthly General Surgery Business Meetings on each site (BGH/GGH/WGH)	2nd								
	Reported to bi-monthly Scheduled Care Quality, Safety and Experience Group through exception reporting	2nd								
	Assurance to be reported to the Board following introduction of temporary rota	2nd								
	GIRFT report on General Surgery which raised the sustainability of general surgery across 3 sites in Hywel Dda - final report awaited									

Date Risk Identified:	Apr-23	**Executive Director Owner:**	Gostling, Lisa
Strategic Objective:		**Lead Committee:**	People, Organisational Development and Culture Committee
Date of Review:	Mar-24		
Date of Next Review:	Apr-24		

Risk ID:	**1649**	**Risk Description:**	There is a risk there will be insufficient skilled workforce available to meet our Ministerial Priorities across all areas (UEC, Planned Care, Cancer and Mental Health etc). This is caused by the scarce supply of healthcare professionals and a shrinking labour market, which is further exacerbated by the Health Board's current vacancy rates. This could lead to an impact/affect on the quality of care provided to patients, delays in care and poorer patient outcomes and experience. In addition, this may lead to the inability to meet statutory and professional requirements in terms of safe staffing levels that are needed to deliver quality patient care. And further impact on the health and wellbeing of teams.
Does this risk link to any Directorate (operational) risks?			

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



Rationale for CURRENT Risk Score:

This risk has been scored as 16 (the likelihood is "likely" and has the potential to have a "major" impact) as the number of staff impacted from staff sickness is still high at Mar-24 compared to pre-Covid levels (c1-2% higher) however, there has been a general improvement over the last 12 months. Staffing levels (acute & community) continue to operate below established levels due to both vacancies and sickness/absence, and use of bank and agency. There is still a significant risk of workforce misalignment with activity and required competence levels. Further work has been undertaken to understand the level of risk across each staff group, speciality and site to fully comprehend the level of risk the organisation carries as a whole. It is hoped as further action is taken through stabilisation, Improving Together and workforce planning to reduce the risk score during 2023/24. However it should also be noted that due to the Health Boards current financial position and considering the wider financial context; (the extent and impact of which at this time is not fully known); this may result in the potential requirement to increase the risk score to 20 once board decisions have been finalised regarding the utilisation of agency, bank and locum staff workforce.

Rationale for TARGET Risk Score:

The Target Risk score indicates the likelihood of the risk occurring (absence target 4.8%). Other intelligence leads as to be alert to workforce issues as evidence suggests that patient acuity is increasing and therefore workforce requirements will increase by proxy until new models/methods to reduce or manage complexity can be identified. Also, it may be that there could be concerns for the specific services and/or the annual risk of a winter surge developing when at full capacity for recovery/ministerial priorities as we have a "finite" resource in our people that can only be stretched so far without causing detriment. Therefore, the probability sits between 75-90% when taking account of multiple factors - respiratory infections, increased patient acuity, the longer term impacts of COVID-19 on the population i.e. inability to access services needed, and workforce resilience. We hope we will be able to take mitigated actions noted below predominantly through our interventions under the Regeneration Framework in the short term and for the medium to long term begin to realign available workforce to new service design and models of care. This risk is wider than a 12 month period as actions taken or not taken today will have a long term legacy on our available future workforce and capacity/capability to manage the associated challenges of service & workforce redesign (linked to Principal Risks 1186 and 1188).

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Organisational Governance Structure People, Organisational Development and Culture Committee (PODCC) Strategic People Planning and Education Group (SPPEG) & underpinning Governance Structure for People Planning & Education to create an organisation wide assessment for our 10 year strategy Professional Leaders Forum now in place and Medically Associated Professionals Task & Finish Group alongside instigation of Allied Health professionals Performance, Planning and Utilisation Group (Check name) In addition the Variable Pay Group is leading on the WHC Improving Together approach to be align to People Planning approach supported by People Planning Team to create an organisational wide approach to in year service challenges Organisational Gap Analysis based on a 10 year profile developed and annual assessment strategic & operational review of workforce (including Education Commissioning Assessment) Inter-People and Corporate Team & Planning Objectives Establishment Control Agency usage	Workforce planning groups need time to mature and develop focus underpinning SPPEG. Capacity and capability in people planning within team and across organisation required. Establishment control cannot be relied on as one source of truth for information as a) partially due to temporary changes linked with pathways, b) 9 sources of information not all feed into the establishment control tool, c) data management issues in ESR, eg, single employer status for our medical workforce and d) Changes in the funded establishment not reflective of "on the ground" situations. Tools to enable modelling in short, medium and long term to enable alignment of population health, labour market, internal labour market, activity & performance	PO 2a: Develop Career Progression Opportunities for all that want them aligned to the overarching workforce plan & strategy (ensuring underpinning methods and processes support this activity i.e. education commissioning)	Glanville, Amanda	Completed	Complete. This was the scoping exercise and this is now complete and managed as business as usual through the SPPEG group.
		Further develop training resources and capacity to support managers with workforce planning challenges to alleviate risks (PO 2c2iii)	Walmsley, Tracy	Completed	Complete - Resources and Training have been developed to support managers and will continue to be developed. Courses delivered as stand alone and integrated into Leadership programmes.
		Approach to future community workforce development model requires alignment to UEC, Primary Care and Community Programmes of work & teams. (PO2c.2v)	Walmsley, Tracy	~~31/07/2023~~ 31/03/2024	Difficulties remain in understanding the workforce model for UEC and needs input from programme. Engagement ongoing. Primary Care Workforce Planner has been successfully bid for by Primary Care and will align to this work. Action to be revised for 2024/5 to align with Clinical Services Plan and wider programmes.

Bank Utilisation & ongoing onboarding of supply Efficient Rostering practice Roll out of new rostering system Overview of organisation and service wide risks (assessment of each service area based on workforce availability) Continuous process of assessment of services to be stood down and deployment options based on service needs (CDG) Targeted prioritisation of recruitment/onboarding of new employees to the highest areas of risk in terms of maintaining service delivery (People & OD Strategic Group) Temporary People Utilisation reports shared regularly to monitor levels of supply Align and iterate to implementation groups i.e. Medical retention. Annual completion and submission of Education Commissioning Plan to HEIW and critical assessment to known service level plans Digital support with workforce planning to support speed in decision making at local, regional & national levels. Corporate Risks have been developed linked to Wellbeing as part of Risk Management approach. Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.	market, activity & performance analysis aligned to financial constraints (work arounds utilised but gaps/issues exist). Critical analysis of people alignment to priorities for delivery within financial considerations for short, medium & long term. A robust framework of competency based people planning and related training to underpin the Team around the Patient initiatives and new model development of care. Essential and necessary reliance on educational frameworks rather than new role development, which is an evolutionary aspiration. Practical next steps will be assessed linking into skills gaps within the workforce and the educational infrastructure to support. This will inform Workforce Plan.	Analysis, design and development of the infrastructure and governance to develop the a new model of care i.e. OBC and Social Model of Health i.e. resource requirements, alignment to current structure and service design programmes (workforce planning for workforce, planning/project management, communications & engagement, clinical oversight).	Williams, Paul	~~30/09/2023~~ 31/03/2024	Resource identification has been reviewed and a phased plan of implementation agreed by Executive Team. Requires alignment of new resources within current operating model/infrastructure to make best use of resource and manage risks. Progress: no further update on specific as Clinical Review with WG in progress and will be complete by Aug23. A re-assessment will be needed aligned to work that will start within the "pathways" and PMO/TPO. Consideration of governance mechanisms to support alleviation of strategic workforce risks (7-10 years). Discussion now needed on next steps. Action superseded by current events/feedback from WG & TI. To be revised and aligned to Clinical Services plan and Stabilisation work.
		Agree actions to mitigate strategic risks of workforce supply based on assessment paper	Gostling, Lisa	Completed	Detailed paper aligned to Workforce Plan to be issued to PODCC for meeting on 15 April 2024 (Submitted 27 March 2024).
		Test "WFP" Project Support Role within a Directorate to strengthen operational and strategic workforce planning: Women & Children	Walmsley, Tracy	Completed	Complete- evaluation to commence April 2024.
		Methodology to support new and enhanced roles to be scoped and implemented.	Walmsley, Tracy	Completed	Completed- New Clinical Role development policy signed off at SPPEG February 2024. Further work will be needed and will form part of the Workforce Plan for 2024/5.

Interrogate financial establishment/SIP to ensure "a source of truth" and align to identified and prioritised risks (operational and strategic).	Walmsley, Tracy	31/03/2024	Meeting to review risk to be set up to link in "Stabilisation" and wider Establishment Concerns (links to Principal Risk 1186). Ongoing dialogue with Finance and critical stabilisation related WOD Teams. Based on Operational Workforce Plan discussions a paper to be drafted and presented to Executive Team April 2024 to outline challenges. Revision of Risk needed in line with this action i.e. "confidence in integrity of alignment of data sets".
1a Develop an attraction and recruitment plan (which enables service sustainability) and deliver a plan which is designed to streamline and modernise processes, recruitment from different talent pools, attract and support candidates	Gostling, Lisa	Completed	Completed- Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment Plan.
1a.1 Redesign all JD & PS to focus on core requirements and skills	James, Michelle	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment Plan.
1a.2 Employ new methods of advertising and appointing to roles	James, Michelle	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment Plan.
1a.3 Develop programmes for employability support	James, Michelle	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment Plan.
1a.4 Develop attraction plan to link with offers for R&D, Service Improvement, Education etc	James, Michelle	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment Plan.
1a.5a Appoint to vacancies via different employment pools (resourcing)	James, Michelle	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment Plan.

1a.5b Appoint to vacancies via different employment pools (learning & development)	James, Michelle	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment Plan.
1a.6 Enhance HB offer to improve lives of local population by social responsibility initiatives i.e. volunteering/employment pathways etc	James, Michelle	~~31/07/2023~~ ~~30/11/2023~~ ~~29/02/2024~~ 31/03/2024	Links to 1a.3 •Future Workforce Operational Group has been created; •Mapping & analysis of data has begun to inform future campaigns; •Choose us and Care 24 bids have been submitted.
2a.1 Identify and target development pools to support future registrant roles	Glanville, Amanda	Completed	The scoping paper has been completed and this is now business as usual through the SPPEG workplan.
2a.3 Reshape higher awards process to link with training needs analysis	Glanville, Amanda	Completed	Completed and being sent to SPPEG for Approval 20/02/24.
2a.4 Develop an interprofessional education plan with full implementation plan by 2026	Glanville, Amanda	Completed	Completed and being sent to SPPEG for Approval 20/02/24.
2a Engage with and listen to our people to ensure we support them to thrive through healthy lifestyles and relationships	Gostling, Lisa	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
2a.2 Wellbeing charters are fully embraced	Davies, Christine	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plan.
2b Continue to strive to be an employer of choice to ensure our people are happy, engaged and supported in work to further stabilise our services	Gostling, Lisa	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.

2b.1 Improve HB education & development offer, supporting enhanced opportunities	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
2b.2 Workforce Effectiveness and Stabilisation Programme to improve experience of staff by reducing reliance on agency/bank and recruiting to posts locally and by overseas means across all professions	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
2b.3 Widen choices relating to contracting opportunities	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
2b.4 Enable job enrichment where appropriate; core principles and design methodology developed	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
2b.5 Plan developed to optimise digital opportunity and cost effective workforce agility	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
2b.6 Further develop and spread people recognition formally and informally	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
2c Develop and maintain an overarching workforce, OD and partnership plan	Gostling, Lisa	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
2c.1 Implement succession planning and leadership & management pipeline	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.

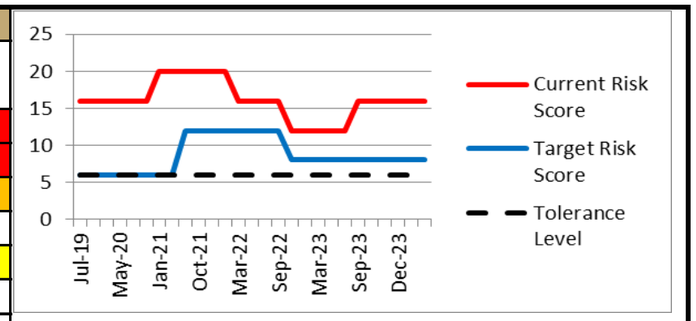
2c.2 Further develop short and long terms plan by services and professional groups	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
2c.3 Understand our people by using quantitative and qualitative data	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
2c.4 Develop a process of listening and learning from staff experiences ensuring regular feedback	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
2c.5 Promote a culture of innovation and enhance the HB reputation	Walmsley, Tracy	Completed	Paused for 2023/24. Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
Agree actions to mitigate strategic risks of workforce supply based on assessment paper	Gostling, Lisa	Completed	Detailed paper aligned to Workforce Plan to be issued to PODCC for meeting on 15 April 2024 (Submitted 27 March 2024).
Explore & assess alternative roles (value, barriers and future plans (MAPS, AP's APP's, CAAPS))	Walmsley, Tracy	Completed	CAAPS discussions ongoing for future years; AP assessment needed going forward links to All Wales work. MAPS inluded in Paper to SPPEG February 2024; Workforce Plan, Education Commissioning and Professional Leaders Forum now in place for scrutiny for 2024/25.
Completion of Education Commissioning Plan to HEIW and critical assessment to known service level plans as at March 2024 submission to Welsh Government (PO2c2ii)	Walmsley, Tracy	Completed	To be submitted to WG 28 March following Executive scrutiny on 27th March 2024. Professional Leaders Forum held on 15 March to assess.
Reiteration will be required for the Health Boards Annual Plan linked to Recovery Scenarios based on Board decisions for the development of All Professions led people plans to align to in year tactical & operational plans linked to the overarching Strategic 10 year Workforce Plan.	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
	Monitoring of workforce SIP and gaps in establishment control	1st				Assessment & continuous development mechanisms linked to Capacity and Capability (including any negative impacts on Wellbeing)	Draft Maturity Matrix and "Panel" approach to be tested	Walmsley, Tracy	Completed	Close Out Report completed for PODCC 15 April 2024; Further actions identified will be included in the Workforce Plan and associated recruitment, retention or development plans.
	Risk management approach to Workforce themed Risks	1st					Overarching Implementation Plan & Assessment of Impact (Approach defined 30/9/23) and delivered no later than 31/03/24 to link to Annual Planning cycles (identified in Audit Wales initial draft report)	Walmsley, Tracy	Completed	Workforce Plan will take account of the needs to address the actions in the Wales Audit Office Report.
	Strategic People Planning & Education Group	1st					Maturity Matrix to be tested with an external panel and assessed for 3rd part scrutiny within HB.	Walmsley, Tracy	31/05/2024	External stakeholder engagement ongoing i.e. other SWP colleagues and HEIW. Meeting HEIW 1 May 2024 for discussion on panel set up. Meeting with regional colleagues separately to link in s part of regional work programmes.
	Workforce levels monitored at Service Level, Professional Groups and Operational Delivery Group & Improving Together meetings	2nd								
	PODCC - IMTP Plan, and process mapped through Planning Sub Group	2nd								
	Workforce Planning Internal Audit (Substantial Assurance) April 2022	3rd								
	Wales Audit Office review of Workforce Planning (Fieldwork underway - report expected Summer 2023)	3rd								

Date Risk Identified:	Jan-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Apr-24
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	May-24

Risk ID:	**684**	**Risk Description:**	There is a risk to the radiology service provision from breakdown of key radiology imaging equipment and associated infrastructure to enable equipment to function. This is caused by equipment not being replaced in line with RCR (Royal College of Radiologists) and other guidelines. This could lead to an impact/affect on patient flows resulting from delays in diagnosis and treatments, delays in discharges, increased waiting times on cancer pathways, increased staffing costs to minimise the impact on patients when breakdowns occur and increased number of breaches over 8 weeks due to increased downtime.
Does this risk link to any Directorate (operational) risks?		925, 114, 1668, 1785	

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:

The Health Board's stock of aged imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites which has a significant impact on the Health Board's ability to meet its Referral to Treatment (RTT) target and impact to patients can include delays in diagnosis and treatment. CT and MR scanners have been replaced and has reduced the frequency of machine downtime compared to previous experience.

The risk score is noted as 16 reflecting that some equipment has been installed and is operational, however further investment is required given recent breakdowns of key imaging equipment. A costed plan along with a rolling programme for the installation of additional equipment is in place. The next batch of equipment for replacement has been prioritised and identified. For 23/24 funding was obtained to replace one X-ray room and due to the RISP risks of non-DR compliant equipment, it was decided to replace the x-ray equipment at Tenby Cottage Hospital and the A&E x-ray room at Bronglais.

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

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

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

Rationale for TARGET Risk Score:

While equipment has been installed as part of the current WG funding allocations, there is uncertainty as at April 2024 with regards to continued equipment replacements for financial year 2024/25 due to the discontinuation of a dedicated imaging equipment replacement allocation. New All Wales PACS procurement requires all equipment to be DR for compatibility. This has meant that replacement priorities have changed, and that some of the older DR compliant equipment are now overdue for replacement, and at risk of being de-prioritised.

As of April 2024, the x-ray unit at Tenby has been replaced and work underway to replace equipment in A&E Bronglais. Additional WGH EOY funding has been secured to replace aged US units and upgrade the software on MRI scanners at BGH and WGH providing latest technology.

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports. # Escalation process in place for service disruptions/breakdowns. # Newly created National Imaging and Capital Priorities Group ensures there is a robust governance process to support a national, sustainable clinically focused capital equipment programme across Wales. This will ensure that all HB's in Wales agree to a prioritisation process which will allow for timely equipment procurement and delivery to support healthcare demands across Wales.	Limitation of spare parts for some older equipment leading to extended outages. This issue may be compounded by Brexit. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Reliance on AWCP for replacement of equipment. Competing demands for replacement equipment due to RISP, as two pieces of equipment will be non-compliant No dedicated diagnostic equipment replacement funding has meant that DCP bids are having to be developed for all equipment replacement. National Imaging and Capital Priorities Group held its first meeting in	To confirm the capital funding to replace existing aged equipment for FY 2023/24	Roberts-Davies, Gail	Completed	A prioritisation list of aged equipment to be replaced has been devised, however confirmation needed on funding in order to undertake the required work. Funding has been given to replace Tenby DR equipment by the end of financial year 2023/24, and a task and finish group set up to monitor. Additional EOY funding has been secured to replace US units across the HB and 2 image intensifiers (BGH & WGH). Tenby equipment has been replaced and work is underway to replace an x-ray set at BGH. US and Image intensifiers recieved.

		September 2023 therefore in its infancy, and has a further work required to ensure a fair and robust process is undertaken to appropriately assess all imaging modalities and which understands individual HB risks to equipment replacement.	To confirm funding arrangements for the remaining equipment that needs to be replaced, supported by individual DCP bids or dedicated replacement funds for 2024/25.	Roberts-Davies, Gail	~~30/09/2023~~ ~~31/12/2023~~ 31/07/2024	Directorate has compiled a list of equipment requirements, which have been prioritised dependant on finance availability and functionality of the existing equipment and presented at Capital Sub-Committee in September 2023. Priority list has also been submitted to the National Imaging Equipment Capital Priorities group (NHS Executive Group) via assessment process, with outcomes currently pending as at November 2023. It is noted that funding has been given to replace Tenby DR equipment by the end of financial year 2023/24, and a task and finish group set up to monitor. NIECP meeting was held in April 2024 where the prioritised list of equipment replacements was be presented for consideration along with those of all HB's. Priorities were reiterated and a list ranked for WG.
			Installation of replacement Gamma Camera, WGH	Roberts-Davies, Gail	31/07/2024	Gamma camera is 9 years old and the only scanner in the Health Board providing a regional service. Recurrent breakdowns are resulting in HIW reportable incidents. Awaiting confirmation of funding as at December 2023. No funding allocated as of 09/02/2024
			Replacement of CT Scanner at GGH	Procter, Sarah	~~31/03/2024~~ 31/07/2024	CT scanner is 11 years old, with increased failures noted and that new technologies are now available. Colleagues in Estates are currently looking at options and prices, and as at December 2023 no capital bid yet provided as awaiting works costs. Will not be replaced in 23/24 this financial year

Replacement of digital x-ray rooms at Tenby Cottage Hospital and South Pembrokeshire Hospital	Roberts-Davies, Gail	Completed	Funding has been given to replace Tenby DR equipment by the end of financial year 2023/24, and a task and finish group set up to monitor. Tenby equipment has been replaced. SPH will not be replaced in the 23/24 financial year.
Replacement of ultrasound systems at BGH & GGH, image intensifier units at BGH & WGH, and Vacuum Assisted Biopsy (VAB) unit for PPH Breast Clinic	Osell, Fiona	Completed	Ageing equipment with replacements required for obstetric scanning, and resilience of services provided to Theatres. BGH and GGH Image intensifiers replaced. VAB equipment not to be replaced at this time. DCP bids have been collated for BGH ultrasound and WGH image intensifier, and exploring opportunities for charitable funding to support VAB unit for PPH Breast Clinic. Outcomes are still pending as at December 2023.
Replacement of Fluoroscopy room, WGH	Whitecross, Faith	~~31/03/2024~~ ~~31/07/2024~~ 31/03/2025	Equipment is 17 years old with significant downtime experienced. Routine testing by Medical Physics department in January 2024 has found that image quality has deteriorated and the equipment is delivering increased doses to account for this. Awaiting confirmation of funding as at April 2024.
Replacement of CR A&E DR room and OPT (Dental) units, BGH	Edwards, David	Completed	Ageing equipment, with the dental unit 26 years old. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. Equipment in process of being replaced as at April 2024.

Replacement of CR X-ray Room 1, WGH	Roberts-Davies, Gail	~~31/03/2024~~ 31/07/2024	Ageing equipment. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. This will not be replaced in the 2023/24 financial year
Replacement of CR X-Ray room, Llandovery Hospital	Osell, Fiona	~~31/03/2024~~ 31/07/2024	Equipment on site is incompatible with the incoming PACS system, and interim solution required. In order to remain in service, this replacement must be completed by August 2026 due to the end of current Fuji contract. Awaiting confirmation of funding as at April 2024.
Replacement of Mammography Units, BGH and WGH	Roberts-Davies, Gail	~~31/03/2024~~ 31/07/2024	Ageing equipment, exacerbated by the failure of Secureview. These will not be replaced in the 23/24 financial year
Upgrade or replacement of MRI scanner, PPH	Osell, Fiona	~~31/03/2024~~ 31/07/2024	Ageing equipment with increasing failures, with new technologies now available. Awaiting confirmation of funding as at April 2024.
Upgrade or replacement of MRI scanner, GGH	Procter, Sarah	31/03/2024	Ageing equipment with increasing failures, with new technologies now available. Awaiting confirmation of funding as at April 2024.
Replacement of Room 3 (Digital x-ray room), BGH	Edwards, David	~~31/03/2024~~ 31/10/2024	Mobile unit currently being used. Awaiting confirmation of funding as at April 2024.
To consider alternative funding options for the DEXA unit, BGH	Edwards, David	~~31/03/2024~~ 30/09/2024	Unit is 17 years old, and previously funded via charitable funds To write business case for charitable funding

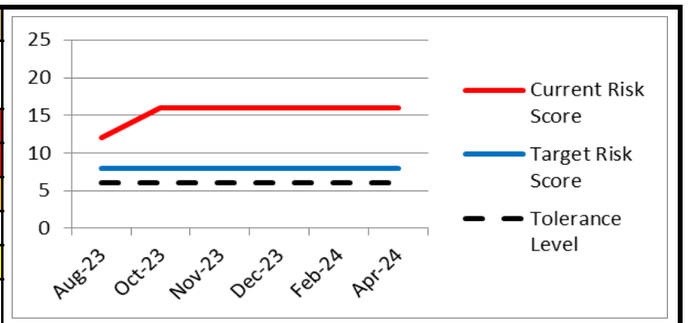
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Reduction of waiting times to under 8 weeks .	Monthly reports on equipment downtime and overtime costs	1st			Radiology Equipment SBAR - Executive Team - Mar19 Further updates CEIMT Feb20 Further updates CEIMT Sep20	Lack of process of formal post breakdown review.				
	IPAR report overseen by PPPAC and Board bi-monthly	2nd								
	Internal Review of Radiology Service Report (Reasonable Rating	3rd								
	WAO Review of Radiology - Apr17	3rd								
	External Review of Radiology - Jul18	3rd								

Date Risk Identified:	Jul-23		
Strategic Objective:			

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

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

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



Rationale for CURRENT Risk Score:

8 dental contracts have been returned to the Health Board in the last 12 months. This has resulted in 25,000 dental patients being displaced. In addition, a further 8 dental practices have not signed up to the contract reform, and signalling that they will return contracts once reform negotiations have concluded. The number of complaints received from the public has increased due to returned contracts, and while the Health Board is currently containing the demand for urgent dental care, it is recognised that patients who don't fall in to this category but require a level of dental care are detrimentally impacted, and that any further contracts returned will exacerbate this situation. The capacity of the Health Board in terms of staffing to absorb further contract reform will impact on the ability to effectively deliver services, and a detrimental impact on staff welfare.

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

Implementation plans are in place with Ophthalmology to support the transition of patients into WGOS4 (clinical pathways for Glaucoma, HQC and Medical Retina) as part of the new Optometry contract implementation which commenced on 1st April 2024.

Rationale for TARGET Risk Score:

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Primary Care Academy in place, which looks at workforce planning, training and development needs and opportunities 5 Facet Survey completed in 2022 to establish a baseline for the GMS estate GMS and Dental Practices undertake annual reporting which includes reviews of statutory compliance requirements 0.25 FTE Primary Care Development Manager for estates in post but with a focus on GMS Escalation tool for GMS and Community Pharmacy (SITREP) Continue effective engagement with struggling practices to support with their issues through close working relationships developed with practices. Programme of practice visits to review Estates provision, and if remedial action is required Requests sent to contractors to assess potential risk of RAAC, with outcomes reported to WG Nationally agreed Breach Management process in place for Community Pharmacies. Requests for contract variation (termination, merger, branch surgery closure etc) are considered in line with national guidance, with panels convened as stipulated. Recommendations are taken through the Primary Care Contract Review Group with papers to Board when required. Strategic Programme for Primary Care (SPCC) bids approved for 2024/25 and 2025/26 to support workforce initiatives	A series of patient facing videos have been developed with Pocket Medic to support patient education in accessing Primary Care Services. Requests for support on addressing the GMS sustainability agenda are with the Strategic Programme for Primary Care as a result of a review paper across all Health Boards on their sustainability pressures. National work on the development of the escalation tool for Dental and Optometry is ongoing but not live. Five Facet Survey and annual reporting of practices has highlighted non-compliance with statutory requirements such as Health and Safety, Fire and IP&C which have now all been addressed. Limited requirements for practices to disclose information to the Health Board about their sustainability pressures, and rare for practices to disclose financial details (reliant on engagement and good will as this is not a contractual requirement as at June 2023). Insufficient resources to support the estates development across all Primary Care services, particularly with independent contractors.	Establish workforce plan and recruitment strategy in line with the development of the national Primary Care Workforce Strategy and as a component of the Primary Care Strategy.	Hughes, Samantha	~~31/03/2024~~ 31/03/2025	Workforce planning continues. GP Practice workforce plans using data from Welsh National Workforce Reporting System (WNWRS) have been pulled together at Cluster level for Collaborative consideration. This information now needs to inform and align to the Primary Care Workforce Strategy. Support is being provided to the Directorate with this work from colleagues in Workforce, and is also discussed via the Primary Care Academy.
		To develop the Primary Care Strategy in consultation with statutory stakeholders and consultees, to cover areas including: •Workforce •Sustainable provision of Primary Care services •Estates •Managing contractual change •Developing pathways and new services •Improving access to services across all contractor professions	Bond, Rhian	~~30/09/2024~~ 31/03/2025	Paper submitted to Board in September 2023 setting out the scope of the Primary Care Strategy, with a further paper presented at Board in January 2024. The issues paper was presented at Board in March 2024, with feedback to be addressed.
		Consider the potential to deliver a wider range of salaried NHS Dental Services through the Community Dental Service.	Owens, Mary	~~30/04/2024~~ 30/06/2024	Modelling is ongoing, however awaiting further contract guidance which is due by June 2024.

	Whilst Community Pharmacy Breach Management process in place, 2 notices are currently under the appeals process - the Health Board is awaiting confirmation on the outcomes of these by Welsh Government, which to date has taken 10 months. Outcomes of these appeal will directly influence the approach taken going forward, and may result in the nationally agreed process unable to be fully implemented. Whilst RAAC declarations were requested, these were not mandatory for contractors to respond.	Implement the Managed Practice Strategy plan will give greater system resilience.	Swinfield, Anna	~~30/04/2024~~ 30/10/2024	The tender process for Neyland and Johnston concluded without a contract award, however taking lessons learnt there is a plan to re-procure for the contract with an estimated contract award date in October 2024.

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

Date Risk Identified:	Nov-21	**Executive Director Owner:**	Henwood, Mr Mark	**Date of Review:**	Apr-24
Strategic Objective:	4. The best health and wellbeing for our individuals and families and our communities	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	May-24

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

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

Rationale for CURRENT Risk Score:

New processes are in place for mortality review, in line with the All Wales Learning from Mortality Framework, supported by the Clinical Lead for Mortality and Mortality Review and Improvement Facilitator. However, these are not fully embedded across all acute sites due to the issues with scanning capacity. Risk score was previously increased to 12 to reflect additional resource requirements for the successful rollout at Glangwili General Hospital (GGH) ahead of the statutory introduction of the Medical Examiner Service. Subsequently, the risk score was increased to 16 due to the proximity of the initial proposed statutory date of April 2024.

The risk score needs to remain at 16, as while we have a definitive date of September 9th 2024, scanners are not in place and may not be recruited into position by the statutory date. Recent scanning absences have also made the service provision even more fragile. There is an increased risk by running two different processes on one site, causing confusion due to the variation. In addition we have a very fragile service in relation to clinical screeners, with only three in place to screen all the letters that are returned from the Medical Examiner Service to the Health Board. Withybush General Hospital (WGH) has experienced some fragility due to long term absences within the team. There is currently insufficient scanning capacity to enable the scanning and sending of case notes to the Medical Examiner Service to enable the full roll-out to GGH wards. GGH scanning staff are currently scanning all of Prince Philip Hospital (PPH) casenotes and a proportion of GGH (all Medical Wards and 1 Surgical). In addition, there is a lack of sufficient clinician capacity across all disciplines to screen Medical Examiner Service letters, with a current back log of 90, with 65 cases coming through on average each month, and is causing a backlog which has the potential for urgent concerns highlighted by the Medical Examiner to become lost.

Rationale for TARGET Risk Score:

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Processes have been developed and implemented in line with the All Wales Learning from Mortality Review Framework to manage cases received from the Medical Examiner Service, covering Bronglais, Prince Philip, Withybush and parts of Glangwili Hospitals. The Medical Examiner Service has delivered some sessions at Grand Rounds previously and there are further sessions planned for February (to outline the basic principles of the Medical Examiner Service and how to complete a Medical Certificate of Cause of Death), through 2024 to introduce the legislative changes once the system becomes statutory on 9th September 2024. Fortnightly Multidisciplinary Review Panel in place, which is Chaired by the Clinical Lead for Mortality and has membership including Deputy Associate Medical Director - Primary Care; Hospital Director; Head of Quality and Governance; Head of Nursing; Assistant Director of Nursing and Quality Improvement; Head of Legal Services; Clinical Pharmacy Lead for Patient Services; Clinical Effectiveness Co-ordinator; Senior Nurse Infection Prevention and Patient Safety Officer. The Mortality Review and Improvement Facilitator is responsible for co-ordinating the Panel. Datix module now being used to record all cases received from the Medical Examiner Service. Community Hospital Roll-out complete and primary care roll-out ongoing (which is required to be in place by April 2024), managed by the Medical Examiner Service, with the Health Board assisting with supporting communications. A Care After Death Steering Group has been established and is scheduled	Different processes are in place across acute sites currently to enable the scanning of casenotes to the Medical Examiner Service, with fragility remaining across sites and Glangwili Hospital being only partially rolled out. An interim solution to transfer casenotes from Prince Philip to Glangwili Hospital to be scanned also needs to be addressed. An SBAR has been developed with resource requirements to resolve this and enable the processes to be fully rolled out. The SBAR has been shared at Executive level. The potential solution of the Internal Scanning Bureau will be explored as a long term, sustainable solution, however this may not be operational by 9th September 2024. Full roll-out in Glangwili still to be achieved due to scanning resources. This is having an impact on global communications and training programmes as there is an inability to inform all staff of the new processes whilst there are different processes in operation in Glangwili. Processes for primary and community deaths in progress. This is being led by the Medical Examiner Service. While a	Acceleration of local plans to support the full implementation in Glangwili General Hospital, and provide a sustainable solution for Prince Philip Hospital (as outlined in the SBAR).	Perry, Sarah	~~30/04/2024~~ 30/09/2024	National date amended to 9th September 2024. Local plans being accelerated to support implementation in Glangwili General Hospital however awaiting agreement of SBAR for additional scanning resources before roll out can be completed. Medical Examiner Service is almost fully operational in Hywel Dda UHB for acute and community hospital sites. Bronglais, Prince Philip and Withybush all fully operational, however there are delays being experienced with implementation in Glangwili Hospital, due to scanning capacity. Interim arrangements to scan Prince Philip case notes in Glangwili need to be addressed - the SBAR includes this. There is also some service fragility in Withybush. Detailed conversations are ongoing with regards to clinical engagement, scanning capacity and mortuary provision. Community Hospitals are fully operational. Discussions with Primary Care ongoing.

A Care After Death Steering Group has been established and is scheduled to meet bi-monthly. The Group is Chaired by the Assistant Director of Nursing, Legal Services and Patient Experience and is attended by: Head of Bereavement Services, Senior Care After Death Project Manager, Clinical Lead for Mortality, Assistant Director of Nursing and Quality Improvement, Head of Effective Clinical Practice and Quality Improvement, Assistant Director, Medical Directorate, County Director representative, General Manager (Community & Primary Care (Ceredigion), Head of Pathology, Lead Biomedical Scientist for Histology and Mortuary Services, Cellular Pathology Services Manager, Regional Mortuary Manager, Regional Mortuary Manager, Assistant Director Acute Services Nurse Representative, Head of Patient Experience, Clinical Nurse representative Women and Children, Clinical Nurse representative Mental Health and Learning Disabilities, Clinical Nurse representative Primary, Community and Intermediate Care, Specialist Bereavement Counselling Service, Chaplaincy Representative, Transplant Co-Ordinator representative, Learning and Development representative, General Practitioner representative, Psychological Services representative.	Medical Examiner Service. While a Care After Death Steering Group has been established, due to operational pressures, meetings have been postponed.	Ensure engagement on and communication of new processes to all Doctors across sites, using information, training sessions (e.g. Grand Rounds) and promotion of SharePoint information.	Hill, Carly	~~31/03/2024~~ 30/06/2024	Engagement and communication is ongoing. Discussions with Hospital and Directorate Triumvirates and other Quality and Governance groups. Global communications are delayed until the process is fully operational on all sites, to avoid any confusion. SharePoint pages developed but as above, not live until processes are fully in place. Training plan in development. Wider communications need to be issued when process is fully operational. Discussion has taken place with Medical Education on programme of training for completion of MCCD.Grand Rounds session undertaken in February 2023. Communication to all Doctors has taken place in relation to responsibilities for completion of MCCD. Awaiting agreement of SBAR to provide additional resources to enable completion of GGH roll-out.
		Identify additional clinical staff across disciplines to screen letters received from the Medical Examiner Service.	Hill, Carly	~~31/03/2024~~ 30/06/2024	Inclusion of request within the Autumn 2023 and Spring 2024 Medical Directorate newsletter for anyone interested in screening cases to come forward. Attempt to secure an additional Medical screener has failed over negotiations around service release.
		Explore the solution of the Internal Scanning Bureau, once operational.	Hill, Carly	30/09/2024	The tender for the scanners is due out by week ending 19/01/2024 and there is a lead in time of around 8 weeks, once a contract is awarded. Estimated time for service to be fully operational not anticipated until Summer 2024.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Number of deaths not scrutinised. Number of Delayed MCCD's completed. Number of deaths not registered due to lack of Medical Examiner involvement.	Number of deaths and number of case notes shared with Medical Examiner Service	1st			Effective Clinical Practice Advisory Panel (05/12/2023) Quality, Safety and Experience Committee (13/02/2024)	The process from death to registration is not captured on one system therefore gaps in completion and delays are dependent on information sharing across organisations including Health Board, Medical Examiner Service and Registrar Offices in Carmarthenshire, Ceredigion and Pembrokeshire.	Discuss with stakeholders improved information sharing arrangements.	Hill, Carly	~~31/03/2024~~ 30/09/2024	Continued discussions with Health Records service to identify one system, however, scanning bureau not yet operational to support this function. Once a central scanning team has been established this will support the assurance on this risk.
	Mortality Scrutiny Group Medical Examiner Service	1st								
	Monitored by Medical Examiner Service	1st								

Date Risk Identified:	Apr-24		
Strategic Objective:	5. Safe and sustainable and accessible and kind care		

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

Risk ID:	**1842**	**Risk Description:**	There is a risk of non-delivery of planned care ministerial targets by March 2025. This is caused by a mismatch between demand and current/forecast capacity in key specialties, workforce limitations and the impact of the HB financial forecast for 2024/25 which limits the amount of recovery funding agreed by the Board to ensure full achievement of the respective ministerial delivery targets. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increasing pressure of adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.
Does this risk link to any Directorate (operational) risks?		1548, 180, 523, 525, 632, 958, 1083, 1027, 1628, 1629	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	5×3=15
Target Risk Score (L x I):	3×3=9
Tolerable Risk:	6
Trend:	*New risk*

Rationale for CURRENT Risk Score:

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

Whilst delivery plans for 2024/25 reflect positive progress in increasing outpatient activity & treatment capacity, underpinned by planned improvements in workforce availability and operational productivity and efficiency, the Annual Plan signalled expected delivery gaps in both specialties.

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

Health Board performance in respect of planned care delivery milestones is also a key feature of its escalation to Targeted Intervention status. The current risk score is assessed to be lower than the inherent risk score due to the significant progress achieved in the past 12 months in improving waiting times, and current performance compares positively with other HB. However as the delivery commitments outlined in the Annual Plan do not support full achievement of the planned care delivery targets in these 2 specialties, the target risk score is yet to be achieved.

Furthermore, revised delivery expectations advised by Welsh Government since submission of the Health Board's Annual Plan have brought forward the expected target dates for achievement of the 104 week Total Pathway maximum wait from March 2025 to December 2024. Delivery plans across all other specialties are being reviewed to assess the implications for achievement of a maximum 104 week Total Pathway wait by this expedited target date.

Rationale for TARGET Risk Score:

The target score of 9 reflects the continuing delivery ambitions which remain, despite the workforce and resource limitations reflected in the Annual Plan. At the end of March 2024, 98.5% of all patients waiting experienced a wait of less than 2 years (104 weeks).

Opportunities to make further progress towards the Ministerial targets in these two specialties will continue to be explored, including exploration of the regional opportunities referred to.

The tolerable risk (6) reflects the longer term recovery ambitions of the Health Board to reduce waiting lists and length of wait to the lowest levels possible.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Comprehensive daily management systems in place to manage planned care risks on daily basis including multiple daily multi-site calls in times of escalation. # Prioritised review of patients based on an agreed risk stratification model. # Provision of dedicated elective beds on 3 sites. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Escalation plans for acute and community hospitals (within limits of staffing availability). # Outpatient transformation programme in place with a continuing focus on alternatives to face to face delivery of outpatient care to enable increases in care volumes delivered. # Robust sickness absence management arrangements in place. # Elective care delivery plan developed for inclusion within Annual Delivery Plan. # Additional Planned Care Recovery proposals developed to utilise the additional recovery funding committed by the Board # Elective optimisation improvement programme in place to improve theatre activity productivity and efficiency, including improvements to waiting list scheduling and pre-operative assessment processes	# Workforce staffing availability to support further expansion of theatre capacity # Sufficiency of Anaesthetic medical staffing capacity to support further expansion of required operating lists. # Sustainability challenges remain in a number of specialty areas which have been targeted for in-depth review via regional planning programmes for key specialties and the Clinical Services Plan review. # Widespread adoption of national best practice guidance to improve elective optimisation and utilisation of available operating capacity # Deficiencies within pre-operative assessment process and overall capacity to support required volume of Pre-Operative Assessment Clinic (POAC) assessments	Deep dive review of of all specialty delivery plans and delivery assumptions to ensure full account of OP transformation and theatre productivity and efficiency opportunities	Jones, Keith	31/05/2024	Reviews have commenced
		Recruitment of additional orthopaedic surgeons to increase operating capacity within specialty to maximise utilisation of remaining sessions	Hire, Stephanie	30/09/2024	Recruitment processes are underway
		Ongoing recruitment an job planning efforts to improve Anaesthetic workforce availability	Hire, Stephanie	30/06/2024	Review of Anaesthetic job plans underway, to be completed by end Q1 2024/25 along with continuing recruitment efforts to fill vacant posts and improve sessional capacity to support elective theatre and pre-operative assessment sessions.
		South West Wales Regional Orthopaedic Delivery Programme established, led by Hywel Dda's Director of Operations as Senior Reporting Officer. Opportunities being explored to maximise capacity across Hywel Dda University Health Board and Swansea Bay University Health Board to support further recovery of waiting times	Jones, Keith	30/06/2024	South West Wales Regional Orthopaedic Programme established. Opportunities for shared use of operating capacity at both Health Boards continue to be explored.
		Review of pre-operative assessment protocols and capacity to ensure alignment with best practice (Getting It Right First Time - GIRFT)	Hire, Stephanie	30/06/2024	Demand & capacity review completed. Review of Pre-Operative Assessment Clinic (POAC) pathway and supporting Standard Operating Procedures underway.
		Re-establish elective operating pathway at Withybush General Hospital following completion of Reinforced Autoclaved Aerated Concrete (RAAC) and Theatre Infrastructure improvement works.	Hire, Stephanie	30/05/2024	Establishment of elective pathway via Ward 9, supporting High Volume Low Complexity (HVLC) same day / short stay pathway patients
		South West Wales Regional Ophthalmology Programme to be established, led by Swansea Bay University Health Board Director of Operations as Senior Reporting Officer.	Jones, Keith	30/06/2024	Programme awaiting formal launch.

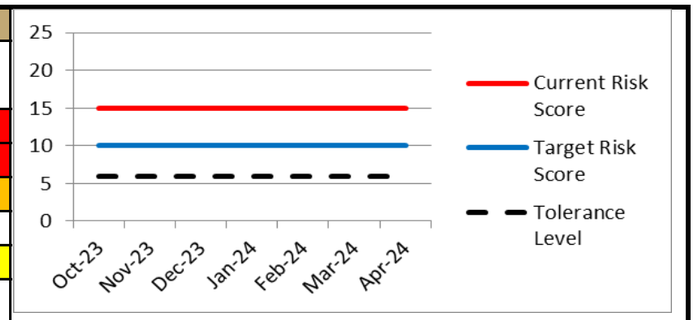
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the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

Date Risk Identified:	Aug-23	**Executive Director Owner:**	Carruthers, Andrew
Strategic Objective:		**Lead Committee:**	Health and Safety Committee

Date of Review:	Apr-24		
Date of Next Review:	May-24		

Risk ID:	**1745**	**Risk Description:**	There is a risk of not being able to deliver safe, effective and timely services across the HB estate, including acute, community and mental health facilities. This risk also impacts the HB's non clinical estate, educational facilities and managed practices. This is caused by further deterioration of our aging buildings and infrastructure with significant amount of the estate beyond its life expectancy. Multiple points of failure, delays in addressing reported defects and limited capital to address the increasing backlog of estate environmental issues. This could lead to an impact/affect on on patient experience, our ability to deliver care in line with expected standards resulting in increased scrutiny and critical reports from auditors, regulators and inspectorates, such as HIW and HSE, and decreased public confidence and perception of our services, facilities and estate environment. Impacts also include increasing revenue costs to supplement the lack of capital funding available required to react to emerging issues, ability to comply with the Health and Safety at Work Act, including other legal regulations and engineering guidance documents such as Welsh Health Technical Memorandums (WHTMS).
Does this risk link to any Directorate (operational) risks?		1795	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	⬌



Rationale for CURRENT Risk Score:

The current risk score is based upon the level of detailed information the Estates departments has for it's buildings, plant and infrastructure. Including external reports, risk information and Estates and Facilities Performance Management System (EFPMS) data submitted to Welsh Government (WG) clearly articulating the scale of backlog and deficiencies across the Health Board (HB).

The HB has been working closely with Welsh Government (WG) for many years to develop a programme business case (PBC) to modernise its estate. In 2018/19, the Health Board (HB) developed a PBC for circa £528m for modernisation of its 4 acute sites, WG requested the HB to review this PBC to consider the A Healthier Mid and West Wales (AHMWW) programme timeframe. In 2020, a revised PBC was completed with a cost of circa £246m to keep Withybush General Hospital (WGH) and Glangwili General Hospital (GGH) operational whilst the AHMWW programme was being delivered. The investments at Bronglais General Hospital (BGH) and Prince Philip Hospital (PPH) remained the same. In 2021 a further review for WG was undertaken to carry out priority works excluding elements included in the AHMWW programme, such as ward refurbishments and fire precautions upgrades at WGH & GGH. This option was agreed and costed at circa £87m for the 4 acute sites. In 2022 WG requested a further piece of work to provide priority schemes specifically for areas of patient safety, the budget was again re-evaluated at circa £130m, this exercise was concluded in Mar23 and submitted to NWSSP-SES for draft scrutiny.

Rationale for TARGET Risk Score:

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

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

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

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

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

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	1×5=5
Tolerable Risk:	6
Trend:	*New risk*

Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
The facilities of Withybush Aseptic unit are currently non-compliant with regulatory standards. The unit is subject to external audit by the National Pharmacy Quality Assurance Lead and the facilities were identified as being a high risk to patient safety in 2019. An audit performed in February 2023 confirmed the facilities were a high risk, and the unit at risk of forced closure. A pharmacy Aseptic unit based at Glangwili General Hospital was forced to close in December 2018 as the facilities were deemed a risk to patient safety. Short term control measures have been implemented by the Health Board to reduce the risk of immediate forced closure (see control measures). However, as the unit and equipment are beyond their useful expected life, there will come a time where the control measures will no longer be sufficient to allow the safe running of the unit. If the unit was forced to close, the Health Board would be entirely reliant on outsourcing cancer therapy from commercial suppliers. Some cancer treatments cannot be outsourced due to their short shelf life. There were 345 reported service and quality-related incidents (e.g. delayed or failed deliveries) linked to outsourcing from commercial suppliers between September 2022 and August 2023 at Hywel Dda. Without a functioning Aseptic unit, the Health Board could not offer over 500 cancer treatments each year, and further treatments would be delayed/cancelled due to supplier service failures. The most recent audit, conducted on the 20th and 23rd February 2024 with the final report received on 7th March, confirmed that the control measures employed are mitigating the risk. Therefore the current risk score has been adjusted from 20 to 15 to reflect the reduction in the likelihood of the risk of forced closure materialising, provided that these control measures remain effective. A business case for the demountable unit at Withybush General Hospital was submitted to Welsh Government in February 2023. The business case also requested funding to convert the current Aseptic unit into drug storage facilities. Based on budget cost estimates of £2.89m the submission was for review and scrutiny by Welsh Government to provide assurance to the Health Board before resourcing, and underwriting the financial risk, of progressing a detailed design for tendering. In September 2023, Welsh Government requested submission of a fully tendered business justification case, which is currently being worked up by the Health Board. As part of the Transforming Access to Medicines (TrAMS) project programme, a regional manufacturing hub will be built in South West Wales that will prepare cancer therapy for Hywel Dda patients. The hub was originally estimated to open during 2028, however there have been delays to the project plan and the opening date is currently unknown. There is therefore a high risk that the current Aseptic unit at Withybush will be forced to close before the South West TrAMS manufacturing hub is operational. In this case, there would be no means of obtaining certain cancer therapy for Hywel Dda patients to be administered within the Health Board locality.	The target risk score is based on the premise that funding for a new aseptic unit is approved by Welsh Government. The unit would be compliant with regulatory standards and once operational, it would be extremely unlikely for the unit to be forced to close. A new unit would allow the Health Board to continue to safely prepare cancer therapy until the TrAMS South West manufacturing hub is operational.

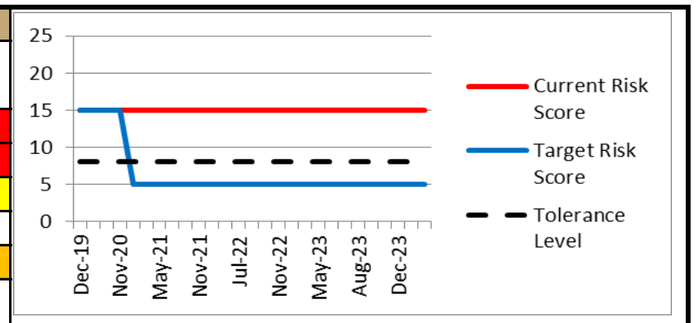
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Transfer of the radiopharmacy service to Singleton Hospital in October 2022; this means less overall activity through the Withybush Aseptic unit reducing the risk of contamination and errors. More time and resource provided to the Quality System (i.e. internal audits, investigation of near misses and microbial growths, maintaining SOPs). Increased training of aseptic staff to develop their skills and knowledge. Increase outsourcing from commercial suppliers; this limits the volume of products prepared within the unit, allowing products that must be made in-house to be prepared safely. New pharmaceutical isolators have been procured to replace the existing isolators that are beyond their working life. The new isolators will be stored with the intention of installing into the demountable unit (if funding is secured) or will be installed into the existing unit if the current isolators fail mitigating the risk of equipment failure causing prolonged service disruption. Removal of outsourced dispensing from the Aseptic unit; this minimises the risk of contamination and potential for error. Preparation of products near to the time of use; this limits the pre-administration storage time. More stringent gowning process; this minimises contamination risk. More stringent cleaning and monitoring programmes; this minimises contamination risk and allows early detection of microbial growth. Oversight and steer from Capital Sub-Committee.	Controls are reliant on a key group of skilled staff (i.e to maintain Quality System, to follow cleaning and monitoring procedures) therefore subject to key person dependencies. Limited accommodation to employ additional staff to expand workforce within the existing unit at WGH. Limited accommodation to store starting materials and finished products or to perform the associated tasks that are required to safely supply cancer treatments. Between 2021 and 2023, the number of cancer treatments requiring aseptic preparation at Hywel Dda increased from 12,718 to 16,648 (average of 14% increase each year). There is limited space within the Pharmacy at WGH to manage this increase in demand. Lack of funding to build a new unit at WGH.	To commence tender process for building a demountable aseptic unit on site at Withybush General Hospital.	Morgan, Cerith	Completed	The Mechanical and Electrical Engineering Professional Services evaluation was undertaken on 28.02.2024. A preferred provider was selected. The project timelines are currently running to schedule. Based on current schedule, the demountable aseptic unit will be operational by November 2025 if business case approved by WG.
		To submit revised business to Welsh Government.	Morgan, Cerith	31/01/2025	The project timelines are currently running to schedule. Based on current schedule, the revised business case will be submitted to WG during January 2025.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Audit Reports from annual audits detailing areas of non-compliance KPI Dashboard in place to provide continuous oversight of unit performance, updated monthly.	Annual Audits by Lead Quality Assurance Pharmacist (NWSSP) .	3rd			Capital Sub Committee (22nd January 2024). MMOG report to QSEC for Feb 2024.		To partake in annual audit (WHC 2024-004) by the Lead Quality Assurance Pharmacist.	Morgan, Cerith	Completed	Audit by Lead Quality Assurance Pharmacist was undertaken during February 2024. The audit confirmed that the facilities remain a high risk to patient safety but the control measures in place are appropriate.

Date Risk Identified:	Oct-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Apr-24
Strategic Objective:	3. Striving to deliver and develop excellent services	**Lead Committee:**	Health and Safety Committee	**Date of Next Review:**	May-24

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

Risk Rating:(Likelihood x Impact)	
Domain:	Statutory duty/inspections
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	1×5=5
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
Phased fire safety improvement works are ongoing across our sites, with significant investments being made to address the recommendations in the Mid and West Wales Fire and Rescue Service (MWWFRS) letters and Enforcement Notices. All programme dates have been agreed with the Health Board, Welsh Government (WG) and MWWFRS senior inspecting officers. We intend to review the progress of our completed actions to determine the risk score as we progress with these works. MWWFRS letter dated 20/01/23 confirms the presentation that the Estates service delivered to them on 08/12/22 was extremely well laid out and provided MWWFRS with an accurate account of the health boards current position and the agreed timeframes for completion. MWWFRS confirmed they are comfortable with the current position. Extensions of time particularly for WGH Phase 1 (Aug 23 to Oct 23) and GGH Phase 1 (Aug 23 to Jan 24) have been fully agreed by MWWFRS. Currently, the risk is felt to still be extreme until further progress is made on the above Fire safety improvement works. This will be reviewed regularly. There are still some significant challenges faced by the Health Board to fully comply with the fire safety order, as a result of further fire brigade inspections across the organisation and the need to address these findings within the timescales expected. Whilst the fire safety team are in a position to provide support now to the Health Board in the form of expertise and technical knowledge. The Health Board still needs to manage and address the physical backlog of fire safety across its estate.	Further improvements in culture and ownership for fire safety. It is the scale of physical backlog for fire safety compliance (additional surveys) that will remain until appropriate measures are put in place to address the deficit. Despite annual investment from statutory capital for fire safety components (circa £200k), the scale of current investment is clearly not adequate to address the true scale of backlog the UHB has. It is anticipated that when training attendance levels specifically for L2 training have reached > 80% targets and are sustained at this level continuously, coupled with the completion of key fire safety investment programmes and phases across our acute sites (completing in circa April 2025), the HB will then be in an informed position to look at the reduction of risk score for risk 813. This decision will be reviewed regularly.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Pre Planned Maintenance (PPM) checks are carried out across the UHB on fire safety components. A detailed physical estates backlog system is in place that identifies the scale (£) and risk of backlog for UHB. Data used to manage backlog maintenance & statutory decision making also regularly reported to WG. Extensive fire safety improvement works are being undertaken at WBH, GGH and at BGH from WG agreed funding (EFAB bids for BGH and funding and From submitted business cases), with phased timelines fully agreed with MWWFRS. Regular communications and dialogue is taking place between HB and MWWFRS. Individual Fire Risk Assessments (FRA's) in place for all sites across the UHB identifying fire related risks. Training Needs Analysis (TNA) for fire safety training in place, as defined in Fire Policy. UHB has implemented a governance structure for fire safety reporting. Estate plans with fire zones, fire doors, fire compartmentation, fire infrastructure items (alarm and detection system). UHB assesses its performance in respect of operational maintenance work carried out on fire safety components and presents this information as a formal paper at all UHB wide fire safety meetings. Annual prioritisation of investment against high risk backlog. Internal governance review (2019/20) initiated by the CEO and all action implemented from review. The HB has now embedded a fully resourced fire safety management team, with appropriate reporting arrangements for fire safety and addressing the backlog of out of date fire risk assessments across the UHB. The UHB has improved fire safety management culture and management ownership for fire safety.	Despite significant investments already in place following enforcement notices and letters of fire safety matters, additional investment is required to address fire safety defects at other sites within the UHB, which are being inspected by MWWFRS. We have firm plans in place to address a range of fire safety projects over the coming years and these are all fully identified as actions within this risk with anticipated timelines. Inability to allocate fire risk actions to appropriate owners on current fire risk assessment system hosted by NHS Wales Specialist Estates Services (NWSSP-SES). Inability to manage and control recommendations within the HB's own Fire Risk Assessments. Despite making improvements to the culture of fire safety management and ownership, the HB does need to ensure this is organisational wide and embedded within it's workforce and cascaded by management. Whilst the new BORIS system is now in place, fire risk assessments are still being transferred from the old system as at July 2023.	Implementation of a new software system to manage the content of the HB's fire risk assessments. Boris software has now been purchased and is currently being implemented. Date agreed as part of internal fire safety governance review.	Evans, Paul	Completed	Boris software now purchased Dec 2020, initial implementation planned for March 2021. Implementation of risk assessments will now be planned for July 2021. System now supports the use of mobile technology therefore risk assessments can be completed live on the system. System now being tested on site, fully operational by Jan (now Feb) 2022
		Additional fire surveys are required across various sites to obtain costs for all fire compartmentation defects, doors, fire alarm systems and other associated items.	Evans, Paul	Completed	fire safety team and compliance team are working with site operations to determine what the gaps are and to agree what surveys will be required.
		Introduce new innovative ways of improving fire training attendance across the HB to increase the percentage figures agreed and set by the HB. As part of the next risk review the fire team intend to split this action into individual sections so we can track and close off action as and when completed.	Evans, Paul	Completed	The fire safety team have been trialing the use of MS teams for L2 Fire training, which has proved to be very successful. We are planning to roll this out to other areas of fire training levels, such as L5/L4 & L3. This will have a positive impact on staff being able to attend the session. We will need to improve communications on this and to ensure staff are made fully aware of the sessions taking place and the dates.
		To introduce ways to help improve the culture and ownership of fire safety across the HB. Although management training is taking place at the "Managers Induction Programme" and this is well received. The HB still needs to do more to avoid areas of poor practice that is sometimes identified.	Evans, Paul	Completed	To look at improving the current training content and programme that's currently on offer for management. Regular global communications of do's and don'ts. Having a fire safety share point system, with links to interesting info on effective fire safety management.

The fire team will also look to implement a regular training global e-mail as a reminder for staff on when and how to book a session. Works already completed following issue of Enforcement Notices and LoFSM at various sites. For EN sites (WBH and GGH) - Advanced Works to vertical escape routes now completed. Also further improvements under LoFSM at Tregaron, Bronglais, Glangwili and Withybush Hospitals. Level 1 & 2 Fire Safety training is delivered via Teams. Level 3 Fire Safety training is provided face to face. Level 4 training (Fire Safety Warden training) is also a face to face session, with an external trainer. Level 5 training is provided on Teams as part of the H&S Managers induction training. There is an improving performance in terms of uptake of training sessions across all levels. Boris fire safety system implemented across the UHB, giving the ability to review all risks from fire risk assessments via a dashboard. Fire Team issued recent Global communications to request additional Fire Safety Wardens, to seek engagement from staff and colleagues across the Health Board. RAAC plank surveys are also being undertaken at the same time as the fire works to minimise the disruption to clinical services where at all possible.	Now the new Boris fire safety system is being implemented across the HB (training planned for June 22 for staff), fire risk assessment actions from this need to be monitored by those responsible. These actions need to be communicated at all fire safety sub groups and fed to the HB wide FSG for complete transparency.	Evans, Paul	Completed	System now live in the HB and staff training programme in place. From this point all fire risk assessment actions will be closely monitored using this system.
	Introduce a system to manage fire risk assessment recommendations more effectively. System to have the ability to assign risks to risk owners, to track/manage risk and to demonstrate progress on the actions.	Evans, Paul	Completed	The fire team are utilising the current system as best as possible. An Excel system is being introduced (completion Jun20) however a more robust automated system is needed by the HB to track the significant number of actions. Progressing this has been delayed due to COVID-19, however quotes have now been obtained and are under discussion with the Director of Facilities. Approval has now been provided to purchase a system. Completion date for system trial on site by July 2021. System now being tested on site on a few Fire Risk Assessments, we plan to go fully live in Nov/Dec 2021.
	Establish a teams training platform to deliver the level 3 and level 4 fire safety training programmes. Although this will also be supported by face to face sessions.	Evans, Paul	Completed	Following a review of level 3 & 4 fire safety training programmes it has been established that these cannot be delivered via Teams. These are now delivered as follows: Level 3 training has been reviewed and requires a face to face practical delivery. Level 4 training (Fire Safety Warden training) is also a face to face session, with an external trainer.
	WBH - Completion of Phase 1 works - For all remaining horizontal escape routes.	Elliott, Rob	Completed	Completed on Dec 15th 2023
	WBH - Completion of Phase 2 works - For all departments, ward areas and risk rooms.	Elliott, Rob	30/04/2025	Phase 2 works remain on programme to be completed by April 2025.

	GGH - Completion of Phase 1 works - For all remaining horizontal escape routes.	Elliott, Rob	~~28/04/2023~~ ~~22/01/2024~~ ~~31/10/2024~~ 31/07/2024	The current forecast completion date is January 2024, however this will need to be closely monitored and reviewed as the project progresses. The revised forecast for completion of Phase 1 at GGH is currently 31/10/24 (this will be regularly reviewed and updated accordingly) Revised date not proposed as 31/07/2024
	GGH - Completion of Phase 2 works - For all departments, ward areas and risk rooms.	Elliott, Rob	~~30/04/2024~~ ~~30/08/2024~~ 30/06/2025	Phase 2 remains on programme to be completed by August 2024 (subject to the full due diligence work needed as part of the Business Case development). Revised date now agreed as at 30/06/2025.
	Develop a Fire Training information pack for distributing to agency staff across all 4 sites.	Elliott, Rob	Completed	Completed - We have supported the HoN on this recommendation and issued our current training material to all agency companies. We will continue to support the HoN with any new welcome packs they introduce.
	To ensure all fire risk assessments are transferred from NWSSP-SES system to Boris	Evans, Paul	Completed	Boris system transfer now completed, review of data now being undertaken

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Maintain a zero or as low as possible number of outstanding fire risk assessments.	Bimonthly review of outstanding actions from fire risk assessments	1st			IA Fire Precautions Report - ARAC Jun18 SBAR submitted to each HSAC meeting, which includes themes of all fire safety risks.	General site management checks/walkarounds on all sites				
	Site Fire wardens reporting fire safety issues	1st								
	Annual Online Fire Audit Self-Assessment submitted to NWSSP	1st								
	Review of compliance through fire safety groups	2nd								

	4 Fire Safety Sub Groups (one at each site) which report into the UHB wide Fire Safety Group (reporting into the HSC)	2nd								
	Fire Safety SBAR reports regularly issued to HSC	2nd								
	Fire inspections by Fire Service & Fire Improvement Notices	3rd								
	NWSSP fire advisor inspections	3rd								
	NWSSP IA Fire Precautions Follow Up May-18 - Reasonable Assurance	3rd								
	IA Fire Governance follow up in July 2022 - Substantial assurance.	3rd								
	IA WGH Fire Precautions Works: Phase 1 in Aug 22 - Reasonable rating.	3rd								
	High level action plan meeting with MWWFRS (Dec 8th 22) - with very positive comments received from then on our commitment to improve fire safety performance.	2nd								

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

Risk ID:	**1822**	**Risk Description:**	There is a risk to the welfare of senior managers within the Health Board. This is caused by several factors including increased scrutiny from Welsh Government, current operational demands, and limited capacity and resources. This could lead to an impact/affect on the work-life balance, morale and satisfaction of management, and impact on their ability to make effective decisions and sustain productivity and performance and manage work programmes. In addition, managers limited capacity could compromise their ability to lead compassionately and this could lead to further detrimental impact on wider staff morale and productivity, potentially leading to increased sickness and a higher turnover of staff.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Workforce/OD
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	4×3=12
Target Risk Score (L x I):	3×3=9
Tolerable Risk:	8
Trend:	*New risk*

Rationale for CURRENT Risk Score:

We are seeing in meetings a general sense from key personnel that the work requirements are exceeding capacity to respond. These requirements cut across a number of work areas including ARCH Regional programme, Clinical Services Plan projects, Recovery and Savings Plans. Engagement with senior operational and corporate personnel are noted, we see the manifestations of this risk in a number of meetings held at a corporate level such as Improving Together, Core Delivery Group, Clinical Services Plans and related sub groups. There are also potential increases in "incidents" and a general inability to review key actions for example "risk registers". We have noted some risks are circa 4 months out of date which would align to the start of the Recovery work in July 2023. Further monitoring across critical workforce service areas and performance indicators will be needed to underpin and assess this risk score; specifically a growth in demand on a) Staff Wellbeing & Occupational Health Services b) Employee Relations cases and c) dashboard performance for turnover and sickness. In addition, the "ask" for further savings may exacerbate the current situation.

Rationale for TARGET Risk Score:

We would hope that controls can be put in place to mitigate negative impact on the management teams, particular key personnel. It is difficult to assess at this juncture the scale of impact or controls needed without a quantification of the impact and the direction of travel the Health Board may take in seeking to meet the expectations of stakeholders. Suggested controls are noted below but may have to be read in context of specific actions that will be potentially taken.

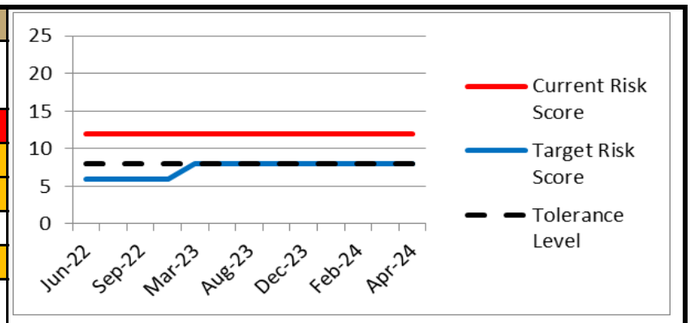
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Policies and procedures, which are readily available to staff via the Health Board intranet pages. These provide guidance to managers and employees on expectation of how we operate and conduct ourselves, for example sickness absence and leave policies. Forums in place with Executive oversight to review performance against objectives - Core Delivery Group, Directorate Improving Together Sessions, Clinical Services Plan Formal governance arrangements via Board and its sub-committees by Executives and Independent Members - People, Organisational Development and Culture Committee, Strategic Development and Operational Delivery Committee. Performance dashboards to monitor sickness, vacancies, grievances which are reviewed by Senior Leads in Workforce and OD, and via local governance structures Structure of Workforce and Organisational Development Directorate encompass a number of pillars with a focus on supporting staff, promoting healthy working culture, and providing support and resources (Occupational Health, Staff Psychological and Wellbeing, Leadership and Management Courses) and ODRM (Organisational Development Relationship Managers) support.	Current financial climate of the Health Board and the choice not to recruit which is impacting on current capacity Several examples of key person dependencies which would present the Health Board with knowledge gaps when staff leave Several workstreams and projects in place with differing governance and reporting structures, resulting in multiple requests (sometimes duplicated) which is increasing the workload on management	To consider the current structural design of corporate functions in the Health Board to optimise capacity and improve organisational memory	Gostling, Lisa	30/06/2024	Progress to be provided at next risk review
		To review the Health Board's strategic plans, and teams to optimise capacity and focus on priorities/workstreams.	Davies, Lee	04/01/2024	Progress to be provided at next risk review
		The Executive to provide clarity on the parameters for agency spend to guide decision making regarding expenditure controls applicable to service delivery service areas. This enables managers to be clear about risk tolerance and not feel they carry that burden alone.	Gostling, Lisa	30/03/2024	Progress to be provided at next risk review
		To legitimise the support for the wellbeing of managers to lead compassionately and ensure performance management and development support is in place.	Gostling, Lisa	31/07/2024	Progress to be provided at next risk review
		To review current partnership arrangements in terms of governance requirements to streamlining and reduce the management requirements input.	Wilson, Joanne	31/10/2024	Progress to be provided at next risk review
		Implement the revised Tier one operational structure across delivery services in the Health Board.	Carruthers, Andrew	30/06/2024	Progress to be provided at next risk review

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Performance Dashboards	Workforce & OD Leadership Team Meetings (Risk led)	1st			No specific papers. Recent papers to PODCC highlighted the deep dive on Workforce Themed Risks in October 2023.	Thematic through appropriate forums of any management wellbeing concerns	Thematic analysis through key forums i.e. DITS, CDG	Carruthers, Andrew	30/05/2024	Progress to be provided at next risk review
	Directorate Improving Together Sessions	1st								
	Core Delivery Group	1st								
	Staff Wellbeing Internal Audit	2nd								
	Executive Team Meetings (Risk led)	2nd								
	PODCC	3rd								
	Wales Audit - Workforce Planning - External Audit	3rd								

Date Risk Identified:	Feb-22	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Mar-24
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Strategic Development and Operational Delivery Committee	**Date of Next Review:**	May-24

Risk ID:	**1350**	**Risk Description:**	There is a risk of the Health Board not being able to meet the 75% target for waiting times in the ministerial measures for 2022/26 for the Single Cancer Pathway (SCP). This is caused by by reduced capacity to meet the expected demand for diagnostics and treatment delays at our tertiary centre. This could lead to an impact/affect on on increased number of patients waiting in excess of 62 days and meeting patient expectations in regard to timely access for appropriate treatment which could potentially lead to poorer outcomes and patient experience, adverse publicity/reduction in stakeholder confidence and increased scrutiny/escalation from Welsh Government.
Does this risk link to any Directorate (operational) risks?			1223, 114, 111, 1537, 1699, 1722, 1723

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



Rationale for CURRENT Risk Score:

The impact of COVID-19 has increased the risk of being able to meet the target. The delays are caused by diagnostic capacity issues across the health board . The main area of concern is Radiology. A decrease in capacity for appointments and results reporting within radiology, current vacancies and planned annual leave and impact of industrial action within two of the four health board sites. Patients have been offered alternative appointments on other sites, however some patients have not agreed to attend and have requested an appointment close to home.

Cancer performance has been variable since quarter 3 2021/22. The consequence of which resulted in short term planned and unplanned step down of activity within outpatients and planned surgery. This led to an increase in the backlog of patients waiting in excess of 63 days. Performance since April 2022 has been variable due to treating higher volumes of patients particularly in the Urology and LGI pathways. Performance was at 49% in January 2024. Performance trajectory is set to improve in 2024/25 due to a reduction in component wait times at 1st OPA, diagnostics and treatment, with a target of 75% in place for March 2025.

Rationale for TARGET Risk Score:

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

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# A GI Improvement Group has been established. The aim is to implement the NOP for the GI Pathways. # Fully established cancer tracking team in place to allow patients to be proactively tracked through their pathways. # A new cancer dashboard developed by Informatics with the support of Business Intelligence (BI) SCP funding from the Wales Cancer Network. This is now live with access for Cancer Services staff and Service Managers, allowing MDTs to actively monitor tumour site specific patients on a SCP. # The health board have been piloting the use of Quarterly Planning and Monitoring reports developed by the NHS Executive since July 23. This has facilitated the development of targeted improvement plans per tumour site and subsequent weekly monitoring thus providing assurance of the robustness of plans. # As per the Wales Bowel Cancer Initiative, a successful FIT10 screening in the management of USC patients on a colorectal pathway was implemented in Jun20. A Straight to FIT test is being implemented within the health board, where depending on the result of the FIT test, as to whether an OPA or any further investigations are required, which will reduce the pathway by 14 days. On 6th April the health board introduced FIT10 screening into Primary care. This has resulted in a reduction in demand of 30% for first OPA. # Virtual appointments are being undertaken via digital solutions e.g. Attend Anywhere. # Weekly Cancer Watchtower meetings where services managers are in attendance. The function of this group is to monitor and address service demand, capacity and risk issues. # Monthly performance meetings with Welsh Government	Anticipated significant gaps within key diagnostic services to address required levels of activity to support SCP. Key diagnostic information systems do not support effective demand / capacity planning. Need for the implementation of new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment pathways. Access to green pathways and tertiary centres fluctuates depending on COVID-19.	Work with newly appointed Head of Radiology to: 1) explore outsourcing opportunities and internal solutions to increase capacity to appointments and reporting utilising non recurrent recovery money. 2) Investigating current capacity for diagnostics to ensure a 7-day turnaround as per the National Optimal Pathways.	Humphrey, Lisa	~~31/03/2023~~ ~~31/07/2023~~ ~~30/11/2023~~ 31/03/2024	Process in place to implement demand capacity modelling tool in line with SBUHB. Radiology are reviewing referral pathway mapping, working with ARCH to build a new Radiology dashboard with support from the Strategic Workforce Team to review workforce elements. The aim is to more timely examinations and reports which will improve the patient pathway and reduce the risk of long waits for investigations and reporting of results, and reduced times on patient pathways. The Radiology dashboard was launched in January 2024.

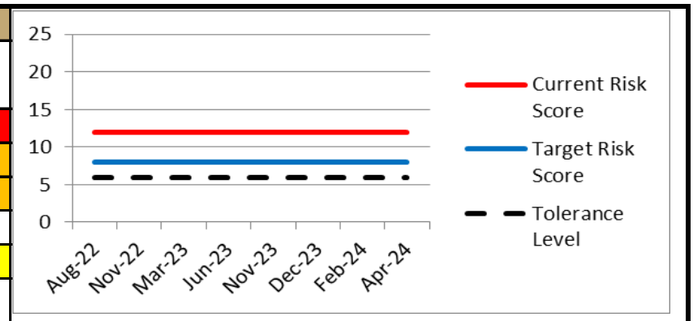
	# Monthly performance meetings with Welsh Government. # Trajectory performance plans have been developed for each tumour site by the relevant services, with regards to improving performance. This also includes Backlog Trajectory plans on how these improvements will be achieved. # Weekly monitoring of Urology diagnostic improvement trajectory via Cancer watchtower. # Cancer Pathway Review Pathway reviews to be discussed at the MDT Business meetings and plans put in place to address and improve any bottlenecks or issues. Pathway reviews will also be a standing agenda item on the Oncology Quality & Safety meeting to ensure governance and part of the relevant Directorate Quality & Safety meetings # Process in place that improves time for patients to first outpatient appointment to improve the 28 day performance target (all patients to be informed etc). # Continue to escalate concerns regarding tertiary centre capacity and associated delays. # One to one escalation meetings held with Cancer Watchtower leads and Tumour Site Service Managers for tumour sites that require intervention. # New Endoscopy booking process implemented in November 2023 which tracks all patients referred for an endoscopy on a USC priority. If capacity is identified as a trending breach reason, the Service Management team supports targeted intervention to address these concerns in order to reduce time on patient pathways.		Each MDT to review and adopt recommended optimal tumour site specific pathways.	Humphrey, Lisa	~~31/03/2023~~ ~~30/09/2023~~ 31/03/2024	The Macmillan Cancer Quality Improvement Manager is working with the teams with regards to implementing the new pathways. One-to-one escalation meetings are held when intervention is required with Cancer Watchtower leads and Tumour site service managers. A new Endoscopy booking process is now in place.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Internal targets - Looking at the performance per tumour site individually concentrating on those tumour sites under 50% ie Gynae, Lower GI and Urology. Monitoring the 28 day performance and overall performance for each tumour site.	Daily/weekly/monthly/ monitoring arrangements by management	1st			* Implementation of Single Cancer Pathway Report - BPPAC - Feb20 * COVID-19 Impact on Cancer Services - Board - May20 * Cancer Updated to QSEAC Jun20 & OpQSESC Jul20 * Risk 633 QSEAC - Feb21 & Aug21 * IPAR Report - Board - Nov22	None identified.				
	Monitor outpatient appointments booked beyond 10 days to identify common themes	1st								
	Service plans in response to COVID-19 overseen and agreed by Bronze Acute & Gold (when instigated)	2nd								
	IPAR Performance Report to SDODC & Board	2nd								
	Monthly oversight by Delivery Unit, WG	3rd								

Date Risk Identified:	May-22	**Executive Director Owner:**	Gjini, Ardiana	**Date of Review:**	Apr-24
Strategic Objective:	4. The best health and wellbeing for our individuals and families and our communities	**Lead Committee:**	Health and Safety Committee	**Date of Next Review:**	Jun-24

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

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



Rationale for CURRENT Risk Score:

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

Rationale for TARGET Risk Score:

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Major Incident Plan (detailing internal command and control structures) # Well established command and control structures for managing pandemic response both nationally and locally # Continuation of current COVID-19 national vaccination programme until at least March 2024 # Extensive knowledge across Health Board in managing a pandemic event # COVID-19 response measures which can be adapted to respond to any future pandemic event # Local Resilience Forum (LRF) multi-agency plans for managing pandemic influenza (approved by Strategic LRF 14/11/18 now under review)		Review of Pandemic Response Framework in progress which broadens remit from Influenza focus to generic pandemic events.	Hussell, Sam	~~31/01/2024~~ 31/05/2024	Draft for review in progress and awaiting completion

# LRF Excess Deaths Plan (which supports the LRF multi-agency pandemic influenza management arrangements) developed as a recommendation from Exercise Cygnus. Plan was ratified by the LRF Health Group. # Health Board Pandemic Influenza Response Framework and associated plan(currently under review) # Quality assurance process via national & local exercise programmes. # Access to national counter measures stockpile # Surge Plans in place to enable HB to respond to future spikes/waves of infection requiring recommencement of contact tracing, testing & vaccination # Continuous learning from COVID-19 # Pandemic Planning Group re-established							

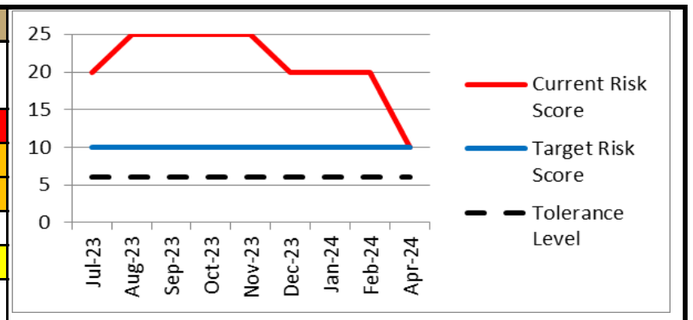
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the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

Date Risk Identified:	Jun-23		
Strategic Objective:			

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

Risk ID:	**1699**	**Risk Description:**	There is a risk that there could be a significant loss of capacity to deliver elective, urgent and emergency and outpatient services at Withybush Hospital (WGH), and the delivery of the Health Board's Annual Plan. This is caused by the requirement to undertake surveys and take immediate disruptive remedial works, where necessary, to address findings of reinforced autoclaved aerated concrete (RAAC) surveys at WGH, which may result in a number of wards being concurrently closed whilst surveys and remedial works are undertaken. This could lead to an impact/affect on the ability to safely manage demand across elective, urgent and emergency inpatient and outpatient services, including patients accessing specialist areas for care (including coronary care, complex oncology, gastroenterology, respiratory and stroke), disruption to pharmacy services, and poorer patient outcomes from overcrowding in the Emergency Department resulting in delays in accessing care and treatment. This will affect the Health Board's ability to achieve ministerial priorities as set out in the Annual Plan 2023/24 (eg, improvements to ambulance response times and emergency department waiting times). There may also be increased scrutiny from key stakeholders, including Welsh Government and other regulators which may lead to the loss of public confidence, and increased pressures on current workforce.
Does this risk link to any Directorate (operational) risks?		1382, 1385, 1657, 1027	

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



Rationale for CURRENT Risk Score:

The major internal incident was stood down on 19th January 2024, reflecting the re-opening of 4 of the 6 affected wards. Updates are continually provided to Executive Team via Control Group. Initial detailed surveys and required remedial actions have been undertaken and completed on all affected wards as at April 2024. These wards are now subject to re-survey, with work commencing in April 2024 on Ward 9. A programme of works is in place to ensure that all re-surveys are completed by the end of 2024.

Visual surveys in Outpatients A identified significant RAAC related issues (P1 planks). Detailed surveys were completed on 10th November with remedial works to follow, and scheduled to return to service at end of October 2024. Alternative locations for outpatient provision has been coordinated and scoped by Scheduled Care directorate. A schedule for detailed survey programme and remedial work for ground floor areas has been developed, with the programme due to complete by 31 March 2025. Remedial works to follow detailed survey in physiotherapy area, resulting in need to decant from February - October 2024.

Given these developments, the likelihood score of this risk has been reduced from 4 to 2 in April 2024, resulting in a reduction in the current risk score from 20 to 10. It is noted that the outcomes of re-surveys may impact future inpatient capacity, with the risk to be reviewed and updated accordingly.

Rationale for TARGET Risk Score:

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Use of Cleddau Ward (East and West) in South Pembs Hospital, to reprovide 28 non acute inpatient beds to those meeting a pre-determined criteria Implementation of different model of care in Cleddau Ward to facilitate improved patient flow Emergency pathways, reviews and developments in place to minimise admissions and length of stay (LOS) in hospital Optimising available inpatient capacity, where possible. Reduced elective surgery activity on site pending completion of remedial works Maximising use of potential bed capacity in areas across WGH not affected by RAAC. Conveyance avoidance measures in place including clinical triaging of Health Care Professional referrals to secondary care Comprehensive plan in place to undertake planned surveys - contractor on site. Fast Track Visual Surveys and detailed surveys complete. Ground floor detailed surveys commenced mid October 2023. Commenced programme of works. Pot Wash area & Wards 9 and 12	Clarity on funding streams required to progress remedial works. Health Board Discretionary Capital allocation used to commence works in Wards 9 & 12. Funding has been approved to March 2024, however funding remains unapproved for FY 2024/25. To continue with this programme at pace is significantly beyond that which can be supported by our Discretionary Programme Clarity on scope and associated timelines of the required remedial works relating to physiotherapy outpatients Ability to manage impacts from loss of medical bed capacity is more challenging as numbers of bed losses increase and winter approaches Operational position on other sites does not easily support transfer of clinical pathways	To minimise scope and level of disruption as far as reasonably practicable by combining Phase 2 Fire Works with RAACs remedial works, where possible	Chiffi, Simon	Completed	The scope document to reduce extent of Fire Investment at WGH was submitted in September 2023. In advance of a decision from Fire Service on this, the decision was made to proceed with the fire requirements as proposed in the submission. This was on the basis that as long as approval was received we would avoid further disruption to the 6 wards impacted by RAAC. As we have proceeded with the RAAC work, the fire elements have been incorporated, and envisaged completion of these works by March 2024. Formal approval now received from MWWFRS on revised scope, with BJC completed and being considered at next SDODC meeting on 29 February 2024. All wards previously closed due to RAAC had Phase 2 planned works completed simultaneously.

commenced programme of works, Pot Wash area & Wards 9 and 12 complete. Ward 7 and 11 ongoing (planned completion mid December). Potential to accommodate physiotherapy outpatient activity being scoped on Ward 3. Wards 8 & 10 due to complete works end March 2024. Utilising Acrowprop and/or hybrid measures to mitigate impact and reduce risk until repair works are undertaken Internal and External Communications undertaken and planned approach going forward Liaise with affected services and departments to communicate the expected impact of service disruption on their areas WGH RAAC Implementation Group, consisting of key estates and service management Control Group directly reports to Executive Team since major internal incident was stood down on 19th January 2024 Liaising with other hospital sites in England to understand how they've managed the situation	Ability to transport emergency and non-emergency patients to alternative sites					

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Project plans in place dependant on outcomes of surveys, and monitored via the WGH RAAC Implementation Group	Fortnightly WGH RAAC Implementation Group meetings	1st			RAAC paper to SDODC (Apr 23) RAAC paper to HSC (Jul 2023) RAAC included in Director of Operations Report to Board (Jul23)	Unaware of the extent and impact of the risk until all surveys have been completed. All inpatient areas now surveyed as at September 2023, with P1 planks identified, and works schedule confirmed. Ground floor detailed survey have now been completed. Amber planks	Urgent programme of assessment to be undertaken to assess remaining areas	Elliott, Rob	Completed	Risk assessments completed on wards as at April 2024 undertaken by the Estates and Facilities Directorate, with work ongoing on departments. Where works are required, a planned programme is in place to manage and mitigate the impact on the site.
	Command and Control Structure established to coordinate Health Board response	2nd								

	RAAC survey findings by external contractor	3rd				remain in situ and require ongoing monitoring with risk of deterioration unknown.				

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

Risk ID:	**1821**	**Risk Description:**	There is a risk that staff will have a poor experience while at work. This is caused by the inability of leaders to lead compassionately due the current climate within which the Health Board is operating within and competing demands. This could lead to an impact/affect on the work life balance, morale and satisfaction of staff at work, and negatively impact the culture which staff experience at work. This could cause detriment to staff wellbeing and create a negative cycle which could lead to increased employee relations issues, team dysfunction, increased sickness absence and a higher number of staff choosing to leave the organisation with a negative effect on staff engagement, productivity and performance.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Workforce/OD
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	3×3=9
Target Risk Score (L x I):	3×2=6
Tolerable Risk:	8
Trend:	*New risk*

Rationale for CURRENT Risk Score:

The Health Board is monitoring a number of areas and metrics to monitor this risk such as turnover, absence etc. Careful consideration is being taken at different organisational levels to mitigate this risk.

Rationale for TARGET Risk Score:

We would hope that controls can be put in place to mitigate negative impact on the management teams and therefore minimise any negative implications for staff welfare generally. It is difficult to assess at this juncture the scale of impact or controls needed without a quantification of the impact and the direction of travel the Health Board may take in seeking to meet the expectations of stakeholders. Suggested controls are noted below but may have to be read in context of specific actions that will be potentially taken.

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

Policies and procedures, which are readily available to staff via the Health Board intranet and the Wellbeing Single Portal. This provides guidance and resources for managers and staff.

Forums in place with Executive oversight to review performance against objectives - Core Delivery Group, Directorate Improving Together Sessions, Clinical Services Plan

Formal governance arrangements via Board and its sub-committees by Executives and Independent Members - People, Organisational Development and Culture Committee, Strategic Development and Operational Delivery Committee.

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**
Current financial climate of the Health Board and the choice not to recruit, impacting on current capacity	To consider the current structural design of corporate functions in the Health Board to optimise capacity and improve organisational memory	Gostling, Lisa	30/06/2024	Progress to be provided at next risk review
Several examples of key person dependencies which would present the Health Board with knowledge gaps when personnel leave	Review the Staff Retention Discovery Work and ensure high level actions are delivered.	Gostling, Lisa	31/12/2024	Progress to be provided at next risk review

Performance dashboards to monitor sickness, vacancies, grievances which are reviewed by senior leadership within Workforce and OD, and in local governance structures Structure of Workforce and Organisational Development Directorate encompasses a number of pillars with a focus on supporting staff, promoting healthy working cultures, and providing support and resources.		Ensure promotion of compassionate leadership principles through a) PADR quantity and quality b) compassionate management and leadership programmes c) localised cultural progression plans	Gostling, Lisa	31/12/2024	Progress to be provided at next risk review

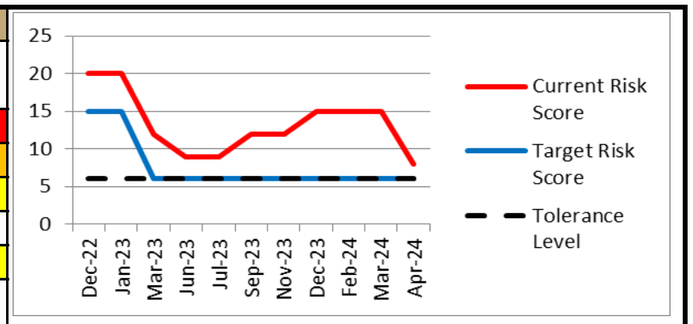
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level		
Performance Dashboards	Wales Audit - Workforce Planning - External Audit	3rd			No specific papers. Recent papers to PODCC highlighted the deep dive on Workforce Themed Risks in October 2023.
	Core Delivery Group	1st			
	Directorate Improving Together Sessions	1st			
	Staff Wellbeing Internal Audit	2nd			
	Workforce & OD Leadership Team Meetings (Risk led)	2nd			
	PODCC	3rd			
	Executive Team meetings (Risk led)	1st			

Gaps in ASSURANCES				
Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Monitoring of management risk outputs	Bi-annual assessment of outputs from management risk	Gostling, Lisa	30/09/2024	Progress to be provided at next risk review

Date Risk Identified:	Nov-22	**Executive Director Owner:**	Gjini, Ardiana	**Date of Review:**	Apr-24
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of Next Review:**	May-24

Risk ID:	**1548**	**Risk Description:**	There is a risk of the Health Board being unable to maintain routine, urgent and emergency service provision across the organisation in the event of industrial action by Health Board staff and staff in other NHS/partner organisations, eg Welsh Ambulance Service Trust (WAST). This is caused by the British Medical Association (BMA) announcing dates of strike action following a ballot to members which received support for industrial action. This could lead to an impact/affect on patient care, patient safety, delivery of services and organisational reputation. Additionally this could also impact delivery of the Health Board's delivery plan, waiting lists (and associated initiatives) and financial position.
Does this risk link to any Directorate (operational) risks?		1027, 1407, 1550, 1641, 1666	

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	2×4=8
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	6
Trend:	↑



Rationale for CURRENT Risk Score:

The current risk score has been reduced as the BMA have announced that they will pause industrial action for all 3 groups (Consultants, SAS and Junior Doctors) as negotiations with Welsh Government have re-commenced. Meetings are currently underway to confirm the timelines for negotiations but it is anticipated that no further industrial action will be announced until mid May at the earliest should the negotiations break down (the mandate for action remains valid). Currently no other Trade Unions have registered a dispute with Welsh Government as pay talks for A4C staff are not likely to commence until May 2024.

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

Mitigation and contingency measures, together with command and control structures put in place during periods of previous action by Trade Unions resulted in a co-ordinated response to minimise impact as far as possible, and this has been re-established.

Three rounds of industrial action have now been held from: 15th-18th January; 21st-24th February and 25th-29th March 2024.

The ballot relating to the Specialty and Specialist (SAS) Doctors and Consultants closed on 4th March 2024 when the BMA confirmed the threshold required to mandate industrial action had been reached. Date for industrial action for the SAS/Consultants was confirmed as 7am on 16th - 7am on 18th April, 2024 - this has now been stood down.

Rationale for TARGET Risk Score:

The likelihood score will only reduce further when there is clear indication that talks between the BMA and WG have been successful. The impact score will only reduce if a "full walk out" approach to any further action changes thus allowing partial continuation of routine activity currently being cancelled.

Executive ownership is joint (Directors of Public Health, Workforce and Operations) but will be supported by the Medical Director and Director of Nursing, Quality and Patient Experience as required.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Industrial Action Planning Group formed for planning, developing contingency measures and response arrangements. Chair and Vice-Chair confirmed. Current meeting scheduled postponed until outcome of WG/BMA negotiations known. Can be stood up with 24 hours notice. Command & Control structures in place at local, regional and national level. Specific response plans developed at service level with rotas covered for the two week Easter period. Process developed for scoping scale of staff intentions to take industrial action in place. Process developed for scoping of staff groups in planned action in place. Data capture process in place to determine impact on service delivery, patient care and financial position. Process for measurement of "harm" in place. Communication strategic approach agreed with staff FAQs, public communications, internal staff communications and partner agencies. Local support in place to enable accurate completion of derogation forms if required.		Specific response plans will be developed following notification from the B,A on dates they intend to take strike action on. These will include early contact between NHS Employers ((on our behalf) and the BMA; derogation process; student arrangements; and links to national process. The updating of previous key controls will be instigated as necessary following the previous action in January 2024.	Gjini, Ardiana	Completed	Will progress via the Industrial Action Planning Group as dates now confirmed.
		To confirm new chair and vice chair of Industrial Action Planning Group	Gjini, Ardiana	Completed	Executive Director of Public Health has been appointed Chair of IA Planning Group, and deputised by Executive Director of Workforce.

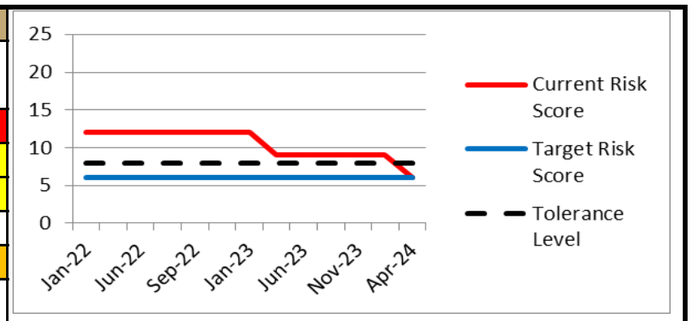
Range of contingency measures ready should any derogations be refused. Medical representation secured for the Industrial Action Planning Group All Wales Industrial Action Workforce & Derogations Group established now merged with the All Wales Operational Planning & EPRR Group. System Resilience Planning and Response Group National Co-ordination Industrial Action Working Group established. Health and Social Services Executive Director Team (HSS EDT) Contingencies Group - Industrial Action Oversight Group established in Welsh Government.		Range of contingency measures to be developed should any last minute in service plans occur. This will include submission of emergency derogations if necessary.	Gjini, Ardiana	Completed	In progress.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
	Industrial Action Planning Group Meeting regularly	1st			Remuneration & Terms of Service Committee 11 January 2024					
	Regular updates to Executive Team and WOD Business Meeting	1st			ARAC Paper April 2024					

Date Risk Identified:	Oct-21	**Executive Director Owner:**	Carruthers, Andrew
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Sustainable Resources Committee
Date of Review:	Apr-24		
Date of Next Review:	Jun-24		

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

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



Rationale for CURRENT Risk Score:

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

Rationale for TARGET Risk Score:

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Health Board Information Asset Register Identified Information Asset Owners (IAOs) Health Records Policies, Procedures and SOPs Some digitalisation projects commenced, eg, physiotherapy, A&E cards Health Board Welsh Nursing Care record e-nursing documentation implementation Planning Objective 5M aligned to SDODC for reporting Electronic systems including: WPAS (Welsh Patient Administration System), WCP (Welsh Clinical Portal), PACS (Radiology), LIMS (Pathology), WAP e-referrals (Welsh Admin Portal), CANIS (Cancer), Diabetes 3, Selma Acquired additional storage facilities to both accommodate excess paper records and establishing a scanning bureau Acquisition of a electronic document records management system (EDRMS) Civica. Lease of a second storage facility Scanning of 387,500 non active patient records DPIAs undertaken on the three contractors for scanning providers, with an additional DPIA being undertaken in June 2023 in relation to RICOH Local Project Steering Group, which meets fortnightly and chaired by Deputy Director of Operations and attended by the Digital Director Programme risk register reviewed at Local Project Steering Group Cataloguing exercise undertaken for the sub-contractor with RICOH	In its paper form, the health record is not under the accountability of any one Executive and hence the degree of influence is potentially compromised. Reduced understanding or records types (across various services) and those appropriate for scanning, long term storage or destruction, leading to a non-consistent criteria for records management during the records life cycle from creation, to retention and ultimate destruction. With the requirement to implement and standardise health records protocols across all services.	Develop and implement scanned health record solution over the next 12 years depending on the split between determination of scanning and deep storage (DHR).	Carruthers, Andrew	31/03/2033	Ã‚£300k per annum for three years made available to prime the project to include acquiring premises to facilitate a scanning bureau along with appointment of a project manager. A paper outlining the direction of travel and key steps to be taken was presented to executive team 28 July 2021 and this was broadly supported. A project implementation plan along with specification for acquiring scanners is being progressed.
		Review current records management arrangements for records that are not within the scope and responsibility of the Central Health Records function. This will require agreement on future record management arrangements, required resources and project support going forward as an essential precursor to the delivering the scanning phase of the project plan. This will be largely driven by individual information asset owners providing comprehensive schedules of information assets under their responsibility.	Carruthers, Andrew	Completed	SBAR submitted to Executive Team in October 2022 outlining the plan for future records management arrangements. Further discussions are now required to fully implement the transition and move records to one centralised locality.
		Director of Operations to meet with Executive Leads with professional responsibility for clinical records to determine agreement on future record management arrangements, required resources and project support. This will be largely driven by individual information asset owners providing comprehensive schedules of information assets under their responsibility.	Carruthers, Andrew	Completed	Meeting with Executives completed on 29/01/2024, with relevant leads appointed to take action and review records management arrangements within their relevant areas of responsibility.
		Follow-up meeting required to complete discussions on the Executive ownership of medical records	Carruthers, Andrew	30/04/2024	Action added resulting from discussions held at Executive Risk Group held on 6th March 2024.

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