Supporting Papers

Wed 29 March 2023, 10:30 - 15:30

Agenda

1. Item 3.10: Velindre Cancer Centre Business Case

Management Case

- 3.10 b nVCC FBC 2023 Management Case - Final.pdf (39 pages)

2. Item 4.3: Strategic Risk Report, March 2023

Appendix Two - Detailed Risk Review

- 4.3 c Appendix 2a_Contents.pdf (2 pages)
- 4.3 d App2 Master DRAFT Mar23.V3.pdf (178 pages)

Full Business Case: March 2023

new Velindre Cancer Centre

Management Case

MANAGEMENT CASE

Contents Page

1 INTRODUCTION

Approach

1.1 The OBC laid out a proposed Project Management structure and governance approach to ensure the effective delivery of the nVCC Project. This included recruiting and developing a number of skilled and experienced project officers to meet the future demands relating to the implementation of the nVCC Project.

1.2 A resourced structure has been in place to guide the project through the commercial set up, pre-qualification, competitive dialogue and successful participant phases, these arrangements have now been refreshed to support the implementation phase of the nVCC Project.

1.3 As previously set out in the Strategic Case the nVCC Project is one of seven projects that make up the Transforming Cancer Services (TCS) Programme. This Programme has the responsibility to ensure effective co-ordination and congruence with the other elements of the TCS Programme and wider Trust.

1.4 This FBC provides an update to the management arrangements to cover the construction, post-construction and evaluation phases of the nVCC Project to time, cost and quality. This FBC Management Case outlines the approach to the following and is supported with a range of detailed appendices:

- Project Management arrangements;
- External advisors;
- Use of specialist advisors within NHS Wales;
- Project scrutiny and assurance;
- Procurement and contracts management;
- Change control;
- nVCC project plan;
- Benefits realisation;
- Communication and engagement;
- Risk management; and
- Arrangements for post-project evaluation.

2 PROJECT MANAGEMENT ARRANGEMENTS

Introduction - Project Leadership

2.1 This section of the Management Case provides an overview of the Project Management structure and individual roles and responsibilities as detailed in Appendix **FBC/MC1**.

2.2 Velindre has recruited (and largely retained) a Project Leadership team to deliver the procurement phase of the project. The aim (as set out in this FBC) is to refresh and confirm this structure to cover the effective management of the construction, post-construction and post-project evaluation phases of the nVCC Project.

2.3 The key individual roles and responsibilities in this structure are set out in Table 1 below:

Table 1 - nVCC Project Leadership Team and Roles and Responsibilities

Role	Name/Status	Responsibility
Senior Responsible Owner (SRO)	Steve Ham	The SRO is accountable for the success of the nVCC Project and the wider TCS Programme. The SRO is responsible for enabling the organisation to exploit the new environment resulting from the nVCC Project, meeting the new business needs and delivering new levels of performance, benefit, service delivery and value. The SRO owns the vision for the nVCC Project and is required to provide clear leadership and direction.
Project Director	David Powell	The Project Director reports to the SRO and is accountable for the nVCC Project delivery to time cost and quality. The Project Director will provide leadership and positive team working to create an environment that facilitates effective project delivery across all phases of the project.
Assistant Project Director (APD)	Mark Ash	A senior role that provides professional advice and support to the nVCC Project Director. Responsible for the financial and commercial aspects of the nVCC Project. This includes the financial planning for the project, financial reporting, and financial risk management. This role leads on management of the Mutual Investment Model (MiM) Project Agreement, Service Level Specifications and the Annual Service Payment mechanism.

2.4 The Project also contains specialist support roles as shown in Table 2 below.

Table 2 - nVCC Project – Specialist Support Roles

Role	Name/Status	Responsibility
Strategic and Commercial Director	Huw Llewellyn	This role provides support and advice on commercial issues as well as providing a bridge to the equipment and digital elements of the TCS Programme.
Technical Director	Phil Morgan (MDA Consult Ltd)	This post oversees the technical elements of the project and ensures oversight of the Developer's technical solutions. This role also links across to the enabling works project within the TCS Programme.
Technical Support Managers	To be Appointed in due course	The Technical Support Managers will report to the Technical Director and have responsibility for monitoring elements of the construction and commissioning of the nVCC and ensuring compliance with all technical obligations.

2.5 The Project Team includes clinical/operational leads as shown in Table 3 below.

Table 3 - nVCC Project - Clinical and Service Leads

nVCC Clinical Leads	Prof Tom Crosby and team	The nVCC Project has a clinical lead responsible for leading a group of clinicians in order to ensure clinical focus on the nVCC Project and that patient experience and quality is always a primary consideration. The role includes 'sense-checking' design solutions and cross-checking these to service requirements, service developments and initiatives elsewhere.
nVCC Service Transformation Director	Andrea Hague and team	The nVCC Project has a Service Transformation Director who will be responsible for delivering the operational requirements of the project. This role, will work closely with the clinical lead and includes responsibility for leading on equipment, digital and hospital transition and commissioning.

Project Management (The Methodology)

2.6 The delivery of the nVCC Project is managed in accordance with PRinCE2 ('Projects in a Controlled Environment') methodology suitably adapted for local circumstances (in order to meet the needs of this Project).

2.7 The nVCC Project follows a set of principles contained within the TCS Programme Execution Plan (PEP) and Project Initiation Document (PID), these principles are:

- Consideration of the views and interests of patients, staff and all stakeholders in all decision-making;

- Compliance with corporate governance and policy;
- Compliance with good project management practice;
- Open and regular reporting of Project progress and performance.
- Effective monitoring/review processes (continuous Quality Assurance (QA);
- Effective change/issues/problem management;
- Comprehensive acceptance procedures;
- Appropriate documentation and record keeping.

Project Governance and Management

2.8 The nVCC Project controls and co-ordinates a series of workstreams that are updated to reflect each phase of project delivery.

2.9 The nVCC Project also looks outwards to the TCS Programme, Velindre's Corporate Governance arrangements and that of Welsh Government's sponsorship, scrutiny and approvals process. In particular, focus is on timely approvals and the effective escalation of risks and issues to senior sponsors.

2.10 The Project Governance Arrangements work on three levels:

- Welsh Government (Strategy & Policy) – **Level 1**
- Velindre University NHS Trust (Corporate) – **Level 2**
- Velindre University NHS Trust (Operational / Project) – **Level 3**

2.11 The details of the Project Governance Arrangements are in Appendix **FBC/MC2**.

2.12 The governance arrangements include a TCS Programme Scrutiny Sub-Committee that provides assurance to the Trust Board. The terms of reference of this sub-committee are included in Appendix **FBC/MC3**.

2.13 An Integrated Assurance and Approvals Plan (IAAP) for the nVCC Project sets out all the required approvals for the Project and the governance route for each key deliverable. This enables alignment of approval decisions with the Trusts' governance schedule of meetings. The IAAP (v3.0) is set out in Appendix **FBC/MC4**.

Project Management Office (PMO): Roles and Responsbilities

2.14 The nVCC Project has a central Project Management Office (PMO) to control and co-ordinate activities. The roles within this team are set out in Table 4 below.

Table 4 - Project Management Office (PMO) and Administration Specific Roles and Responsibilities

Role	Name / Status	Responsibility
Principal Project Manager (PPM)	Andrew Davies	The Principal Project Manager has overall responsibility for the delivery of all sub projects/workstreams to time, cost and quality. The Principal Project Manager also ensures the project is aligned to the overarching TCS Programme. Key to the success of this role is the efficient and effective recruitment and use of project resources, the identification and management of, interdependencies, risks and issues, benefits delivery, providing project assurance and ensuring effective decision making through VUNHST internal governance and Welsh Government governance structures.
Authority Construction Surveyor (ACS)	To be confirmed	The Authority Construction Surveyor will oversee delivery of the nVCC Projects construction works in accordance with the Trust's requirements. The ACS will monitor the work of contractors and subcontractors and notify the Client's Agent (CA), Independent Tester / Certifier and contractor of any potential issues. The ACS will review the quality of works on site taking into consideration workmanship, building in accordance with the design/ specification, overseeing the commissioning etc and will be the daily site liaison officer with all site stakeholders.
Senior Project Managers (SPM)	Peter Sowerby *(Additional recruitment TBC)*	The Senior Project Managers have the responsibility for supporting the sub-project leads with the initiation, planning, execution, monitoring, controlling and eventually closure of their sub-projects. They provide a structured approach to support the delivery of the key deliverables and provide an escalation route for risks. They report professionally to the Principal Project Manager.
Project Managers (PM)	Craig Salisbury; Hannah Moscrop; Michelle Pearce *(Additional recruitment TBC)*	The Project Manager(s) are responsible for supporting the PPM with the delivery, monitoring, controlling and eventual closure of the nVCC Project. As with the SPM, they will provide a structured approach to support the delivery of the key products and provide an escalation route for risks.
Finance Business Partner	Eurwen Williams	The Finance Business Partner will provide financial accounting, planning, management and governance advice along with support and information to the Project.

Role	Name / Status	Responsibility
Role	**Name / Status**	**Responsibility**
Project Support Officer (PSO)	Jenny Welsby	The Project Support Officer will provide project support and administration services. This will include co-ordinating meetings, capturing issues, decisions and actions. The post-holder will act as a configuration management librarian and oversee all document control.
Project Administrator (PA)	Sue Poole; Stefan Dale; Ellie Gregory; Jessica Jenkins	The Project administrator's duties include scheduling meeting times and locations, taking meeting minutes, capturing action points and arranging training for project staff. In addition, the project administrators participate in budget administration, providing analysis and maintaining project records and facilitating procurement.

Other Roles

2.15 There are a range of ancillary roles within the nVCC Project which are set out in Table 5 below.

Table 5 - Other Roles

Role	Overview
Project MIM Transactor	The Transactor is a Welsh Government (WG) Officer responsible for Government oversight of the project and managing the interface of the nVCC Project with the WG team.
Chief Digital Officer	The Chief Digital Officer is responsible for delivering the enabling digital requirements for the nVCC ensuring congruence with Velindre and Welsh NHS digital strategies and initiatives.
Communication	The Communication Lead is responsible for managing internal and external communications during the construction, post-construction and evaluation phase.
Engagement	The Engagement Lead is responsible for managing engagement activities with staff, patients, public and key stakeholders.
Estates & FM	The Estates and Facilities Management (FM) Lead is responsible for ensuring the Project addresses the operational requirements of Velindre.

Project Delivery Model

2.16 nVCC Project's delivery will be managed through a series of workstreams, each supported by a Terms of Reference, led by a member of the nVCC Project Leadership Team as set out in Table 6 below:

Table 6 - Project Delivery Model (workstreams)

Workstream	Lead
Construction Monitoring	Project Director
Hospital (Design Management)	Project Director
Commercial / Legal	Assistant Project Director
Community Benefits	Assistant Project Director
Facilities Management	Assistant Project Director
Transition & Commissioning (All)	nVCC Service Transformation Director
Equipment	nVCC Service Transformation Director
Digital	nVCC Service Transformation Director
Post Project Evaluation / Benefits Realisation	Project Director
Management Forum	Assistant Project Director
Communication & Engagement	Assistant Director of Communications
Enabling Works Alignment	Project Director

2.17 The Project Management Office (PMO) will support the project delivery workstreams. Their roles will migrate through the next stages of the nVCC Project to include all matters pertaining to the implementation and commissioning.

TUPE and Employment Matters

2.18 It is not anticipated that there will be any Velindre University NHS Trust staff transfers under the "Transfer of Undertakings (Protection of Employment) Regulations (TUPE) 2006" as amended by the "Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014" to Project Co (or its Sub-Contractors) in respect of the Project.

2.19 This assumption has been made as a result of detailed discussions with service leads within the existing Velindre Cancer Centre and by using their local and detailed knowledge of future service changes and advancement of clinical treatments.

2.20 As the project approaches Financial Close, the Authority will continue to monitor all workforce assumptions, including those relating to TUPE.

2.21 If there are any non-Trust staff identified as being at risk at the end of the 25-year period when the building's ownership is handed over to the NHS the Trust will act in accordance with the TUPE legislation that is applicable at that time.

Project Tolerances and Delegated Authority

2.22 The nVCC Project tolerances have been approved by the Trust Board as part of the approval of the procurement strategy and will be monitored throughout the project lifecycle. These are set out in Table 7 below:

Table 7 - Project Tolerances

Description	Category	Measure	Escalation trigger
Overall project completion date	**Time**	Plan as approved by Programme Delivery Board	+3months or moves 1st Patient to beyond 4th quarter of 2025
Overall annual cost of solution	**Cost**	Unitary Charge approved in OBC	+5%
Project capital costs	**Cost**	Capital cost approved in OBC	+5%
Project transaction costs	**Cost**	Project costs as approved by WG	+5%

2.23 In addition to the approved tolerances the nVCC Project has a delegation framework, which allows for streamlined approvals and the effective escalation of risks and issues to a level where senior sponsors can intervene as necessary. Any expected breach of the tolerances outside of those specified above will be escalated to the Strategic Capital Board (SCB), or a higher authority.

2.24 Delegation of authority is integrated within, and aligned to, the Trusts' governance arrangements. This will provide clarity in respect of delegated authority for the Leadership Team and ensure that the nVCC Project Board and Trust Board have the appropriate level of scrutiny, oversight and control during the process, and overall accountability throughout the lifecycle of the project.

Equipment and Digital Procurement, Commissioning and Implementation

2.25 The Director of Strategic Transformation, Planning and Digital is the Project Director for Digital and Equipment for the nVCC Project.

2.26 During implementation, oversight of the digital and equipment commissioning process is provided by an Equipment Committee. This Committee is prescribed in the Project Agreement and supported by the Successful Participant, Equipment Advisors, suppliers and NHS Wales Shared Services Partnership (NWSSP) Specialist Estates Service. The Equipment Committee will deal with the detailed planning, coordination and implementation of all equipment at the nVCC.

2.27 A detailed Digital Activity Plan has been produced to set out the full range of activities required to ensure the digital capability of the new Velindre Cancer Centre. The Digital Activity Plan is included within appendix **FBC/MC5.**

2.28 The equipment for the nVCC divides into a range of groups 1 to 5, each equipment group has different specification, procurement and installation responsibilities which are aligned to the commercial deal with the Successful Participant (SP). A copy of the draft Key Clinical Equipment Outline Commissioning Programme (KCEOCP) is set out at appendix **FBC/MC6**.

2.29 The groups of equipment 1-5 and their respective descriptions and responsibilities are set out below:

Group 1A

This equipment is specified by the Authority and provided and installed by the SP – the programmes and processes for selection and installation are included in the SP's commissioning programme.

Group 1B

This equipment is specified, provided and installed by the SP – the programmes and processes for selection and installation are included in the SP's commissioning programme.

Group 2A

This equipment is provided and installed by the Authority – this relates mainly to the Trusts Integrated Radiotherpay Solution (IRS) equipment. This element of equipment is subject to an interface agreement as laid out in the commercial case. The Authority's IRS team will oversee the management of the commissioning process and use the Equipment Committee to deal with planning and interface issues.

Group 2B

This equipment is specified, procured and delivered by the Authority, but installed by SP. The Trust in collaboration with the relevant procurement frameworks will seek to further enhance the standard framework terms and conditions to include a stronger commercial link with the MiM Project Agreement.

Group 2C

This equipment is specified, procured by the Authority but delivered and installed by the SP. The Trust in collaboration with the relevant procurement frameworks will seek to further enhance the standard framework terms and conditions to include a stronger commercial link with the MiM Project Agreement.

The project procurement documents cover a set of principles in relation to this element of equipping (The SP letter confirms these principles (see appendix **FBC/MC7**).

Group 3

This equipment is provided and commissioned by the Authority. This breaks down into 3 principle groups:

- **IRS Equipment:** as described above, the IRS equipment co-ordination and installation (mainly Group 2a) will be overseen by the IRS Implementation Board.

- **Furniture and Fittings:** due to the interface with interior design, the Authority design team will oversee the procurement and installation of this element.

- **Miscellaneous equipment including FM equipment:** the Authority equipment team will oversee the procurement and commissioning of this category. It will require co-ordination with the furniture and fittings workstream.

Group 4

This equipment group is predominantly low-cost equipment that often does not have a requirement for fitting or are consumable in nature. This equipment is the responsibility of the Trust to specify and procure. Some Group 3 and 4 equipment will be suitable to transfer.

Group 5

All Group 5 equipment is equipment, that is being transferred from the existing VCC and is further split into two subgroups 5A and 5B

- **5A** – The Authority is responsible for the delivery and installation, via a sub-contractor eg IRS Linacs.

- **5C** – SP is responsible for the delivery and installation and initial technical commissioning eg CT SIMS.

Management of Programme Interdependencies

2.30 There are a number of key programme interdependencies that need to be managed to ensure successful delivery of the nVCC Project. This relates especially to the major equipment interface.

2.31 These, and other dependencies, currently sit under the TCS Programme overseen by the TCS Programme Delivery Board (PDB). This arrangement has been in place from the inception of the nVCC planning. However, Velindre is currently refreshing these governance arrangements to reflect new Board Structures set out in Table 8 below, as the Trust moves into the implementation phase of the programme:

Table 8 – TCS Governance future arrangements

Strategic Capital Board (SCB) (former PDB)	Velindre Futures
Project 1 – Enabling Works	Project 3a IRS (Implementation)
Project 2 – nVCC	Project 4 – RSC (Clinical Service model only)
Project 3a – IRS (Capital aspects only)	Project 5 – Outreach (Clinical Service Model)
Projects 3b & c – Equipment (Clinical and Non-clinical)	Project 6a – Design of nVCC Clinical Model
Project 4 – RSC infrastructure only	Project 6b – nVCC Clinical Model delivery
Project 5 – Outreach (Capital aspects only)	Nuffield Recommendations for VCS
Projects 7 – VCC Decommissioning	
Digital (content and scope TBC)	
Project 6c Transition to nVCC (to report into both VF and SCB)	

2.32 The interdependencies and project alignment will be reviewed monthly against the Master Programme, with regular risk reviews and exception reporting also being undertaken.

2.33 The Integrated Assurance and Approval's Plan (IAAP) (see appendix **FBC/MC4**) allows the nVCC Project Board and overarching TCS Programme Delivery Board to coordinate key deliverables and Programme interdependencies with the required levels of scrutiny and governance.

2.34 In order to maintain co-ordination and alignment of these connected initiatives the nVCC Leadership Team have direct links into both projects. The overarching Programme Plan, which includes the nVCC Project, identifies the connections between each Project and the critical path of dependent activities. All the Project Directors are members of the currnet TCS Programme Delivery Board.

2.35 The design of the IRS Project (and the resultant IRS Contract) relates to all facilities. The project also supports the maintenance of operational services at the existing Cancer Centre through the transitional period into the new operating arrangements. Interfaces between each of the projects are monitored and risks managed at both project and programme level. The current TCS Programme Plan sets out the critical interdependencies between the respective Projects within the TCS Porgramme, this is regularly reviewed for alignment and to ensure that the respective projects are on track.

2.36 The nVCC Project also interfaces with projects within Velindre's service change initiative the Velindre Futures Programme, where there are also critical interdepencies.

3 CHANGE CONTROL AND CHANGE MANAGEMENT

Introduction

3.1 This section of the Management Case sets out the approach to change control and change management.

Change Control

3.2 The Change Control process is managed by the Project Management Office (PMO). The Change Control administration comprises of:

- Change Control Management Document - which gives guidance of version control in regard to documents and the change control procedure;
- Change Management Log - captures all version controlled PMO documents/products;
- Change Form - formal process staff are required to follow to request change to a version-controlled document/products; and
- Change Log - this captures all change requests.

3.3 The Project Team, and external contractors, are expected to comply fully with the Change Control Procedure.

Change Management Principles

3.4 The Change Management principles of the framework are to:

- Recognise the need to maximise the benefits of the change for patients, who should be at the heart of the changes made;
- Take advantage of the time required to complete the development to start the change process immediately and avoid risks related to a 'big bang' approach;
- Test and prove the changes through careful piloting of any aspects of the new models and processes that can be implemented before the new facility is finally commissioned;
- Work in partnership with staff and other stakeholders both within and outside VCC to engage all those involved in the delivery of care in the change process; and
- Focus on staff skills and development required so staff are both capable and empowered to deliver healthcare effectively and to a high-quality standard in the new facility through new models of care.

The Project Change Management Approach

3.5 The PMO has designed a change management approach that encompasses the framework and principles outlined above.

3.6 The change management process was implemented alongside the development of the OBC.

3.7 Where proposed changes to service impact on the workforce, the NHS Wales Organisational Change Policy will apply. This document makes clear the onus upon the service to consult with staff affected and their individual employment rights.

The Change Management Plan

3.8 A Change Management Plan will be developed. Once the FBC has been approved, three actions will occur:

- The Core Plan will be reviewed to identify other relevant areas that need to be included;
- Detailed plans will be developed for each of the tasks in the Core Plan; and,
- A change timetable will identify the high-level milestones.

3.9 Table 9 below sets out the core plan and the main tasks identified to date.

Table 9 - Change Management Plan

Area	Planned tasks
Planning phase	✓ Appoint key Project roles and Change Managers, confirming responsibilities and leadership ✓ Confirm stakeholders and interested parties both within and outside VCC ✓ Develop core plan in more detail, identifying high level milestones for the Change Management Plan, mapped to the overall Project Plan ✓ Confirm involvement of HR, managers and other individuals/groups in the process
Communications and stakeholder engagement	✓ Confirm communications lead and protocols (route and timing of approval of communications) ✓ Develop communications routes, including face to face briefings bulletins, intranet pages ✓ Formulate and agree key communications messages against high level milestones ✓ Set up stakeholder map and engagement plan ✓ Launch change Programme ✓ Ongoing communications work

Area	Planned tasks
Training and development	✓ Complete detailed workforce planning to identify 'shadow' structures, roles and competencies for those roles ✓ Work with staff through workshops and other training to clarify the workings of the new Service Models and how these will impact in practice ✓ Identify training and development required to fulfil roles and competencies ✓ Develop training plan, aligned to pilot work and overall milestones in implementation plan ✓ Link training and development into communications plan
Piloting	✓ Identify and confirm areas where piloting of new models and practice will be implemented ✓ Confirm schedule of pilot work, mapped against high level project and change management milestones ✓ Agree feedback arrangements from pilots and how this links into training/development, communications and overall change management plan ✓ Execute pilots, feedback and report progress
Full Implementation	✓ Identify scheduling/phasing of full implementation at VCC ✓ Using results of piloting and training work, develop detailed implementation and transition plan, mapped to project phasing ✓ Discussion and agreement with key staff ✓ Execute implementation and transition plans

3.10 Detailed planning to manage the transition of the current service and operations at the existing Velindre Cancer Centre to the new site will form the basis of a dedicated project (Project 6c Service Transition) under the direction of the Director of Transformation.

3.11 Project 6c reports jointly to both the Velindre Futures Programme Board and Strategic Capital Board to ensure alignment and consistency of planning.

3.12 A comprehensive Transition Plan will be developed as part of this project.

3.13 Assurance of the transition process will also be provided via a Gate 4 Review: Readiness for Service which will be undertaken after the project has been approved as ready for service.

4 EXTERNAL ADVISORS

4.1 This section sets out the external consultant arrangements that support the delivery of the nVCC Project and their respective roles.

4.2 The contract management arrangement for external advisors is set out in the Procurement Section of this Management Case.

4.3 Table 10 below sets out the Project's external advisory team:

Table 10 - External Advisors

Technical Advisors

Consultant	Roles and Responsibilities	Trust Lead
MDA Limited	Engineering design advice and services	Project Director
JCA Limited	Architectural advice and services	Project Director
Phil Roberts	Design and sustainability consultancy	Project Director
Mott MacDonald	Facilities Management and Energy advice	APD
Hulley & Kirkwood	Mechanical Engineering advice and support	APD
Macgregor Smith	Provide Landscape advice and support	APD
Phil Jones	Environmental design support	APD
Urbanists	Planning advice for the nVCC and associated access	APD
WSP	Civil and Structural engineering support	APD
Simon Fenoulhet	Arts consultancy	APD

Professional Advisors

Consultant	Roles and Responsibilities	Trust Lead
Pricewaterhouse Coopers	Financial and modelling advice	APD
DLA Piper	Provide legal and procurement advice	APD
Willis Tower Watson	Provide specialist insurance advice and services	APD
Archus UK Limited	Business Case and economic modelling services	APD
Faithful & Gould	Cost consultancy	APD

Other Advisors

Consultant	Roles and Responsibilities	Trust Lead
Down to Earth	Environmental design and community benefits advice	APD
Channel 3	Digital advice and support	APD

**APD – Assistant Project Director*

5 USE OF SPECIALIST ADVISORS WITHIN NHS WALES

5.1 The nVCC Project utilises a number of specialist advisors provided via the NHS Wales Shared Services Partnership (NWSSP) and other areas of the NHS in Wales.

5.2 These include the following:

- NWSSP – Specialist Estates Services;
- NWSSP – Procurement Services;
- NWSSP – Legal and Risk Services;
- Health Education and Improvement Wales (HEIW); and
- Digital Health and Care Wales (DHCW)

6 EXTERNAL PROJECT SCRUTINY AND ASSURANCE

6.1 To provide project assurance, a range of external reviews and audits will take place. These fall into the following categories:

- Gateway Reviews or Project Assurance Reviews;
- Commercial Approval Points (Mutual Investment Model); and
- Internal Audit.

Gateway Reviews

6.2 The Infrastructure Projects Authority (IPA) Gateway Review process examines Projects at key decision points in their lifecycle. As part of this process, an independent expert team assesses the delivery confidence of a Project or Programme.

6.3 The different gates are identified below in Table 8 and are as follows:

Table 8 - Gateway Review Themes

Gate	Scenario
0	Strategic Fit (Programmes Only)
1	Business Justification
2	Delivery Strategy
3	Investment Decision
4	Readiness for Service
5	Operations Review and Benefits Realisation

Commercial Approval Points (CAPs)

6.4 The Welsh Government MIM assurance framework includes Commercial Approval Points (CAPs).

6.5 A CAP considers the impact of project-specific commercial factors in relation to:

- Affordability;
- Value for Money;
- Deliverability; and
- Commercial and compliance aspects of a Project.

6.6 The sequence and stage of Commercial Approval Points (CAP's) are set out in the Table 9 overleaf.

Table 9 - CAP Sequence

Description of Procurement Activity	CAP No.
Pre OJEU	1
Pre-Competitive Dialogue	2
Mid Dialogue	3
End of Dialogue	4
Pre-Financial Close	5

Internal Audit

6.7 NHS Wales Shared Services Partnership provides Internal Audit services to Velindre. The nVCC Project forms an integral part of the Trust's annual audit cycle due to its significance to the organisation.

6.8 There is a continuous stream of Internal Audit reviews of the Project and Internal Audit attend the nVCC Project Board.

6.9 Table 10 below sets out the audit and assurance reviews that have been undertaken on the nVCC Project to date. A Gate 3 review "Investment Decision" is due to coincide with the Welsh Government scrutiny of this Full Business Case (see appendix **FBC/MC8** for Welsh Government Gate 2 (Critical Friend Review) report undertaken in April 2018).

Table 10 - Assurance Reviews Summary and Outcomes

Assurance Review	Stage / Title	Date	Outcome
Commercial Approval Point	1	February 2021	Proceed
	2	July 2021	Proceed
	3	February 2022	Proceed
	4	May 2022	Proceed
	5	Feb/Mar 2023	tbc
Gateway	1	N/A*	N/A*
	2	January 2017	Amber
	2 (Critical Friend Review)	April 2018	Amber
	3	Feb/Mar 2023	tbc
	4	tbc	tbc
	5	tbc	tbc
Internal Audit	MIM Procurement	June 2022	Substantial Assurance

*Note * - Gateway 2 in January 2017 was the first gate review of the project.*

7 PROCUREMENT AND CONTRACT MANAGEMENT

Introduction

7.1 This section of the Management Case describes the Trust's approach to managing the procurement of the nVCC. It will cover the following areas:

- The managerial and governance approach to delivering a successful MIM Competitive Dialogue process;
- Scope of all procurements relating to nVCC;
- The management and oversight of the construction period; and
- The Trust's organisation to manage contractual arrangements during the operational phase.

Procurement Scope

7.2 The overall scope of procurements required to deliver the nVCC are outlined in Table 11.

Table 11 – Scope of Procurements

Project	Procurement Arrangements
Construction of nVCC	Supported by NWSSP – Procurement Service and External Advisors **Route** OJEU/FTS **Process** 1. Project Agreement and Procurement Documents; 2. Competitive Dialogue; 3. Preferred Bidder
Clinical and Non-Clinical Equipment	Supported by NWSSP – Procurement Service and Capital Equipping Team **Route** OJEU for Integrated Radiotherapy Solution Procurement (*See Radiotherapy solution PBC*) Other Major Equipment (OJEU or Framework)
IM&T	Supported by NWSSP-Procurement Service and Capital Equipping Team **Route** Exploit existing IM&T Frameworks

New Velindre Cancer Centre (nVCC)

7.3 The nVCC will be funded, procured and maintained via Welsh Government's MIM. This model has a standard form Project Agreement (PA) which requires the Trust to personalise it (within agreed parameters) to meet the needs of the specific nVCC Project.

7.4 As outlined in the Commercial Case, the nVCC launched the procurement via an Official Journal of the European Union (OJEU)/ Find a Tender Service (FTS) advertisement.

7.5 The method of procurement was via a Competitive Dialogue process where bidders competed against one another to improve on a reference design. Final tenders were submitted from the bidders and Acorn consortium was selected as the Successful Participant (SP).

7.6 The Acorn consortium team includes Kajima Partnerships, Sacyr, Aberdeen Investment, and Kier Facilities Services.

Method and Approach

Process to Financial Close

7.7 Following appointment of the SP, Acorn and Velindre are working together to secure the following:

- Determination of Reserved Matters;
- Completion of Design to Stage 3;
- Completion of competent set of enabling works;
- Refinement and completion of PA;
- Confirmation of financial and commercial terms;
- Funder sign-off.

7.8 Following these actions, the Trust and Acorn will execute a Financial Close and sign the PA.

Contract Management during Construction

7.9 The Successful Participant will develop agreed plans for the nVCC, have submitted a Reserved Matters application in October 2022 and will commence construction after Financial Close.

7.10 Due to the size and complexity of the build there will be the need to consider the management of change controls throughout the construction. Issues will

arise, whether these are simply points of clarity, unforeseen design challenges, or omissions in the original design. The Project Agreement makes provision for the formal notification of changes during construction.

7.11 All change controls and early warnings must follow the specified governance arrangements which will remain in place for monitoring and approval purpose throughout the construction, post-construction and evaluation phases.

7.12 To fully control this process the Trust has purchased the Asite sharing portal which was successfully used during the procurement phase. It is proposed Asite will be used to manage all construction change controls as it is a fully auditable system that allows for the mark-up of architect's drawings, recording early warning notifications and compensation events.

7.13 The Trust will provide an internal team to liaise and monitor the performance and delivery of the MIM contractor:

i) The nVCC Project Director (supported by the Project Team) will be accountable for managing all change controls during construction, post-construction and evaluation phases and early warning notifications, thus ensuring the best possible balance of time, cost and quality is achieved.

ii) The team will meet regularly with the MIM contractor to review:
   a. Programme;
   b. Change Controls;
   c. Compliance with external site restrictions imposed;
   d. Equipment Commissioning;
   e. Medical Equipment Commissioning; and
   f. The Independent Tester / Certifier reports.

7.14 The Trust will support the team by the appointment of:

i) The Trust's Legal and Financial Advisors (to advise on any change controls or early warning notifications).

ii) A "Shadow Design" team (to provide engineering, architectural and design consultancy advice) who will be at the Trust's disposal during the construction period to advise on any change controls or early warning notifications.

iii) The Trust will also have access to Shared Services, Specialist Estates Services to provide input into any issues around the Technical functionality of the Design, as and when required, and to provide assurance during the commissioning of the hospital facility working with / alongside the Independent Tester/ Certifier.

Role of the Independent Tester / Certifier

7.15 The project will use an Independent Tester / Certifier in accordance with the MIM guidance, which is set out in Schedule 13 of the Project Agreement. The Project Agreement specifies the certification requirements, informed by lessons learned from other major schemes such as Edinburgh Schools.

7.16 The role of the Independent Tester / Certifier is to ensure that the project meets completion tests in accordance with the requirements of the contract. The Authority Construction Surveyor will monitor the quality of the work and align closely with the Independent Tester.

7.17 It is a core requirement of Welsh Government that a specialist team of advisers are in place to provide additional levels of assurance. They will undertake an appropriate level of due diligence during the design and construction of the hospital to ensure all aspects are being delivered in accordance with the requirements and terms of the Project Agreement.

7.18 The level of due diligence to be applied will be determined through an informed assessment of the associated risk and the implications of non-compliance.

7.19 The team structure will be developed around the core structure in Figure 1 to ensure robust contract management, record keeping, reporting, escalation and communications protocols are in place:

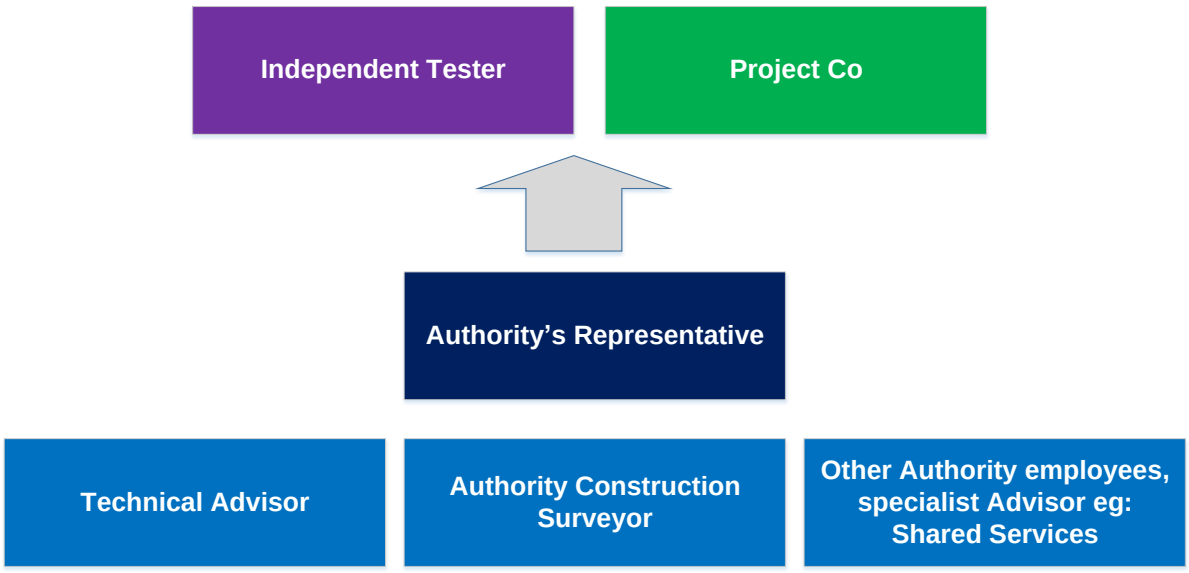


Figure 1 - Structure around Independent Tester / Certifier

In-life Contract Management

7.20 The Trust has assessed the anticipated requirements of the In-life Contract Management and has formulated a management structure that will ensure the effective management of the operational contract to ensure it is efficient, effective and achieves optimal performance. The Trust has identified the competence and capacity to achieve this, which is set out in Appendix **FBC/MC9**.

7.21 The Trust has recognised that the implementation of this new way of working will require a change in functional capability and structure within the Trust. The Trust will ensure that the knowledge, capacity and expertise to manage the contract and hold the supplier to account is provided through dedicated individuals within the new management team.

7.22 The roles of the team will vary from individuals with technical knowledge of the delivery of services, through to individuals with the knowledge and experience of contract management and have the appropriate and suitable negotiation skills to ensure that the contract is run to its optimal level.

7.23 The Team will be supported by external advisors (as and when required) and agreed reports from the Independent Tester. This will be in addition to the continuous support from colleagues in NWSSP Specialist Estates Services.

7.24 The management of the contract will be mindful of the agreed standards and the monitoring regime required to comply with:

i) Schedule 12, the Service Level Specifications.
ii) Thermal Energy and Efficiency Testing Procedure (Green Credentials).
iii) Building Information Modelling (BIM) requirements.
iv) Community Benefits.
v) Change Procedures.
vi) Hand back Procedures.
vii) Helpdesk performance

7.25 The in-life management team will be fully conversant with the administration and application of the pay mechanism associated with the contract. Agreed protocols for deductions or increases will be agreed with the Welsh Government prior to implementation.

7.26 The management structure will ensure continuous liaison with colleagues in the Welsh Government, to develop protocols around medium to large change procedures within the contractual agreements of the MIM contract and to report on the effective and efficient delivery of the contract.

8 nVCC PROJECT PLAN

Introduction

8.1 This section sets out:

- The Project Stage Boundaries;
- Project Planning Methodology;
- High Level Planning Assumptions; and
- Estimated Construction Timeline.

8.2 All Projects are effectively split into stages; these stages often reflect the key activities that are being undertaken during the defined time period. Stage Boundaries provide useful review and authority to proceed to points in the Project.

8.3 The nVCC Project comprises five defined stages that are described in the Figure 2 below that illustrates an estimated timeline.

Project Stages	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Q1 2026	Q2 2026	Q3 2026	Q4 2026
Design & Planning (Stage 1)	PS1																								
Procurement & Enabling (Stage 2)			Project Stage 2																						
Construction (Stage 3)											Project Stage 3														
Commissioning & Operational (Stage 4)																				PS4					
Consolidation & Closure (Stage 5)																						PS5			
** Table in calendar years / quarters*	*Q1 - January to March Q2 - April to June Q3 - July to September Q4 - October to December*																								

Figure 2 - Project Stage Boundaries

Project Planning Methodology

8.4 To achieve a baseline Project Plan major areas of delivery have been scoped and estimated timescales have been derived with advice from the Trust's technical advisors and Welsh Government colleagues. This has allowed baseline activity durations to be developed. This planning process, based on estimated "earliest time to complete" has allowed the development of a baseline Project Planning position.

8.5 This project planning methodology has not had any adjustment for optimism bias or schedule risk analysis and therefore provides an optimistic project timeline.

8.6 The key milestones of the nVCC Master Programme and enabling projects are outlined in Table 12 overleaf.

Table 12 - nVCC Project – Key Milestones (Quarters refer to *calendar* year not *financial* year)

Key tasks	Target Completion Date	Complete
Planning Application for the nVCC approved by Cardiff City Council's Planning Committee	**December 2017**	✓
nVCC OBC approved by commissioners	**April 2018**	✓
nVCC OBC approved by Trust Board	**July 2019**	✓
nVCC OBC submitted to Welsh Government	**July 2019**	✓
Asda's Development Agreement approved by Welsh Government	**December 2019**	✓
Pre-procurement activities: Issue Prior Information Notice (soft market testing) for nVCC Project	**January / February 2020**	✓
Asda planning process "triggered"	**February 2020**	✓
nVCC Project Agreement and Procurement Documents approved	**February 2020**	✓
Planning Application for Asda (access) approved by CCC	**September 2020**	✓
SRO requests CAP1 for nVCC Project	**Quarter 4 2020**	✓
Planning Application for Asda access - Reserve Matters and Judicial Review completed	**Quarter 4 2020**	✓
Welsh Government scrutiny of nVCC OBC completed	**Quarter 4 2020**	✓
Welsh Government scrutiny of Enabling Works OBC completed	**Quarter 4 2020**	✓
Easements and land matters (excluding Utilities) complete	**Quarter 1 2021**	✓
nVCC CAP 1	**Quarter 1 2021**	✓
Ministerial Approval of nVCC OBC	**Quarter 1 2021**	✓
Ministerial Approval of Enabling Works OBC	**Quarter 1 2021**	✓
nVCC OJEU publication issued	**Quarter 1 2021**	✓
ITPD Issued	**Quarter 3 2021**	✓
ITSFT Issued	**Quarter 2 2022**	✓
Enabling Works – Phase 1	**Quarter 1 2023**	✓
nVCC Competitive Dialogue concludes (Financial Close)	**Quarter 1 2023**	
Commencement of nVCC construction	**Quarter 2 2023**	
nVCC open (First Patient)	**Quarter 3 2025**	
nVCC Fully Operational after Transition	**Quarter 4 2025**	

Construction Timeline

8.7 The construction timeline has been developed by Acorn. The current construction timeline is 25 months; this overall timeline includes handover of the Imaging Block to happen after 22 months, followed by 5 months of major equipment commissioning. The first patients will be treated at the nVCC in Quarter 3 2025; however other non-clinical areas will still be being finalised up until the 27-month timeline (see appendix **FBC/MC10**).

8.8 Figure 3 below sets out the Project plan for Construction and Commissioning.

P2. nVCC Construction	**810 days**	**Tue 01/11/22**	**Mon 08/12/25**	
IRS Link	**120 days**	**Mon 28/10/24**	**Fri 11/04/25**	
Lead time for radiotherapy treatment machines - order to delivery	120 days	Mon 28/10/24	Fri 11/04/25	14,380FF-240 days
Site preparation and habitat management activities	**261 days**	**Tue 01/11/22**	**Tue 31/10/23**	
On-site activities	**230 days**	**Mon 12/12/22**	**Fri 27/10/23**	
Habitat enhancement / creation (offsite and on site)	80 days	Mon 12/12/22	Fri 31/03/23	
Reptile fencing and winter clearance (Phase A - Southern End)	46 days	Fri 10/03/23	Fri 12/05/23	137,148,146
Reptile translocation (Phase A - Southern End)	35 days	Mon 15/05/23	Fri 30/06/23	374
Stage 2 vegetation clearance (Phase A - Southern End)	75 days	Mon 15/05/23	Fri 25/08/23	374
Reptile translocation and stage 2 clearance (Phase B - Northern End)	40 days	Mon 04/09/23	Fri 27/10/23	376
Construction - Acorn	**709 days**	**Wed 22/03/23**	**Mon 08/12/25**	
Acorn mobilisation and early works	69 days	Wed 22/03/23	Mon 26/06/23	360
Phase 1 Radiotherapy/imaging block (incl. 1a construction - bunkers	467 days	Mon 03/07/23	Tue 15/04/25	144,360,171,48FF,5
1a Exclusive access	34 days	Wed 16/04/25	Mon 02/06/25	380
1a Beneficial access	20 days	Tue 03/06/25	Mon 30/06/25	381
Initial linac commissioning	54 days	Wed 16/04/25	Mon 30/06/25	380
Phase 2 - rest of hospital including landscaping	515 days	Tue 11/07/23	Mon 30/06/25	144,360,171,48FF,5
Service Transition	15 days	Tue 01/07/25	Mon 21/07/25	384,382
Milestone - First Patient Treated	0 days	Mon 21/07/25	Mon 21/07/25	383,385
Phase 1b (bunkers 5-6)	516 days	Mon 03/07/23	Mon 23/06/25	380SS
1b Exclusive access	56 days	Tue 24/06/25	Tue 09/09/25	387
1b Beneficial access	15 days	Wed 10/09/25	Tue 30/09/25	388
Phase 1c (bunkers 7-8)	546 days	Mon 03/07/23	Mon 04/08/25	380SS
1c Exclusive access	31 days	Tue 05/08/25	Tue 16/09/25	390
1c Beneficial access	10 days	Wed 17/09/25	Tue 30/09/25	391
Commissioning / Transfer of final linacs	120 days	Tue 24/06/25	Mon 08/12/25	387,390FF
Milestone - Fully open - all patients treated	0 days	Mon 08/12/25	Mon 08/12/25	393,386,389,392

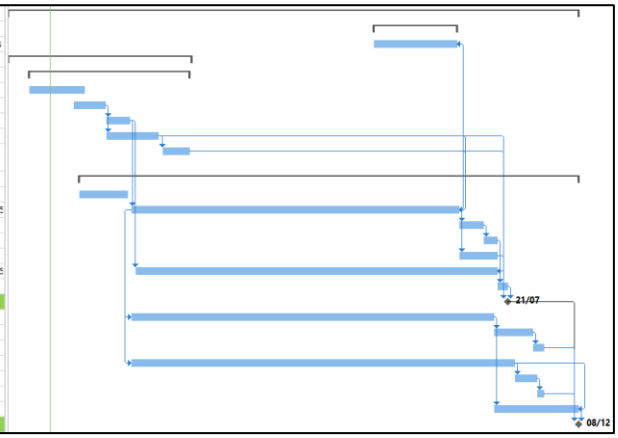


Figure 3 - The Project Plan for Construction and Commissioning

8.9 The Trust is continually reviewing the Master Project Plan for the nVCC Project, part of the TCS Programme, and is in regular contact with the Welsh Government and key stakeholders regarding this matter (see Appendix **FBC/MC11**). There are a range of potential risks that could threaten the current timeline that are currently being mitigated.

9 BENEFITS REALISATION AND ARRANGEMENTS FOR POST-PROJECT EVALUATION

Introduction

9.1 This section of the Management Case will describe how the Trust will manage the delivery of the benefits associated with the nVCC Project.

9.2 The Outline Business Case outlined the approach to quantified benefits. The quantification of benefits relating to the nVCC include macro benefits / societal benefits from the wider TCS Programme but only where they can be directly attributable to the re-provisioning of the Velindre Cancer Centre, or care pathway attributed to Velindre as an organisation. The Full Business Case assesses the validity of these benefits.

Wider Project Success Measures

9.3 The project has recognised that benefits of successful implementation of the nVCC Project extend further than those articulated/directly quantified in the Economic Case. The project also recognises the value of prospective evaluation (i.e., not waiting until after the Project is complete). This has led the nVCC Project and the TCS Programme Delivery Board to design a dynamic process to evaluate a set of 34 success measures that cover:

- Design outcomes
- Quantifiable benefit outcomes
- Community benefit outcomes
- Commercial outcomes
- Process

9.4 The nVCC Project Initiation Document includes details of these benefits, outcome descriptors, SMART measurement methods, and data sources. They are drawn from the project vision and objectives articulated in the Outline Business Case, Procurement Documents, and the Design Brief.

Dynamic Evaluation and Post-Project Evaluation

9.5 The nVCC Project has established a Research, Development and Innovation (RD&I) group which will lead on the dynamic evaluation of the project during its lifetime as well as facilitating additional benefits arising from the project.

9.6 The RD&I group has already launched a range of projects in partnership with local research institutions. The RD&I group will continue to launch projects during the construction, commissioning and bedding-in phases of the project. The current projects (November 2022) are appended (see **FBC/MC12**).

9.7 The project will capture the results of this evaluation process in a Benefits Register. The project will build this register throughout the stages of the project and disseminate learning to all interested parties. The register will include the quantified benefits analysed in the economic case as well as the wider benefits (see **FBC/MC13)**.

9.8 The RDI group reviews the projects in delivery, future opportunities and the project list at its monthly meetings.

9.9 The RD&I group reports into the nVCC Project Board.

9.10 Once the project has completed the construction phase, it will undertake a Gate 5 review to review this work.

9.11 The nVCC Project Director will be responsible for delivery of the post-project evaluation (PPE). The Assistant Project Director will be responsible for day-to-day oversight of the PPE process, reporting to the nVCC Project Director.

10 COMMUNICATION AND ENGAGEMENT

Introduction

10.1 Following the development of the Programme Business Case and the nVCC Outline Business Case, the project developed a communication and engagement strategy (Appendix **FBC/MC14**).

10.2 The strategy identified a list of key stakeholders including the following groups:

- Patients, families and carers;
- Staff and staff representatives;
- Health Boards;
- Higher Education Institutions;
- Potential strategic/commercial partners;
- Local community groups;
- The Local Authority;
- Local Politicians; and
- Welsh Government Ministers.

10.3 The project issues monthly update reports on engagement. The Project Team presents these reports to the Project Board.

10.4 The Programme Team incorporates the project engagement plans into an overall Programme report.

10.5 As part of the approach to Future Generations, the Project Team has referenced all the project activities and objectives to the Future Generations Act.

10.6 The project has tied the Future Generations objectives including method and depth of engagement into its RD&I workstream.

11 RISK MANAGEMENT PLAN

Introduction

11.1 This section of the nVCC FBC sets out the Projects approach to risk and issues management and presents:

- Risk Management Overview;
- Issue Management and Risk Management Philosophy;
- Recording and Assessment of Risk;
- Risk Management Framework;
- Responsibility for Managing Risk Registers;
- Risk Mitigation;
- Review and Escalation of Risk; and
- Current Risk Register.

Risk Management Overview

11.2 The nVCC Project utilises its governance structure and arrangements to ensure the effective management of risk. The governance structures allow for risks to be escalated from project groups and subgroups, through to the nVCC Project Board, Strategic Capital Board (which replaces the PBD) and onto the TCS Programme Scrutiny Sub-Committee and / or the Trust Board as appropriate.

11.3 All risk registers (which are present in all levels of the nVCC project) are regularly reviewed and updated. A monthly risk report is presented at the nVCC Project Board and Strategic Capital Board. This risk report will highlight new risks, the movement in existing risks and issues and where appropriate it will recommend the closure of resolved risks or issues. Risks and Issues are escalated to the Strategic Capital Board, if applicable.

11.4 The TCS Programme Scrutiny Sub-Committee, upon receiving the nVCC risk register (via the SRO), will consider if the mitigating actions are sufficient and if the identified risks are receiving the right level of treatment. The TCS Programme Scrutiny Sub-Committee will consider the escalation of nVCC Project Risks onto the Trust Risk Register as appropriate, using Datix. The remainder of this section sets out the detailed management of risks and issues.

Issue Management and Risk Management Philosophy

11.5 The nVCC Project Board's philosophy for managing risks is by adopting a holistic approach, seeing effective risk management as a positive way of achieving the project's wider aims. The nVCC Project Board regards risks as the mirror opposite of benefits. Inadequate risk management would therefore reduce the potential benefits to be gained from the delivery of the nVCC Project.

11.6 Effective Risk Management supports the achievement of wider aims, such as:

- Effective Change Management;
- Enhanced use of resources;
- Better Project Management;
- Minimising waste and fraud; and
- Innovation.

11.7 The Project utilises the Trusts' Risk Management Framework to systemically identify, actively manage and minimise the impact of risk. This is achieved by:

- Identifying possible risks before they manifest themselves and put stringent mechanisms in place to minimise the likelihood of them materialising with adverse effects on the project;
- Putting in place robust processes to monitor risks and report on the impact of planned mitigating actions;
- Implement the right level of control to address the adverse consequences of the risks if they materialise into issues; and
- Having strong decision-making processes supported by a clear and effective framework of risk analysis and evaluation.

11.8 Once risks are identified, the response for each risk will be one or more of the following types of action:

- **Prevention**, where countermeasures are put in place that either stop the threat or problem from occurring, or prevent it from having an impact on the project;

- **Reduction**, where the actions either reduce the likelihood of the risk developing or limit the impact on the project to acceptable levels;

- **Transfer**, where the impact of the risk is transferred to the organisation best able to manage the risk, typically a third party (e.g., via a penalty clause or insurance policy, or contractual responsibility);

- **Contingency**, where actions are planned and organised to come into force as and when the risk occurs; and

- **Acceptance**, where the nVCC Project Board decides to go ahead and accept the possibility that the risk might occur, believing that either the risk will not occur or the potential countermeasures are too expensive. A risk may also be accepted on the basis that the risk and any impacts are acceptable.

11.9 The nVCC Project Board will adopt a proactive approach to the identification, assessment and management of risks throughout the whole project lifecycle. The effective management of risk and the prevention of issues arising will support the timely delivery of the nVCC Project, by preventing delays, avoiding costs and ensuring quality is upheld.

11.10 The management of nVCC Project risk will be in accord with the principles of the Trust's Risk Management Policy.

Recording and Assessment of Risk

11.11 The nVCC Project will have a Risk Register, which will be updated with all new identified risks being assessed. All risks will have an individual identifier, an assigned owner and be scored using the standard impact v likelihood criteria to ascertain the risk-rating colour.

11.12 It is worth reiterating that as set out in the Commercial Case a number of the risks associated with the MIM procurement will be wholly either transferred or shared with the Successful Participant partner.

11.13 In developing the preferred solution, the Project Management Office examined three categories of risks for each option. These are set out in Table 13 below, together with a summary of how these were assessed.

Table 13 - Risk areas

Area	Description	How assessed
Capital Risks	Capital risks relate to unknown or unidentifiable factors that increase the cost and time of the project construction.	Qualitative and quantitative risks assessed by Quantity Surveyor and / or through workshops.
Optimism Bias	Optimism bias is the demonstrated Systemic tendency for appraisers to be over optimistic about key project parameters. This creates a risk that predicted outcomes do not fully reflect likely costs	Standard methodology to identify extent of optimism bias, with mitigating factors confirmed through nVCC Project assessment
Revenue Risks	These are risks relating to everyday management encompassing cost and activity as well as external environmental factors	Risks identified, with quantitative and qualitative assessment through workshop

11.14 The risk values for the shortlisted options were identified and evaluated as part of the assessment process in choosing the preferred option in the Economic Section. Although the focus of this section is on the approach to managing the risks of the preferred solution, the scope of Risk Management will continue to cover all three areas of risk.

Risk Management Framework

11.15 Velindre University NHS Trust have designed a Risk Management Framework that focuses on identification, reporting and management of risk.

11.16 The Project Management Office (PMO), led by the nVCC Principal Project Manager (PPM), will oversee the operation of the Risk Management Framework and will be the Risk Management Lead for the Project. It will be the responsibility of the PPM to coordinate the Risk Management Sub-Group and to liaise with project's risk champion to ensure individual risk owners actively manage risk mitigations

11.17 Although overseeing the Risk Management Framework the PPM will not be responsible for the actually taking forward risk mitigating actions (this will be the nominated risk owner). The risk management roles are set out in Table 14 below.

Table 14 - Risk Management Roles

Role	Responsibility	Reporting & accountability
Risk Management Lead	Manages the process for identifying and addressing risk, maintaining the risk register on a day-to-day basis	SRO and Project Board
Risk Management Sub-Group	Brings together key risk owners to co-ordinate the identification and assessment of risks plus the management of key risks	Project Team and Project Board
Risk Owner	Individual or group responsible for developing and implementing risk mitigation measures for individual risks they are responsible for	Risk management lead and Risk Management Sub-Group

11.18 The Trust has recognised and acted upon its responsibility for leading effective risk management throughout each stage of the nVCC project. This is particularly important at FBC stage, to ensure that the risks associated with the preferred solution have been identified and addressed. The paragraphs below set out the work completed to date, demonstrating the proactive approach to risk management.

Responsibility for Managing the nVCC Project Risk Register

11.19 The nVCC Project Director is accountable for ensuring that there is robust and proportionate risk management for all their accountable projects. To do this it is important that the relevant information on risk is available. The responsibility for managing the nVCC Project Risk Register lies with the nVCC Principal Project Manager who will review the Risk Register and where necessary hold Risk Reduction Meetings as and when required. Otherwise, the Risk Register will be issued monthly with updated changes.

11.20 The Risk Register will be updated and reviewed continuously throughout the course of the nVCC Project lifecycle and capture the following information for each risk:

- Risk Register Risk number (unique within the Register);
- Risk type Author (who raised it);
- Date identified;
- Date last updated;
- Description (of risk);
- Likelihood / Impact;
- Interdependencies (between risks);
- Expected impact;
- Cost;
- Bearer of risk;
- Mitigating actions; and
- Risk status (action status).

11.21 All the risks identified in the Strategic Case and Economic Case sections of the nVCC Project must be accounted for within the nVCC Project Board Risk Register (see Appendix **FBC/MC15**).

Quantification of Project Risks

11.22 The build of quantified risk has been developed in a number of areas within this FBC. Capital risks have been completed as part of the capital risks utilising expert advice from advisors such as PWC.

Mitigation of Risk

11.23 The nVCC Project Board risk register will be formally reviewed monthly at the Project Board meetings. All Project Groups and Sub-Groups will also have their individual risk registers. All Risk Registers must have mitigating actions associated with them. All risks will then be re-evaluated after considering the effect of the mitigating actions, resulting in a post mitigation risk score.

Review and Escalation of Risk

11.24 The Project Groups and Sub-Groups will consider and mitigate risk and maintain those, which can be actively managed by the Sub-Group. However, when a risk is deemed so potentially severe post mitigation that it could affect the overall delivery of the nVCC (to time, cost or quality) the risk will be escalated to the nVCC Project Board for more senior oversight. The nVCC Project Board will manage risk that directly affects their prescribed deliverables. The members of the nVCC Project Board will review the Risk Register at each meeting adding, reassessing, escalating or closing risks as necessary.

Issue Management

11.25 Issues are Risks that have materialised. Similar to risk, the nVCC Project Board will hold an Issues Register and follow the same escalation path (see Appendix **FBC/MC16**).

11.26 All issues should have an owner and an allied action plan, will be reviewed during all nVCC Project Board meetings, and are categorised as high, medium and low priorities.

11.27 Issues will be regularly reported to the nVCC Project Board and escalated to the TCS Programme Scrutiny Sub-Committee and Trust Board as appropriate.

11.28 Issues that are outside the scope or authority of the nVCC Project Board will be referred to the Strategic Capital Board and / or the Trust Board as appropriate.

12 APPENDICES

For Information

The following Appendices are available in support of this Case:

Appendix Reference	Title
FBC/MC1	Project Management Structure – Roles and Responsibilities
FBC/MC2	TCS Project Governance Arrangements by Committee or Board
FBC/MC3	nVCC TCS Programme Scrutiny Sub-Committee, Programme Delivery Board and Strategic Capital Board – Terms of Reference
FBC/MC4	Integrated Assurance and Approvals Plan
FBC/MC5	Digital Activity Plan
FBC/MC6	Key Clinical Equipment Outline Commissioning Programme (KCEOCP) – *Acorn's draft submission on 16.01.2023,*
FBC/MC7	Successful Participants Clarification Issues
FBC/MC8	Welsh Government Gate 2 Report (NB - Gate 3 to follow)
FBC/MC9	In-Life Contract Management Role and Responsibilities
FBC/MC10	Acorn Construction timelines
FBC/MC11	MIM Project Plan
FBC/MC12	Benefits Realisation and Project Evaluation
FBC/MC13	Benefits Register
FBC/MC14	Communication and Engagement Plan
FBC/MC15	Project Board Risk Register (February 2023)
FBC/MC16	Project Board Issues Register (February 2023)

Aneurin Bevan University Health Board

Strategic Risk and Assurance Report

March 2023

Risk Reference Number	Page
013	1
030	9
037	14
040	20
017	27
045	34
019	40
023	46
039	56
028	64
008	68
003	76
007	82
033	87
016	93
032	101
042	108
027	115
004	120
012	125
025	132
021	145
041	158
002	166
036	179

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR013 Director of Nursing

KEY:		
Priority 1	• Every Child has the Best Start in Life	
Priority 2	• Getting it Right for Children and Young Adults	
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	X
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety • Partnership First • Research, Innovation, Improvement, Value • Workforce & Organisational Development • Finance • Digital, Data, Intelligence • Estate • Regional Solutions • Governance	X X

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TOLERATE

Overall Level of Assurance (RAG):

	X	

Risk of: *Widespread hospital and community harm, with potential increase in demand and acuity of hospital or community acquired infections.*

Due to: *Failure to effectively manage community and hospital transmission of Health Care Acquired Infections (HCAIs) to include respiratory pathogens.*

Likelihood of Current Occurrence: 2 = Do not expect it to happen / recur but it is possible it may do so

Impact if Occurred: *Potential impact on staffing, resources and infrastructure of an already pressured acute hospital system. Further potential impact on Primary and Secondary care services if need in communities are not managed. Impact on individual patients by increased morbidity and mortality.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X – risk appetite – low adverse to risk		**X – current score** **X – target score**
				X – capacity score

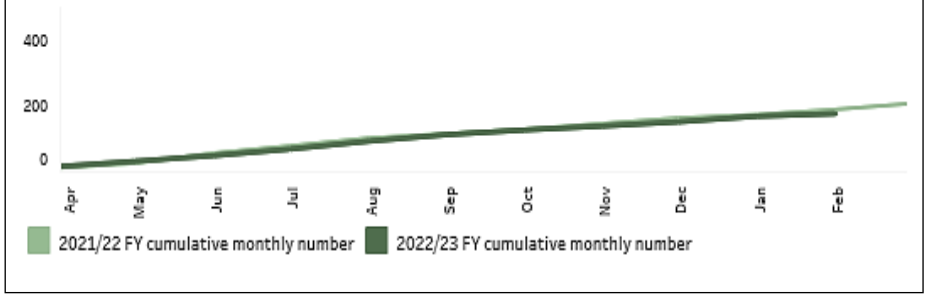
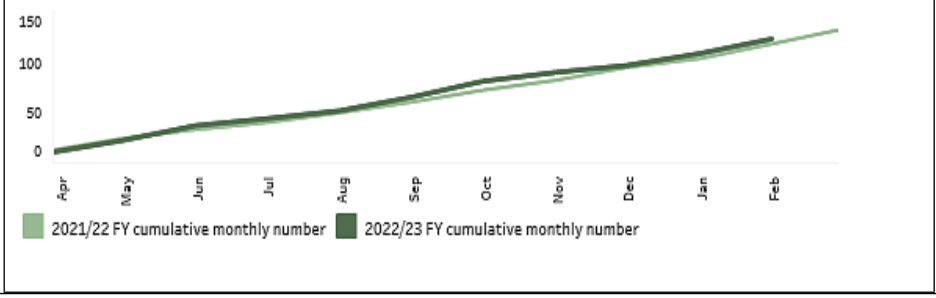
Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

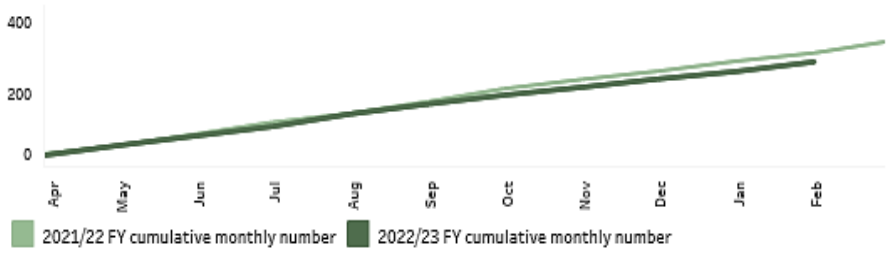
Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
3	***5***	***2***	***5***	***2***	***5***
15		***10***		***10***	

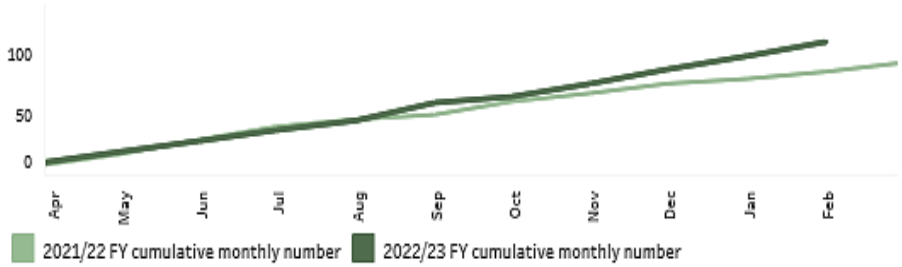
Justification for Risk Appetite and Risk Capacity Level & Target Score:
The risk appetite level is low in this area in the interests of patient safety and experience.

	The risk capacity level reflects the level at which the Health Board can ultimately tolerate this risk and is in line with the inherent risk score. The target score reflects the current score and therefore, the Board is requested to **TOLERATE** this risk, subject to on-going monitoring, evaluation and review. ***Risk Trend:*** **C difficile**  **Staph Aureus** 

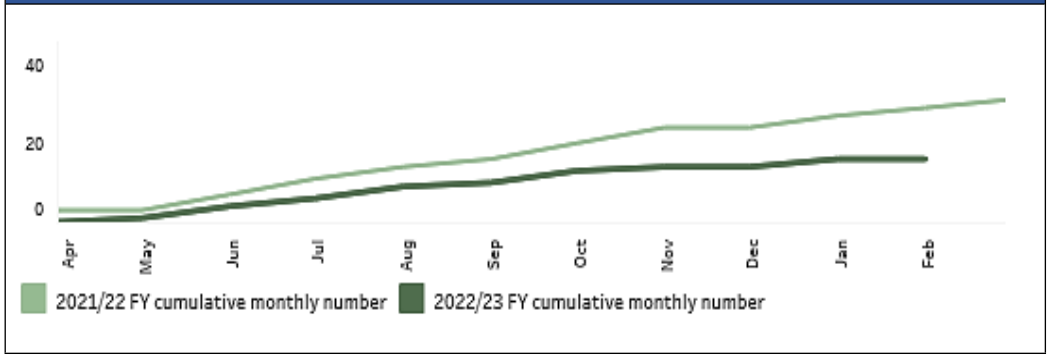
E coli



Klebsiella



Pseudomonas



Current Controls:

- *Daily surveillance of infection data with RCA across the Health Board*
- *Annual program of work*
- *Ongoing education program and audit monitoring*
- *Receive national alerts associated with infection and share accordingly*
- *Ongoing policy reviews and updated in line with changes in national guidance*
- *COVID hospital transmission standard operating procedures is in place, to include the Hierarchy of Controls and with frequent auditing and monitoring via RNTG*
- *Annual HPV proactive enhanced cleaning program*
- *IPT support and advise in Divisional Quality and Patient safety forums*
- *Consultant Microbiology support and advise across Organisational programs*
- *Antimicrobial wards rounds and the roll out of ARK*

Reported via

- *Reducing nosocomial transmission group (RNTG) which is clinically led, reports to Executive Team monthly*
- *Quality and patient safety operational group*
- *Quality and patient safety outcomes committee*

	• *Ongoing monitoring of Welsh Government reduction targets action plan via RNTG* • *Monthly Divisional data*

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Review alternative technology to undertake deeps cleans that's has less impact on capacity	**Rhys Shorney/Moira Bevan**	**June 2023**	**Ongoing**	

Review ventilation within ELGH	**Mark Ascott/Moira Bevan**	**Oct 2023**	**Dependant on business case**	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of* ***operational***, ***organisational*** *and* ***independent*** *assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

Criteria to consider: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?

Assurance Map

Evidence of Controls (mitigations to manage risk)	1st Line of Defence (Operational)	2nd Line of Defence (Organisational)	3rd Line of Defence (Independent)	Overall Assurance (RAG rated)	Gaps in Assurance
Monthly IPAC reporting to Executive Committee (via RNTG)	**X**				
Organisational Action Plan to monitor Welsh Government Reduction targets and respiratory pathways monitored via RNTG		**X**			**95% compliance not sustained within all areas**

RNTG reporting via Quality and Patient Safety operational and outcomes committee.		**X**			

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Continue IPT support and monitoring via the Divisional quality and safety forums	**Moira Bevan**	**March 2024**	**Ongoing**	

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR030 Director of Nursing

KEY:		
Priority 1	• Every Child has the Best Start in Life	X
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	X
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety • Partnership First • Research, Innovation, Improvement, Value • Workforce & Organisational Development • Finance • Digital, Data, Intelligence • Estate • Regional Solutions • Governance	X X

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: *The risks associated with poor level 3 training compliance means that the practitioner may miss a safeguarding concern or not understand the process to report, work with a Safeguarding plan or escalate safeguarding concerns. Risk of us failing in our duty to report.*

Due to: *No level three adult or child safeguarding training was available in quarters 2,3 & 4 of 2022/23 in ABUHB.*

Likelihood of Current Occurrence: 3 = Possible - Might happen or recur occasionally

Impact if Occurred: *Level three safeguarding training is mandated for register health and care practitioners, who engage in assessing, planning, intervening, and evaluating the needs of children and adults at risk of harm and abuse. The training needs to be completed every three years whilst a practitioner is in the above roles. safeguarding laws and legislations change all the time in response to real-life events, and as such, you will typically need to refresh your training. There is an associated risk to the population and organisational reputational risk.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X – risk appetite – low adverse to risk		**X – target score**
				X – current score
				X – capacity score

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
5	***5***	***4***	***5***	***2***	***5***
25		***20***		***10***	

	Justification for Risk Appetite and Risk Capacity Level & Target Score: *The risk appetite level for this risk is low in the interests of patient safety, experience and outcomes.* *The risk capacity level reflects the level at which the Health Board can ultimately tolerate this risk and is in line with the inherent risk score.* *The target score for this risk (2x5)10 aims to decrease the likelihood of this risk manifesting.* *The remainder of the risk assessment demonstrates how the Health Board will seek to realise the target score.* ***Risk Trend:*** *The risk has now been re-framed to provide a focus on training, therefore previous trend not yet available.* **Current Controls:** • Safeguarding Training offered at level 1 & 2 via ESR. (Current compliance data - adult & child level 1 -81%; Children level 2 55.7% Adult level 2 58.0) • Supervision and case review available. • Robust monitoring of safeguarding activity through the Safeguarding Committee via quarterly reporting. • Good use of the adult and child safeguarding hub facility for ad hock advise from a band 7 safeguarding lead nurse; Monday – Friday 09.00 – 17.00 • Utilising all communication methods available to promote completing safeguarding training.
Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*	

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Updated training packages	**Fiona bullock**	**March 2023**	**Complete. Both have been trailed and evaluated well**	
Training sessions booked for children and adult level three safeguarding training	**Fiona Bullock**	**March 2023**	**Complete. (Monitoring of uptake ongoing, with plans to add additional dates where needed)**	
Communication with practitioners, via share point intranet pages, emails to divisional nurses.	**Fiona bullock**	**ongoing**	**Direct contact with Communications team, to maximise exposure**	
Level 2 safeguarding training compliance levels below expectation of 85%	**Fiona Bullock**	**ongoing**	**Email sent to all divisions to ask for compliance focus**	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place*

to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?

Assurance Map					
Evidence of Controls (mitigations to manage risk)	**1st Line of Defence (Operational)**	**2nd Line of Defence (Organisational)**	**3rd Line of Defence (Independent)**	**Overall Assurance (RAG rated)**	**Gaps in Assurance**
Health Board- safeguarding level three adult and child training		**X**		**Mapping has taken place, using the Royal College of nursing intercollegiate document; which is backed up by the Welsh Government safeguarding training guidance.** **Training packages for child and adult level 3 training have been reviewed and made current.** **A training schedule has been advertised across the health board.** **Barrier to compliance monitoring removed. (competency booklet) Additional ways of knowledge assurance being considered.**	**As level three training is mandated every three years. The expectation is that we will not see acceptable level of compliance until 2026**
Safeguarding training compliance	**x**			• **To improve safeguarding training compliance practitioners require management support to complete level 2 safeguarding training on ESR and book onto level three**	. **Uptake for adult safeguarding training sessions remains low.**

				safeguarding training dates on share point. Uptake for adult safeguarding training sessions remains low.	**Poor compliance with level 2 ESR safeguarding training.**

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR037 Director of Nursing

KEY:		
Priority 1	• Every Child has the Best Start in Life	X
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	X
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	
	• Workforce & Organisational Development	X
	• Finance	
	• Digital, Data, Intelligence	
	• Estate	
	• Regional Solutions	X
	• Governance	X

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: *Inability to provide safe and adequate levels of care in line with good practice and guidance.*

Due to: *High registered nurse vacancies and absenteeism, increased levels of patient acuity presenting to hospitals, cared for in single occupancy environments.*

Likelihood of Current Occurrence: 2 = Do not expect it to happen / recur but it is possible it may do so

Impact if Occurred: *Negative impact on staff morale, patient experience and outcomes. Non-compliance with legislative and statutory requirements, creating exposure to reputational damage.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

				X – target score
		X – risk appetite – low adverse to risk		
				X – current score
				X – capacity score

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
4	***5***	***4***	***4***	***1***	***5***
20		***16***		***5***	

Justification for Risk Appetite and Risk Capacity Level & Target Score: Nurse staffing levels remains one of the most significant risks within the Health Board with potential to impact

	on patient safety, quality of care and experience. If all mitigation and actions come to fruition, there is the ability to reduce the risk substantially hence the score of 5 has been applied as the target risk level. ***Risk Trend:*** The risk level has remined at level 15 (after all controls and mitigation is applied) over the last 6 months. **Current Controls:** • Nurse Staffing Levels (Wales) Act 2016- recalculation of roster establishments. • Monthly Strategic Nurse Workforce Meetings – monitor and manage trends. • On-going local and international recruitment of registered nurses and HCSW's. • Pro-active recruitment via streamlining. • Review of skill mix to include Assistant Practitioners. • Prudent RN approach – introduction of new roles to release registered nurse's time. • Implementation of local bank incentives and specialist bank rates of pay. • Daily site meetings to ensure appropriate allocation of staff to manage risk across all sites. • Bespoke recruitment events • Recruitment wheel for RN's and HCSW's • Roll out of SafeCare

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**

Develop Nursing Workforce Strategy.	Linda Alexander	March 2023	Completed – awaiting Exec approval 23.3.23	
Focused recruitment campaigns (local and national) tailored too hard to fill areas. Speciality driven campaigns.	Sian Bigmore in collaboration with Divisional Nurses	March 2023 - ongoing	Annual recruitment wheel cycle established; first event completed.	
Enhance existing nurse resource bank.	Ann Bentley/Sian Bigmore	March 2023 - ongoing	Annual recruitment wheel cycle established; first event completed. Existing bank nurses to be offered substantive contracts.	
International recruitment	Linda Alexander/Shelly Williams	May 23-Sept23	Paper to be received at Execs 23rd March 2023	
Improve recruitment service by streamlining the process to ensure timely commencement and improved on-boarding process.	Sian Bigmore	May 2023	KPI's being developed to track and monitor improvement in reducing time to hire	
Increased focus on retention.	Shelley Williams	May 2023	Review current flexible working offer. Ensure all marketing material support flexible working opportunities.	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with*

clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map

Evidence of Controls (mitigations to manage risk)	**1st Line of Defence (Operational)**	**2nd Line of Defence (Organisational)**	**3rd Line of Defence (Independent)**	**Overall Assurance (RAG rated)**	**Gaps in Assurance**
Nurse Staffing Levels (Wales) Act 2016 – compliance with the Act monitored annually.		**X**			
Nurse Staffing Escalation Framework	**X**				
Strategic Nursing Workforce Meetings		**x**			

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR040 Director of Nursing

KEY:		
Priority 1	• Every Child has the Best Start in Life	X
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	X
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	
	• Workforce & Organisational Development	X
	• Finance	
	• Digital, Data, Intelligence	
	• Estate	
	• Regional Solutions	X
	• Governance	X

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: *Lack of public confidence, reputational and financial damage/impact.*

Due to: *Continued and sustained non-compliance with The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011*

Likelihood of Current Occurrence:
4 -Likely - Will probably happen/recur, but is not a persisting issue but consequence 3 Moderate therefore Risk = 12

Impact if Occurred: *Adverse impact on patients, complainants, carers, staff, along with organisational reputational damage, ultimately effecting levels of public confidence. Potential financial impacts for complaints and clinical negligence claims.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X – risk appetite – moderate/cautious risk taking **9 – target score**	**12 – current score**	
			X – capacity score	

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
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3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
4	***4***	***4***	***3***	***3***	***3***
16		***12***		***9***	

Justification for Risk Appetite and Risk Capacity Level & Target Score:
A moderate risk appetite level has been applied to this risk, accepting that the Health Board will need to adopt a cautious approach to seeking risks to realise optimal opportunities in management of the risk.
The risk capacity level has been set at (4x4)16 and aligns with the inherent risk score.

	The target risk score seeks to decrease the likelihood from the current score but maintain the impact of the risk being realised. ***Risk Trend:*** *Maintained.* **Current Controls:** • Putting Things Right Procedure for the Management of Concerns (Complaints) • Procedure on the management of Public Services Ombudsman for Wales (PSOW) investigations • Putting Things Right Policy (Complaints, Claims and Patient Safety Incidents) • Policy and Procedure for the Management of Patient Safety Incidents (Including Nationally Reportable Incidents) • Toolkits on PTR webpages • IO Face to Face training • Corporate ADN meeting with Divisional SMT • Fully established Corporate Concerns Team and increased QPS support in Divisions • Yorkshire Contributary Factors Framework • Quality Strategy (currently in draft) • The Health and Social Care (Quality and Engagement) (Wales) Act 2020 • Patient Experience and Involvement Strategy

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Further promotion of empowering staff to report	Divisional Triumvirate teams	Ongoing	Compassionate leadership Programme	

incidents and concerns where appropriate – supported by a 'Just Culture' e.g., no blame	PTR team Organisational Workforce		Compassionate Leadership in Investigating Officers Quality Strategy Patient experience and involvement strategy	
Triangulation of data to further understand contributing factors relating to Never Events, Patient Safety Incidents and serious concerns	Assistant Director of Nursing, Assistant Director for Quality and Patient Safety and Assistant Director of ABCi	1st April 2023	Governance away day Quality Strategy Thematic reviews Delivery plan for the quality strategy -27th March 2023 Theatre safety collaboration group re-established for education, sharing and learning Theatre safety meeting have been reinstated Review of SI process The current divisional QPS resource is being reviewed and it is anticipated that some of this resource could support this compliance	
To increase compliance with PTR regulations	Divisional Triumvirate teams PTR team	Ongoing	Toolkits on PTR webpages IO Face to Face training Corporate ADN meeting with Divisional DMT	

			Fully established Corporate Concerns Team and increased QPS support in Divisions Patient Experience and Engagement Strategy The current divisional QPS resource is being reviewed and it is anticipated that some of this resource could support this compliance Advisory review in progress	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of* ***operational***, ***organisationa****l and* ***independent*** *assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

Criteria to consider*: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map

Evidence of Controls (mitigations to manage risk)	1st Line of Defence (Operational)	2nd Line of Defence (Organisational)	3rd Line of Defence (Independent)	Overall Assurance (RAG rated)	Gaps in Assurance
Putting Things Right Policies		X			Under review
Internal Audit on PTR – reasonable level of assurance gained September 2021			X		
Compliance with Putting Things Right Regulations – report to WG and PSOW quarterly stats on compliance		X			

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**

Updating and reviewing Putting Things Right Policies in line with up to date legislative requirements	Executive Director of Nursing	April 2023	Await confirmation from WG	

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR017 Full or partial failure of ICT systems and cyber security Director of Planning, Performance and ICT

KEY:		
Priority 1	• Every Child has the Best Start in Life	X
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	
Priority 5	• Dying Well as part of Life	
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	
	• Workforce & Organisational Development	
	• Finance	
	• Digital, Data, Intelligence	
	• Estate	
	• Regional Solutions	X
	• Governance	X
		X

Assurance/Oversight Committee: Finance and Performance Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: *Security of Patient, Staff or Health Board information being compromised leading to harm or damages.*

Due to: *Complete or partial failure of ICT systems to protect patient information (malware attack) across the Health Board (including independent contractors and partners) incorporating system outages, provided nationally by third parties or locally provided systems.*

Likelihood of Occurrence: 3 – Possible - Might happen or recur occasionally.

Impact if Occurred: *Patient safety and outcomes would be adversely impacted, could breach multiple legislative requirements, public confidence, un-favourable financial impact due to fines etc.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X Low risk appetite level		X Target score
				X Capacity score
		X Current score		

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
4	***5***	***3***	***5***	***2***	***5***
20		***15***		***10***	

	Justification for Risk Appetite and Risk Capacity Level & Target Score: Low appetite in relation to adverse impact on Quality, Safety, Outcomes and Experience. **Current Controls:** • Cyber has developed a Remedial Action Plan to address issues identified within the NIS CAF assessment 2021. This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which was developed by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed annually. • Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff • Cyber now undertakes scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report. • Cyber has also worked with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber and the Teams to review compliance levels against policy. Results are captured within the monthly Cyber Report.. • Cyber has worked with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The less service impacting Version 1 is being managed through ICT Departmental risk management process. • Cyber has maintained the use of Trustware for all emails Trustwave provides inspection and protection from malicious links embedded within emails • Cyber has begun the roll out simulated phishing campaigns the initial phish has been tested on ICT Department and reported within the Cyber Report. Cyber will continue campaigns during 2023 to increase email security awareness among staff. • Cyber has also introduced scenario-based incident response exercising using National Cyber Security Centre developed 'Exercise in a box' the aim is to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber plans to run several more exercises during 2023

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
None identified by the ICT Directorate				

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

Criteria to consider: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?

Assurance Map

Evidence of Controls (mitigations to manage risk)	1st Line of Defence (Operational)	2nd Line of Defence (Organisational)	3rd Line of Defence (Independent)	Overall Assurance (RAG rated)	Gaps in Assurance
Cyber Security remedial action plan against NIS CAF Assessment		Establishment of HB office of the SIRO	Oversight from NHS Wales Cyber Resilience Unit		Amber as HBOTS inaugural meeting still to take place
Templar Report		Establishment of HB office of the SIRO	Oversight from NHS Wales Cyber Resilience Unit		Amber as HBOTS inaugural meeting still to take place
Cyber Security support at all relevant stake holder groups	Governance and Assurance Groups	Establishment of HB office of the SIRO	Oversight from NHS Wales Cyber Resilience Unit		Amber as HBOTS inaugural meeting still to take place
Monthly Cyber report to include patching and O/S compliance					

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance.*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
HBOTS inaugural meeting to take place.	**Director of Digital**	**Q2 2023**	**Remains in progress.**	

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR045 LINC Programme – inability to implement. Interim Chief Digital Officer

KEY:		
Priority 1	• Every Child has the Best Start in Life	X
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	
Priority 5	• Dying Well as part of Life	
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	
	• Workforce & Organisational Development	
	• Finance	
	• Digital, Data, Intelligence	x
	• Estate	
	• Regional Solutions	X
	• Governance	X
		X

Assurance/Oversight Committee:

Finance and Performance Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: *If the new LIMS service is not fully deployed before the contract for the current LIMS expires in June 2025*

Due to: *Then operational delivery of pathology service may be severely impacted.*

Impact: *5* ***-*** *Resulting in reduced or unsafe Pathology services which could cause potential delays in diagnosis/treatments for patients, provision of results that support diagnosis and treatment, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact. If the Pathology service is without a LIMS system, business continuity plans would need to be enacted increasing risk to patient safety, speed at which the service can respond, impact on patient flow at hospital sites and ability to manage wider services to outpatient/primary care.*

Likelihood of Occurrence: *5 - The current LIMS system national contract comes to an end in March 2025. DHCW have negotiated a 3-month extension to June 2025. There are concerns nationally and locally about the readiness of the new LINC system and confidence in the current supplier is low. If the LINC system is not ready before the current LIMS contract ends, the ABUHB pathology service will be without a LIMS system.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

				X Capacity Score X Current Score

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophi
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
5	***5***	***5***	***5***	***1***	***5***
25		***25***		***5***	

Justification for Risk Appetite and Risk Capacity Level & Target Score:
Based on impact this risk meets the criteria set out in the Corporate Strategy and risk appetite definitions as low (averse to risk), and therefore target scores have been set within the low ranges:
'The Health Board aspires to avoid (except in very exceptional circumstances) risks that may result in reputation damage, financial impact or exposure, major breakdown in services, information systems or integrity, significant incidents of regulatory and/or legislative compliance, potential risk of injury to staff/service users.'

Risk Trend: *First time this has been reported since risk identification.*

Current Controls: *Local Project board and governance in place and local SRO recruited. The national SRO is ABUHBs Executive Director of Therapies & Health Science, Peter Carr, which provides ABUHB with an additional level of assurance and influence at a national level. The national SRO presents updates regularly at CEG. Attendance at national LINC programme board meetings and feedback mechanisms established. Clinical Support Service Oversight Board meets monthly and Digital Delivery Oversight Board meets quarterly to manage escalated programme and project risks. Risk and issue approach and escalation processes in*

	place as part of the informatics project management framework. DHCW contractual processes in place to manage supplier to commercial delivery milestones. ABUHBs decision to detach blood transfusion from the current LIMS system means that if this risk is realised, the HB will still have a functioning Blood Transfusion service.

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Set up local project team to support timely implementation of new system (resource appropriately) – project management, SME's, governance structure, business change support, project team	Simon Hoad	31st March 2023	Local project established, governance structure in place. There is a meeting on 16th March to determine operational support and roles and responsibilities. We are still waiting on a decision from the national programme in relation to additional funding for	

			resource to support implementation	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

Criteria to consider: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?

Assurance Map

Evidence of Controls (mitigations to manage risk)	**1st Line of Defence (Operational)**	**2nd Line of Defence (Organisational)**	**3rd Line of Defence (Independent)**	**Overall Assurance (RAG rated)**	**Gaps in Assurance**
Project risk log	Project Management Framework – Risk Management Approach & process	LINC Project Board and National Programme Board			
Business Continuity Plans	Business Continuity Plans (Pathology)	Business Continuity Plans (Hospital site wide)			Additional resource would be required to run business continuity for a prolonged period of time. Service would

					be reduced as an impact and patient safety risks would increase.
ABUHB Director of Therapies is the National SRO			There is likely to be confidential national mitigations (plans) being worked through that would support mitigation of this risk		It is unknown what these mitigation or plans may be due to the sensitive and confidential nature

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Additional resource would be required to manage a prolonged period of system downtime / unavailability	Simon Hoad	**n/a**	**No progress**	
Suggest executives seek assurance from national SRO that national mitigations are being progressed, if required	Peter Carr is national SRO	**n/a**	**n/a**	

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR019 Director of Operations

KEY:		
Priority 1	• Every Child has the Best Start in Life	
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	
Priority 4	• Older Adults are Supported to Live Well and Independently	
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	X
	• Workforce & Organisational Development	X
	• Finance	X
	• Digital, Data, Intelligence	X
	• Estate	X
	• Regional Solutions	X
	• Governance	X

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: *Failure to meet the needs of the population who require high levels of emergency supportive care and inability to release ambulances promptly to respond to unmanaged community demand.*

Due to: *Significant delayed transfers of care, domiciliary and care home constraints.*

Likelihood of Current Occurrence: 4 = Likely - Will probably happen/recur but it is not a persisting issue

Impact if Occurred: *Significant negative impact on patient flow throughout the acute care system in conjunction with a poor patient experience which may in turn produce poor patient outcomes.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X – risk appetite – low risk taking		
				X – target score
			X – current score **X – capacity score**	

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
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3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
5	***5***	***4***	***5***	***3***	***5***
25		***20***		***15***	

Justification for Risk Appetite and Risk Capacity Level & Target Score:
*This risk has a **low-risk appetite** in respect of quality and patient safety.*

	*The **risk capacity** for this area is **high** due to the nature of the consequence of the risk being catastrophic, if realised.* *The **target score** has been set at **15** due to an inability to reduce the consequence but some ability to reduce the likelihood albeit, this is informed by external factors outside of the Health Board's control.* ***Risk Trend:** Maintained* **Current Controls:** • Health Board Emergency Pressures Escalation Policy (revised Nov 2021) • Health Board surge plans. • System Leadership and Response – whole system planning – meets x2 weekly. • Cross-site meetings to discuss system and flow pressures meets x2 daily – reduced to release clinical staff. • Escalation meetings as required. • Executive escalation for any crew delayed for over 2 hours, and 2 hourly thereafter. • Emergency Care Improvement Board – meets monthly. • Urgent Care Transformation Board • Lightfoot data being used to inform plans. • Community Division seeking to accept acute transfers pre-mid-day to mitigate late transfers to community and to release capacity in emergency department.

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**

Implement the AB safety flow model	**Clinical Executives**	**Implemented**	**Enable moves through the system to manoeuvre patients through the system and zero tolerance of 4 hour waits on ambulance (local target) outputs are being actively monitored by EASC dashboard.**	
Pathways of care – collaborative acute, community and being led by Welsh Government	**Annie Lewis**	**Ongoing implementation**	**Reviewing number of patients in acute hospitals who are able to be discharged and not solely reliant on social care input. Data being reported to Welsh Government monthly, in place for the last 3 months.**	
Reviewing care pathways related to hospital admissions. To establish care pathways where patients can be most appropriately managed in collaboration with the flow centre.	**Owain Sweeting/Flow Centre**	**April 2023**	**Early nominations and discussions are being undertaken and update to Divisional DMT.**	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of* ***operational***, ***organisationa****l and* ***independent*** *assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

Criteria to consider*: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map

Evidence of Controls (mitigations to manage risk)	1st Line of Defence (Operational)	2nd Line of Defence (Organisational)	3rd Line of Defence (Independent)	Overall Assurance (RAG rated)	Gaps in Assurance
Health Board Escalation Policy (under review)		**X**			**Policy under review currently to ensure robust and cohesive policy in place.**
Local Business Continuity Plans (BCPs) including the testing of the plans.	**X**				**BCPs in place in most areas but further testing needs to take place.**
Urgent Care Transformation Board – responsible for monitoring and implementation of plans associated with 6 goals of urgent and emergency care.		**X**			**Due to the vast nature of the business of the 6 goals of emergency care, further focus is required in the smaller workstreams to achieve**

					green in this area overall.

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Reviewing the Health Board Escalation Policy	**Wendy Warren**	**April 2023**	**Information being collated to inform red escalation cards, identification of triggers and actions required.**	
Further testing of BCPs across the operational team.	**Andy Goodenough/Wendy Roberts**	**June 2023**	**Some testing has been undertaken. A planned exercise Euclid from Welsh Government will test our ability to respond to a major incident and therefore test the strength of BCPs. ICT BCPs have been tested successfully, specifically for the operational team.**	

Review of governance arrangements for urgent care transformation board including the workstreams that comprise it.	**Paul Underwood**	**Ongoing**	**Initial reporting to operational DMT has commenced however, further work is required to ensure reporting is consistent and drives forward change and patient outcomes.**	

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR023 Director of Operations

KEY:		
Priority 1	• Every Child has the Best Start in Life	
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	
Priority 4	• Older Adults are Supported to Live Well and Independently	
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	X
	• Workforce & Organisational Development	X
	• Finance	X
	• Digital, Data, Intelligence	X
	• Estate	X
	• Regional Solutions	X
	• Governance	X

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TOLERATE

Overall Level of Assurance (RAG):

	X	

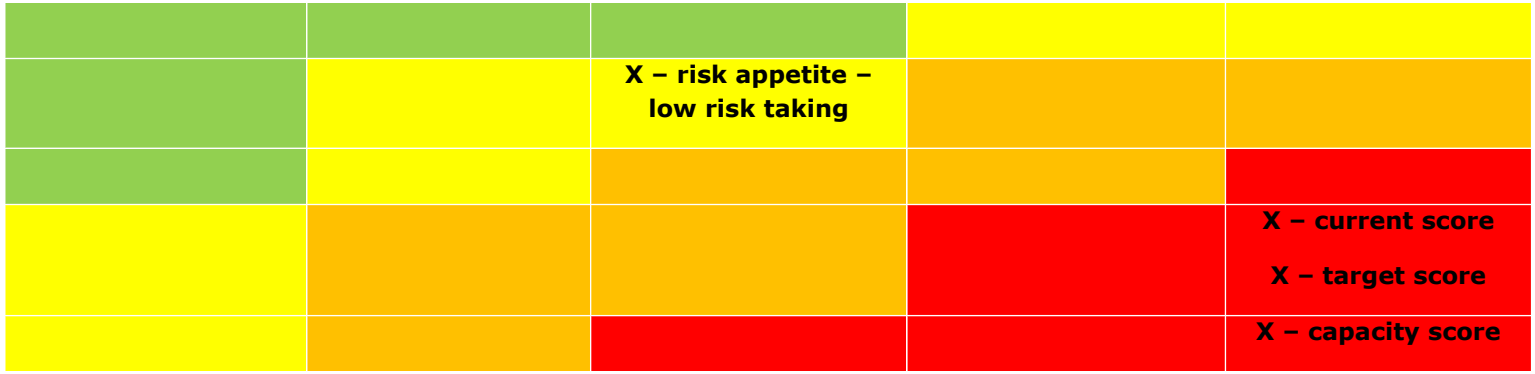
Risk of: *Unknown or unmet non-COVID harm across population health*

Due to: *Priority being given to management of the COVID pandemic.*

Likelihood of Current Occurrence: 4 = Likely - Will probably happen/recur but it is not a persisting issue

Impact if Occurred: *Significant impact on demand for primary, secondary and tertiary care services with patient acuity increasing and patients waiting longer to access appointments. Patient safety and outcomes, levels of public confidence, reputational and financial will be impacted adversely.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*



Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
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3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
5	***5***	***4***	***5***	***4***	***5***
25		***20***		***20***	

	Justification for Risk Appetite and Risk Capacity Level & Target Score: *The risk appetite for this risk is set at a low level, due to impacts on patients' safety and outcomes and unknown harm.* *The risk capacity level for this area is 25 as this is the level at which the risk has been tolerated previously before local mitigations were put in place.* *The target risk score for this area is (4x5)20 and the risk is reported as achieving its target. The challenge for the Health Board remains to maintain this position and identify any other actions that could further reduce the risk and align to risk appetite level. Therefore, the Board is asked to* ***TOLERATE*** *this risk, above risk appetite but within risk capacity level.* ***Risk Trend:*** *Maintained* **Current Controls:** • Planned Care Recovery Plan – Ministerial priority. • Early recovery plan agreed focusing on Cancer, 52 weeks, Follow Up waits, Diagnostic and Therapies waiting times, and Eye Care. • Risk stratification and validation of lists is ongoing, and focus is on Urgent and Cancer work. • Weekly tracking of recovery plus tracking of new ways of working in place • WLI OPD sessions for clinically urgent patients, maximising PAC and theatres and on a transformational level, • Adapt and sustain progress being monitored through Exec Team meetings via Director of Operations. • Plan in place for green recovery (treatments) RGH – all specialities excluding orthopaedics. • Orthopaedic operating at OSU and NHH (P2) • Outpatient Steering Group • Robust escalation reporting and escalation arrangements within primary and community services division.

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Application of INNU Policy	**LW/RME/JP/CM**	**Ongoing**	**Current policy circulated. Quarterly review of statistics for each speciality – currently only able to view at treatment stage. WPAS being adapted to record 'rejection due to INNU' this will enable HB to monitor at front end of pathway All Wales review of INNU Policy to take place**	
Hospital cancellations under six weeks	**LW/JP/CM**	**Ongoing**	**Task and finish group in situ. Action Plan developed. Reasons for cancellations identified by speciality. Main reason is approval of annual leave/study leave under six weeks. Annual leave policy re-issued to Divisions and Directorates. X 3 hospital cancellations – policy being developed.**	
Decrease DNAs	**LW/JP/CM**	**Ongoing**		

			Task and finish group in situ. **DNA rates monitored.** **Action plan developed.** **Focused work on DNAs within tumour sites.** **Use of Dr Doctor to contact patients to establish why they have DNAs with analysis of outcomes.** **Patient focus groups to be organised (working with CHC).**	
Increase use of clinic space/increased utilisation	**LW/JP/CM**	**Ongoing**	**Fortnightly meetings in place with sisters of OPD areas.** **Requests for space directed through this forum** **Specification for outpatient booking system completed and business case underway. Aim of system is to optimise use of clinics space, enable services to request/book space for both ad hoc and longer-term requirements**	
Patient Contact of new outpatients to establish if they still wish to have their appointment, to ensure the	**LW/JP**	**Ongoing**	**Monthly programme in place to contact patients with agreed SOPS**	

HB has 'clean' and up to date waiting lists **Contact of patients on P4 treatment lists being contacted (agreed specialities only)**			**ENT and GS commenced, with timetable for other agreed specialities**	
SoS (see on symptom) and PIFU (patient -initiated Follow-ups)	**LW/JP/CM**	**Ongoing**	**New pathways identified for helping to manage follow-up demand. First element is in terms of ensuring that patients are discharged from follow-up waiting lists where appropriate. In terms of SOS/PIFU - particular concentration on surgical specialities where waiting lists are longer, such as: ENT/GS/T&0/Urology/Gynae/ Derm etc.** **This helps towards ensuring that capacity is used for those patients who need to be seen.** **These pathways enable the patients to be managed**	
Outpatient Speciality Plans	**LW/JP/CM**	**Revised plans to be completed by 30th April**	**Plans to capture outpatient transformational plans by**	

			speciality. Informs programme plan for 23/24.	
E: Advice	**LW/JP/CM**	**31st March 2023**	**Launch of E: Advice within HB** **To assist with decreasing referral demand into the HB**	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map

Evidence of Controls (mitigations to manage risk)	**1st Line of Defence (Operational)**	**2nd Line of Defence (Organisational)**	**3rd Line of Defence (Independent)**	**Overall Assurance (RAG rated)**	**Gaps in Assurance**
Application of INNU Policy		**Re-issue of Policy** **Monitoring mechanism in place**	**All Wales Review of INNU Policy**		**Updated policy required. Potential for more categories to be added to the Policy.**

Hospital Cancellations Under six weeks		**Annual Leave and Study Leave Policy** **Monitoring mechanism in place**			**Divisions/directorates to adhere to the policy**
Decrease DNAs		**Re-issue of Policy** **Monitoring mechanism in place**	**All Wales RTT Policy which includes management of DNAs**		**Divisions/directorates to adhere to the policy**
Increase use of clinic space/increased utilisation		**Bi-weekly meetings**			**Funding for booking system**
Patient Contact of new outpatients to establish if they still wish to have their appointment, to ensure the HB has 'clean' and up to date waiting lists **Contact of patients on P4 treatment lists being contacted (agreed specialities only)**		**Programme plan in situ**			
SoS (see on symptom) and PIFU (patient -initiated Follow-ups)		**Task and finish group**	**All Wales target of 20%**		**Continued discussions with directorates and clinical leads. Review pathways from other**

					HBs to establish whether they are suitable for specialities within ABuHB
E: Advice		**Working with Informatics Team**			**To be launched by end of March 2023. However only partial implementation with further work required to implement the process fully.**
Outpatient Speciality Plans		**DM meetings**			**Being refreshed for 23/24**

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Automated booking system – completion of business case	**Julie Poole**	**May 2023**	**Partially complete. Budget costs obtained. Scoping exercise completed and draft specification.**	
E Advice	**Julie Poole/John Frankish**	**TBC**	**Work with informatics team to identify priority and**	

			timeline to complete full process	
Outpatient speciality plans	**Julie Poole/Directorates**	**May 2023**	**New template developed. Meetings held with AGMs for all Divisions. Meetings organised with DMs**	

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR039 Director of Operations and Medical Director

KEY:		
Priority 1	• Every Child has the Best Start in Life	
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	X
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	
	• Workforce & Organisational Development	X X
	• Finance	X
	• Digital, Data, Intelligence	
	• Estate	
	• Regional Solutions	
	• Governance	

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: *Delayed cancer treatments delivered to patients.*

Due to: *Deteriorated position in cancer performance specifically in relation to 62 day waits.*

Likelihood of Current Occurrence: *4 = Likely - Will probably happen/recur but it is not a persisting issue*

Impact if Occurred: *Reduced levels of patient quality, outcomes and experience, public confidence, and potential reputational damage to the Board.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X - risk appetite - low (averse to risk)		**X – target score**
				X – current score
				X – capacity score

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)	Consequence:

Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophi
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
5	***5***	***4***	***5***	***2***	***5***
25		***20***		***10***	

Justification for Risk Appetite and Risk Capacity Level & Target Score: *Cancer performance has been clearly outlined as a key operational target by Welsh Government with an expectation to have achieved 70% and reduced long waiting patients (>104 days) by the end of March 2023.*
104 days on cancer pathway has been set as the threshold at which harm should be considered for the patient. We currently have 130 patients actively waiting over this threshold.

	Risk Trend: *Maintained* **Current Controls:** • Cancer Services Board to monitor and review delivery plans associated with cancer targets (KPIs) • Regular reporting on cancer KPIs to Welsh Government. • Cancer Directorate performance meetings. • Use of business intelligence tools (Lightfoot SFN, Qliksense, Performance warehouse data).

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Cancer Assurance meeting recommencing from February 2023 focussing on backlog reduction, 62 day and 14-day	**Richard Morgan-Evans**	**February 2023**	**In progress, meetings commenced 20/02/2022**	

compliance as key metrics for supporting faster treatment.				
Pathology outsourcing to continue. Improvements in USC TAT are expected to improve once routine backlog cleared, and urgent samples begin to be outsourced.	**Arvind Kumar**	**Feb/March 2023**	**Outsourcing has successfully reduced total turnaround times for USC. Further reduction in waiting times required plus additional capacity requirement for expected demand growth**	
14 days first seen measure remains as priority to ensure rapid access to diagnostics. 75% target set for April 2023	**Leanne Watkins**	**April 2023**	**February 14 day compliance was 64.4%**	
Optimal Cancer Pathway manager to begin in post 13.02 with early focus on H&N and Urology	**Michael Eastwell**	**August 2024**	**Manager in post. Awaiting imminent launch of pathway project**	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map					
Evidence of Controls (mitigations to manage risk)	**1st Line of Defence (Operational)**	**2nd Line of Defence (Organisational)**	**3rd Line of Defence (Independent)**	**Overall Assurance (RAG rated)**	**Gaps in Assurance**
Cancer Services Assurance meetings to act as key metric operational review.	**x**				Meetings currently running fortnightly and by exception. Likely gap in employment of the Cancer Service Manager role monitoring metric trajectories.
Regular reporting on cancer KPIs to Welsh Government.			**X**		Monitoring of ABUHB quality metrics regularly fed back through operational cancer meetings. Potential gap in method of feedback from delivery unit to Health Board
Cancer PTL tracking meetings	**X**				Weekly patient level meetings held between Cancer Services and tumour site teams to resolve patient level blockages.

Use of business intelligence tools (Lightfoot SFN, Qliksense, Performance warehouse data).		**X**			Assurance required that Qlik information is being regularly utilised within operation teams.

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Cancer delivery quality metrics to me agreed and disseminated amongst tumour-site teams and monitored through fortnightly assurance meetings.	**Richard Morgan-Evans/Michael Eastwell**	**31/03/2023**	**In progress**	
Cancer Services operational structure to be agreed and implemented.	**Leanne Watkins**	**31/04/2023**	**In progress**	

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR028 Director of Operations

KEY:		
Priority 1	• Every Child has the Best Start in Life	
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	
Priority 4	• Older Adults are Supported to Live Well and Independently	
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	X
	• Workforce & Organisational Development	X
	• Finance	X
	• Digital, Data, Intelligence	X
	• Estate	X
	• Regional Solutions	X
	• Governance	X

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: *Continued inappropriate admissions of children aged under 18 to acute adult mental health wards. Particularly where admissions are of under 16-year-olds, are for longer than 72 hours and/or are not compulsory detentions under the Mental Health Act.*

Due to: *Inability to access appropriate acute/crisis beds for this age group in the region.*

Likelihood of Current Occurrence: 4 = Likely - Will probably happen/recur but it is not a persisting issue

Impact if Occurred: *Significant impact on demand for primary, secondary and tertiary care services with patient acuity increasing and patients waiting longer to access appointments. Patient safety and outcomes, levels of public confidence, reputational and financial will be impacted adversely.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

				X – target score
		X - Moderate (cautious risk taking)		
				X – current score
				X – capacity score

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
5	***5***	***4***	***5***	***2***	***5***
25		***20***		***10***	

Justification for Risk Appetite and Risk Capacity Level & Target Score:

	The risk appetite for this risk is set at a moderate level, advising cautious risk taking. The rationale for this is to identify innovative actions of mitigating this risk that has not previously been undertaken. Also, the frequency of this risk recurring is low, therefore, it allows for a higher threshold of risk appetite in seeking the rewards of the mitigations. *The risk capacity level for this area is 25 as this is the level at which the risk has been tolerated previously before local mitigations were put in place.* *The target risk score for this area is (2x5)10 as the Health Board seeks to reduce the frequency of this risk recurring through the mitigations identified through this risk assessment.* **Current Controls:** • Health Board Policy is in place for the use of adult Mental Health beds for up to 72 hours. • Designated bed in Extra Care Area • Children and Young People aged under 16 are nursed 1:1 and are prevented from mixing with other patients on the ward. • If Young Person is detained under the Mental Health Act, the safeguards inherent with this legislation apply.

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
CAMHS is working with partners to develop enhanced Crisis support for Children and Young	**Kolade Gamel**	**Ongoing**		

People which will include crisis beds.				

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map

Evidence of Controls (mitigations to manage risk)	1st Line of Defence (Operational)	2nd Line of Defence (Organisational)	3rd Line of Defence (Independent)	Overall Assurance (RAG rated)	Gaps in Assurance
Health Board CAMHS Crisis Flow Policy		**X**			**Further assurances required in determining if the Policy remains fit for purpose and if staff are aware/have received the appropriate training and guidance.**

The Health Board was successful in obtaining capital funding for the proposal to repurpose former Bettws Ward, St Cadocs hospital to become a CAMHS crisis suite.		**X**			**Full plan to be developed and reported to Executive Committee, Partnerships, Population Health and Planning Committee and finally, the Board.**

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
A review of the policy to be undertaken to ensure clear staff guidance is provided.	**Kolade Gamel/Leanne Watkins**	**May 2023**		
A robust plan to be developed and reported to relevant groups/Committees to provide Board with assurance the mitigation for this risk is progressing.	**Kolade Gamel/Leanne Watkins**	**Q4 2023/24**		

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR008 Director of Operations

KEY:		
Priority 1	• Every Child has the Best Start in Life	
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	
Priority 4	• Older Adults are Supported to Live Well and Independently	
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	X
	• Workforce & Organisational Development	X
	• Finance	X
	• Digital, Data, Intelligence	X
	• Estate	X
	• Regional Solutions	X
	• Governance	X

Assurance/Oversight Committee:
Finance and Performance Committee

Risk Decision (4Ts): TOLERATE

Overall Level of Assurance (RAG):

	X	

Risk of: *The current Health Board estate is not fit for purpose.*

Due to: *An inability to adequately maintain an aging Health Board estate.*

Likelihood of Current Occurrence: 3 = Possible - Might happen or recur occasionally

Impact if Occurred: *Service delivery and patient experience is compromised, loss of public confidence, lack of therapeutic environments for patients, health and safety being compromised, negative financial impact, negative wellbeing impact on staff.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X – low risk appetite – adverse to risk		
				X – current score **X – target score**
				X – capacity score

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
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3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
5	***5***	***3***	***5***	***3***	***5***
25		***15***		***15***	

Justification for Risk Appetite and Risk Capacity Level & Target Score:

The risk appetite for this risk is set at a low level, which confirms that the Health Board is averse to seeking risks in this area. The rationale for this is to minimise harm to patients and staff and comply with Health and Safety regulations. However, the Health Board recognises

	that the challenge is now to maintain the position to avoid any further deterioration to the Health Board estate. *The risk capacity level for this area is 25 as this is the level at which the risk has been tolerated previously before mitigations were put in place.* *The target risk score for this area is (3x5)15 and is in line with the current score. Therefore, the Board is asked to* ***TOLERATE*** *this risk above the appetite although it will continue to be monitored through the corporate risk register.* **Current Controls:** • Health Board endorsed Estates Rationalisation Strategy • 6 Facet survey completed in 2019. • The divisional risk register reviewed quarterly at Senior Management Board this is reported to Quality Patient Safety Operational Group. • Multiple policies and SOPs published and communicated to staff. • Robust internal training program in place covering all aspects of Estates management including food hygiene. • Asbestos reinspection programme (over the next 3 years)

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Estates prioritisation/ rationalisation takes	**Divisional Director Estates and Facilities**	**Routine annual review (specific dates to be determined)**	**A new Divisional Director is due to take up post in April 2023**	

place annually to focus available investment.			**and this will form part of initial objective setting.**	
A water/ventilation engineer to enable all critical ventilation systems to undergo annual validation in accordance with HTM 04/01.	**Divisional Director Estates and Facilities**	**Ongoing**	**This is undertaken regularly as part of the Health Board Estate maintenance programme.**	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map

Evidence of Controls (mitigations to manage risk)	1st Line of Defence (Operational)	2nd Line of Defence (Organisational)	3rd Line of Defence (Independent)	Overall Assurance (RAG rated)	Gaps in Assurance
Regular annual audits across all services conducted by NWSSP. Recent audits include HV,			**X**		**Water & Ventilation Audits.**

Water, Ventilation and Waste Management. All achieved reasonable assurance with the exception of Water & Ventilation which require further improvement.					
Health Board endorsed Estates Strategy		**X**			**Although the strategy is in place, further clarity on monitoring of delivery of objectives is required.**
Divisional reporting of Statutory and Mandatory training of staff	**x**				**Staff training levels are monitored and reported regularly. If areas of non-compliance are noted, targeted training can be resourced to ensure compliance.**
Health Board policies and procedure related to maintenance of Health Board estate		**X**			**There are some policies that are out of date and targeted work is being undertaken with the Division to ensure policies reflect updated legislation and best practice.**
Asbestos reinspection programme		**X**			**Reporting mechanisms and systems of escalation to be reviewed to ensure it continues to be appropriate.**

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Clarity in relation to the governance model of the Estates Strategy	**Divisional Director of Estates/Deputy Director of Operations**	**Q3 2023**	**TBC**	
A remodelling of the management structure for soft FM services is being considered to enhance compliance, comply with national standards, improve governance and standardisation of approach.	**Divisional Director of Estates/Deputy Director of Operations**	**TBC**	**TBC**	

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR003 Director of Primary, Community and Mental Health Services

KEY:		
Priority 1	• Every Child has the Best Start in Life	
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	
Priority 5	• Dying Well as part of Life	
Enablers	• Experience, Quality & Safety • Partnership First • Research, Innovation, Improvement, Value • Workforce & Organisational Development • Finance • Digital, Data, Intelligence • Estate • Regional Solutions • Governance	X X X X

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

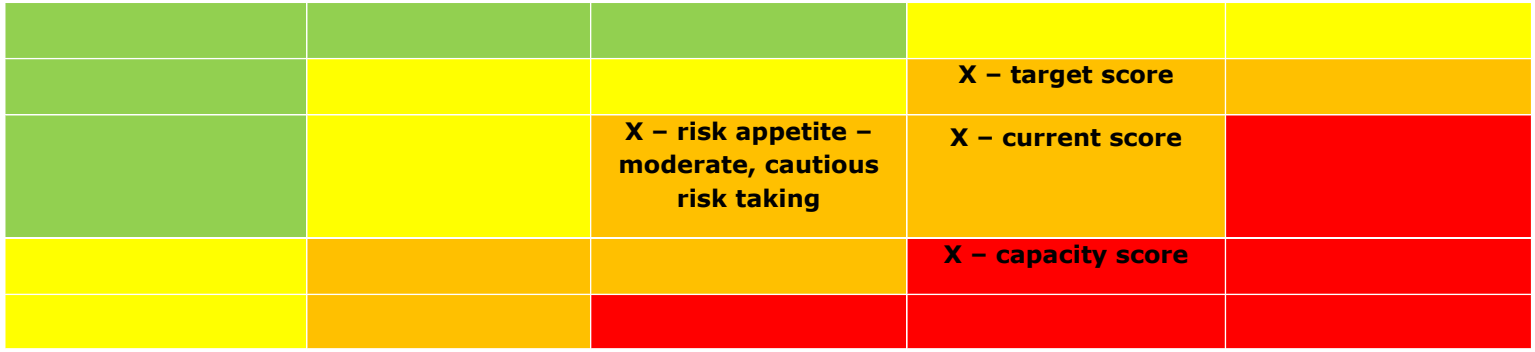
Risk of: *Mental Health services will fail to meet the current and future demand of the Health Board population.*

Due to: *Current WCCIS system implementation, impacting on the ability to understand and report performance, inability to monitor demand and the negative impact of this on patient outcomes.*

Likelihood of Current Occurrence: *4 Likely - Will probably happen/recur but is not a persisting issue.*

Impact if Occurred: *Levels of population well-being could decline creating enhanced and sustained reliance on mental health services for children and adults. Unmet demand in communities potentially leading to increase in demand for Secondary Care Mental Health Services. Inability to provide assurance and reporting under mandatory Mental Health Measure and Psychology Waiting time compliance, resulting in an increase in waiting times for treatment across all services.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*



Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
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4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
4	***4***	***3***	***4***	***2***	***4***
16		***12***		***8***	

Justification for Risk Appetite and Risk Capacity Level & Target Score:
A moderate risk appetite level has been applied to this risk to demonstrate the Health Board's intention to innovate the electronic service whilst maintaining patient safety, experience, and outcomes levels. The Health Board recognises that it may need to seek risks in this area to optimise opportunities.
The risk capacity level is (4x4) 16 which is the level at which the Health Board can tolerate this risk manifesting and is in line with the inherent risk score.
The target score for this risk is (2x4)8. This recognises the Health Board's ambition to reduce the likelihood of the risk being realised and the remainder of the actions within this risk assessment outline the way in which the Health Board can achieve the target score.

Risk Trend: *Maintained.*

Current Controls:

- 1. WCCIS Programme in place, with clear and identified risk and issue escalation protocols within ABUHB, and in conjunction with Advanced and DHCW national programme team.
- 2. Dedicated performance support within MHLD Division and monthly progress and monitoring meetings to work through dedicated WCCIS reporting timeframes and progress.
- 3. Dedicated resource within Informatics in the development of a new Qlik application for all MHLD reporting, which will include dedicated KPI monitoring and MHM reporting dashboards.

	• 4. Bi-weekly WCCIS steering group in conjunction with WCCIS Programme team and MHLD Divisional partners to monitor and review ongoing performance and backlog issues and potential risks across the programme. • 5. Dedicated resource to support operationalising data to support teams with current waiting list views and the support to cleanse and audit current migrated and new data within the WCCIS system.

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Ending of current designated contract with Qlik developer, seek further funding for extension to ensure full	Lorna Allcock / Lynne Wilde	31st March 2023	Funding currently sought, confirming extension of contract with developer and contracting agency.	

completion of all MHM compliance dashboards on Qlik.				
Seek additional funding to support agency and overtime of staff to complete team backlog across referrals and appointments.	Divisional Senior Management Team & Directorate Leads	31st March 2023	Currently no funding sought to cover additional staffing resource past March 31st. Emails sent to Informatics manager to see if funding previously designated can be extended past March 31st. Emails and risk logged around the lack of post arch funding for backlog activities.	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map

Evidence of Controls (mitigations to manage risk)	1st Line of Defence (Operational)	2nd Line of Defence (Organisational)	3rd Line of Defence (Independent)	Overall Assurance (RAG rated)	Gaps in Assurance
WCCIS Programme Board	**X** Programme Board	**X** Executive Board	**X** Advanced / WCCIS National Programme Board (WG)		Potential opposing priorities across parties, Advanced priorities and MHLD Divisional priorities.
Dedicated performance support from MHLD Division, Service Improvement and Support Manger and Data Analyst.	**X** MHLD Divisional Manager	**X** Interim Executive for Mental Health			Independent assurance.
Dedicated resource for Qlik Development.	**X** Informatics Manager ABUHB	**X** Executive Director for Informatic Services.			Independent Assurance

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR007 Director of Planning and Performance

KEY:		
Priority 1	• Every Child has the Best Start in Life	X
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	X
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety • Partnership First • Research, Innovation, Improvement, Value • Workforce & Organisational Development • Finance • Digital, Data, Intelligence • Estate • Regional Solutions • Governance	

Assurance/Oversight Committee: Partnerships, Population Health and Planning Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: *The Health Board is unable to meet the changing demographic need for its population.*

Due to: *Current service models maintaining service delivery in the face of demographic changes.*

Likelihood of Current Occurrence: *3 = Possible - Might happen or recur occasionally*

Impact if Occurred: Increased reliance on services for future generations, *reduced levels of patient quality, outcomes and experience, decreased public confidence, potential reputational damage to the Board, inability to achieve approved IMTP status with Welsh Government, further impact on recurrent funding.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X - risk appetite - low (averse to risk)	**X – target score**	
			X – current score	
			X – capacity score	

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)	Consequence:

Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophi
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
4	***4***	***3***	***4***	***2***	***4***
16		***12***		***8***	

Justification for Risk Appetite and Risk Capacity Level & Target Score:
In relation to patient quality, safety and outcomes, the Health Board risk appetite level is low (adverse to risk).
The capacity level is level at which the Health Board can tolerate the risk and is therefore the inherent risk score.

	The target score of 8 demonstrates that although the impact of the risk being realised cannot be managed to below 4, the likelihood could be reduced to 2 if the Health Board can develop a system that is intuitive enough to flex to the dynamic and evolving needs of the general population that it serves. ***Risk Trend:*** *Maintained* **Current Controls:** • Health Board IMTP and associated KPIs • Public Health Wales surveillance data – COVID, flu and other communicable diseases • Qliksense – performance information • Population Needs Assessment and Area Plan developed by the RPB
Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*	
RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL	

Action	Responsible Officer	Deadline	Progress	Implementation Status (RAG)
Area plan is being refreshed through the RPB	**Roxanne Green**			
Population health management – test and learn using segmentation and risk stratification using linked data to target resource	**Bevleigh Evans**	**September 2023**	**On track for linked data of managed practice by end of March 2023**	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map

Evidence of Controls (mitigations to manage risk)	1st Line of Defence (Operational)	2nd Line of Defence (Organisational)	3rd Line of Defence (Independent)	Overall Assurance (RAG rated)	Gaps in Assurance
Health Board IMTP 2022/23		**X**			

Population Needs Assessment – completed by RPB			**X**		
Area Plan – outcome of the Population Needs Assessment			**X**		
Gwent Public Service Board – targets population Health prevention					
Marmot Region Programme		**X**			

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance.*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR033 Director of Planning and Performance

KEY:		
Priority 1	• Every Child has the Best Start in Life	X
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	X
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety • Partnership First • Research, Innovation, Improvement, Value • Workforce & Organisational Development • Finance • Digital, Data, Intelligence • Estate • Regional Solutions • Governance	

Assurance/Oversight Committee:
Finance and Performance Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: *Widespread harm to Health Board staff and patients*

Due to: *Failure to comply with the full set of civil protection duties (2004).*

Likelihood of Current Occurrence: *3 = Possible - Might happen or recur occasionally*

Impact if Occurred: *Significant impact on patient and staff safety, reduced levels of patient quality, outcomes and experience, decreased public confidence, potential reputational damage to the Board.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X - risk appetite - low (averse to risk)		
		X – target score		
			X – capacity score **X – current score**	

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)	Consequence:

Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophi
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
4	***5***	***4***	***5***	***3***	***3***
20		***20***		***9***	

Justification for Risk Appetite and Risk Capacity Level & Target Score:
In relation to patient quality, safety and outcomes, the Health Board risk appetite level is low (adverse to risk).
The capacity level is level at which the Health Board can tolerate the risk and is therefore the inherent risk score.

	The target score of 9 demonstrates that although the impact of the risk being realised cannot be managed to below 3, the likelihood could be reduced to 3 if the Health Board can develop a major incident plan and relevant Business Continuity Plans and Action Cards. ***Risk Trend:*** *Maintained* **Current Controls:** • Health Board Major incident plan • Local/Divisional action cards • Civil Contingencies Act (2004) – this is being revised later this year and an update to the Health Board will be communicated in due course. • Health Board Pandemic plan – currently being developed by the Emergency Planning Team and would replace previous plans

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of	**Andy Goodenough/Wendy Warren**	**Ongoing**	This work continues to progress although service pressures is delaying BCM activity.	

the organisation, conduct BIA's develop plans, exercise, review, to mitigate the risks and threats to service delivery.				
The EPRR team will plan to conduct an audit of all service BC plans set against the current high level risk area of a loss to network applications/functions. This will provide data that will provide the HB with snapshot of engagement in the BC process and where gaps exist. The desired outcome will be targeted engagement and develop with areas that require support.	**Andy Goodenough/Wendy Warren**	**Sept 2022**		
Development of Pandemic Plan	**Wendy Warren**	**April 2023**	**Plan is being developed but requires Health Board ratification and endorsement.**	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with*

clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map					
Evidence of Controls (mitigations to manage risk)	**1st Line of Defence (Operational)**	**2nd Line of Defence (Organisational)**	**3rd Line of Defence (Independent)**	**Overall Assurance (RAG rated)**	**Gaps in Assurance**
Health Board Major Incident Plan		**X**			
Testing programme of Business Continuity Plans	**X**				A programme plan to be developed to see at a glance, in what areas further strengthening is required.
Review of revised Civil Contingency Act anticipated later this year to determine the impact on the Health Board.			**X**		Not received as yet and out of Health Board control.
Development of Pandemic Plan		**X**			Not yet finalised however, plans in place to drive progress and gain Health Board endorsement.
Regular liaison with Gwent Local Resilience Forum (Strategic and Tactical)		**X**			

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Programme plan to be developed to address the weaknesses in business continuity planning.	**Andy Goodenough**	**Q2 2023**		

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR016 Director of Finance, Procurement and Value

KEY:		
Priority 1	• Every Child has the Best Start in Life	
Priority 2	• Getting it Right for Children and Young Adults	
Priority 3	• Adults in Gwent Live Healthily and Age Well	
Priority 4	• Older Adults are Supported to Live Well and Independently	
Priority 5	• Dying Well as part of Life	
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	
	• Workforce & Organisational Development	X X
	• Finance	X
	• Digital, Data, Intelligence	
	• Estate	
	• Regional Solutions	
	• Governance	X

Assurance/Oversight Committee:
Finance and Performance Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: *Failure to achieve financial balance at end of 2022/2023.*

Due to: *Operational pressures and uncertainties caused by -*

- *the COVID-19 Pandemic,*
- *acute emergency and urgent care pressures,*
- *delayed transfers of care*
- *the elective delivery targets.*
- *Non-delivery of transformation plans for improved efficiency.*
- *and potential significant cost of the organisational response to the above key pressures and risks, above IMTP 22/23 – 24/25 planned levels.*

Likelihood of Current Occurrence: *4 = Likely - Will probably happen/recur but it is not a persisting issue*

Impact if Occurred: Breach of Standing Orders, Standing Financial Instructions, potential public confidence and reputational damage and fragmented relationships with Welsh Government.

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X - risk appetite - low (averse to risk)		
			X – target score	
			X – current score	**X – capacity score**

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
5	***4***	***4***	***4***	***3***	***4***
20		***16***		***12***	

Justification for Risk Appetite and Risk Capacity Level & Target Score: The rationale for a low-risk appetite is fundamentally due to the Health Board's obligation to ensure its Statutory Duties are not breached. The capacity level is the level at which the Health Board first identified the risk, and the target score is informed through previous management of this risk and other similar risks.

	The current and historical funding for the Health Board to operate services effectively has been provided through a mix of recurrent and non-recurrent allocations. The operating costs have generally all been recurrent and continue to be. Thus, based on this pattern, there is a residual recognition that there will be tension and risk to the long-term financial plan. ***Risk Trend:*** *Maintained* **Current Controls:** • Health Board IMTP 2022/23-24/25 • Standing Financial Instructions (SFIs) • Health Board Standing Orders • FCP Budgetary control • Budget holder training • Audit reviews • 22/23 savings plans & opportunities. • Regular monitoring at Executive Team reviewing level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. • Health Board financial escalation processes. • Health Board Pre-Investment Panel (PIP) process. • IMTP Delivery Framework and Divisional Assurance meetings in place which will incorporate implementation of savings plans and delivery of service and workforce plans within available resources. • Financial assessment and review (as agreed at Board, regular financial reports to Board, FPC and Welsh Government) to incorporate financial impact of COVID-19 and other key costs. • Quarterly financial budget plan approach agreed.
Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*	

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
IMTP Financial Plans submitted to Welsh Government include financial consequences of Core service delivery, COVID-19 response and exceptional national cost pressures (Energy) as part of ongoing discussions to secure additional funding.	**DoFPV**		**Completed**	
Quarterly budget setting process established with Board.	**DoFPV**		**Completed**	
Executive team agreed internal financial recovery turnaround focus to manage risks to achievement of financial balance.	**DoFPV**		**Completed**	
Efficiency Opportunity Compendium developed and circulated.	**DoFPV**		**Completed**	
As new priorities emerge service, workforce and financial plans developed	**DoFPV**		**Completed**	

to identify financial risks and support funding discussions with Welsh Government (e.g. mass vaccination programme).				

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map

Evidence of Controls (mitigations to manage risk)	1st Line of Defence (Operational)	2nd Line of Defence (Organisational)	3rd Line of Defence (Independent)	Overall Assurance (RAG rated)	Gaps in Assurance
Standing Orders and Standing Financial Instructions established as the key control framework	**X**				
Scheme of Delegation		**X**			

Financial Control Procedures		**X**			
Internal and External Audit Reports			**X**		Accountability mechanisms need to be more focussed on budgetary control delivery.
Board and Committee Structures and ToR for monitoring Health Board business.		**X**			
Executive groups and structures established to deliver statutory duties.		**X**			Greater focus required on services, workforce and financial plans all balancing to achieve financial sustainability.

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Long term, short term financial recovery to be established as a priority and structure.	**DoFPV**	**31st March 2023**	**Established**	
Revise accountability arrangements being	**CEO**	**31st March 2023**	**Work in progress**	

progressed as part of Executive governance.				
Revised budget management arrangements to be established for 2023/24 including new budget setting methodology and savings targets allocation.	**CEO/DoFPV**	**31st March 2023**	**Completed**	

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR032 Director of Finance, Procurement and Value

KEY:		
Priority 1	• Every Child has the Best Start in Life	
Priority 2	• Getting it Right for Children and Young Adults	
Priority 3	• Adults in Gwent Live Healthily and Age Well	
Priority 4	• Older Adults are Supported to Live Well and Independently	
Priority 5	• Dying Well as part of Life	
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	
	• Workforce & Organisational Development	X X
	• Finance	X
	• Digital, Data, Intelligence	
	• Estate	
	• Regional Solutions	
	• Governance	X

Assurance/Oversight Committee: Finance and Performance Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: *Non-achievement of the Health Board's long-term financial strategy.*

Due to: *Ongoing service pressures, under-achievement of recurrent savings and efficiency delivery and investments not supported with recurrent funding sources. Transformation Plans not delivering sustainable solutions in line with expected timelines.*

Likelihood of Current Occurrence: *4 = Likely - Will probably happen/recur but it is not a persisting issue*

Impact if Occurred: *Breach of statutory duty, reputational damage, lack of public confidence, further risk of decreased funding and non-compliance with Health Board Standing Orders, Standing Financial Instructions and other regulatory duties.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X - risk appetite - low (averse to risk)		
			X – target score	
			X – current score	
			X – capacity score	

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
5	***4***	***4***	***4***	***3***	***4***
20		***16***		***12***	

Justification for Risk Appetite and Risk Capacity Level & Target Score: The rationale for a low-risk appetite is fundamentally due to the Health Board's obligation to ensure its Statutory Duties are not breached. The capacity level is the level at which the Health Board first identified the risk, and the target score is informed through previous management of this risk and other similar risks.

	The current and historical funding for the Health Board to operate services effectively has been provided through a mix of recurrent and non-recurrent allocations. The operating costs have generally all been recurrent and continue to be. Thus, based on this pattern, there is a residual recognition that there will be tension and risk to the long-term financial plan. ***Risk Trend:*** *Maintained* **Current Controls:** • Health Board Standing Orders • Financial Control Procedures • 22/23 savings plans & opportunities. • Regular monitoring at Executive Team reviewing level of deliverable recurrent savings along. • Health Board financial escalation processes. • Health Board Pre-Investment Panel (PIP) process. • Focus in IMTP planning process. • Health Board IMTP 2022/23-24/25 • Standing Financial Instructions (SFIs)

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
IMTP Financial Plans submitted to Welsh Government include financial plan for 3 years	**DoFPV**	**March 2022**	**Submitted 31st March 2022 and approved by Welsh Government.**	

and recurrent improvement of underlying position.				
Transformation Programme approach to long term financial recovery and sustainability.	**Executive Team**	**Ongoing**	**Programme approach is being revised due to lack of delivery.**	
Executive team agreed internal financial recovery turnaround focus to manage risks to achievement of financial balance – including recurrent opportunities.	**DoFPV**	**Ongoing**	**Progress £16m savings plan expected to be delivered by 31st March 2023.**	
As new priorities emerge service, workforce and financial plans need to demonstrate efficiency and value improvement for future sustainability.	**DoFPV**	**Ongoing**	**Pre-Investment Panel (PIP) process to be refreshed for greater compliance.**	
Prioritisation process being developed for investment decisions.	**CEO**	**Draft proposal being reconsidered.**	**This will be established as part of ongoing discussions with the Board.**	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with*

clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map					
Evidence of Controls (mitigations to manage risk)	**1st Line of Defence (Operational)**	**2nd Line of Defence (Organisational)**	**3rd Line of Defence (Independent)**	**Overall Assurance (RAG rated)**	**Gaps in Assurance**
Standing Orders and Standing Financial Instructions established as the key control framework	**X**				
Scheme of Delegation		**X**			
Financial Control Procedures		**X**			
Internal and External Audit Reports			**X**		Accountability mechanisms need to be more focussed on budgetary control delivery.
Board and Committee Structures and ToR for monitoring Health Board business.		**X**			
Executive groups and structures established to deliver statutory duties.		**X**			Greater focus required on services, workforce and financial plans all balancing

					to achieve financial sustainability.

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Long term, short term financial recovery to be established as a priority and structure.	**DoFPV**	**31st March 2023**	**Established**	
Revise accountability arrangements being progressed as part of Executive governance.	**CEO**	**31st March 2023**	**Work in progress**	
Revised budget management arrangements to be established for 2023/24 including new budget setting methodology and savings targets allocation.	**CEO/DoFPV**	**31st March 2023**	**Completed**	

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR042 Interim Director of Primary, Community and Mental Health Services

KEY:		
Priority 1	• Every Child has the Best Start in Life	X
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	
Priority 4	• Older Adults are Supported to Live Well and Independently	
Priority 5	• Dying Well as part of Life	
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	
	• Workforce & Organisational Development	X
	• Finance	
	• Digital, Data, Intelligence	
	• Estate	
	• Regional Solutions	X
	• Governance	X

Assurance/Oversight Committee: Audit, Risk and Assurance Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

X		

Risk of: Inability to provide adequate quality of care to asylum seekers, migrants populations and Unaccompanied Children Asylum Seekers (UCAS)

Due to: Expected increase in numbers of asylum seeker arrivals and resettlement of refugees to the Health Board area.

Likelihood of Current Occurrence: *3 = Possible - Might happen or recur occasionally*

Impact if Occurred: *Adverse impact on the capacity of the Health Inclusion Service (HIS) Team, within the Primary and Community Services Division, possible depletion of the Health Board Testing Team to address resource/workforce challenges. Reputational, public confidence, compliance, patient safety, experience, and outcomes, financial*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

			X – target score	
		X – risk appetite – moderate, cautious risk taking		
				X – current score
				X – capacity score

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)	Consequence:

Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophi
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
5	***5***	***4***	***5***	***2***	***4***
25		***20***		***8***	

Justification for Risk Appetite and Risk Capacity Level & Target Score:
A moderate level risk appetite has been applied to this specific risk in relation to the potential significant consequence to the Health Board and the migrant population, should the risk materialise. However, the Health Board would need to ***ACCEPT*** *and* ***TOLERATE*** *a level of risk due to the geopolitical position being beyond the Health Board's control, noting that the target score of (2x4)8 remains within the risk capacity level of (5x5)25.*

	To provide robust assurance to the Board that the Health Board is effectively managing this risk, the controls in place have been listed within this risk assessment and an internal assessment as to the level of effectiveness of these controls, has been undertaken. **Current Controls:** • Weekly tactical meetings with Gwent Police and Newport City Council • Wales Strategic Migrant Partnership Meeting • Regular update reporting to Executive Committee as required. • Internal HB policies procedures • Welsh Government has published Refugee and asylum seeker plan (nation of sanctuary) | GOV.WALES and there are several Welsh Health Circulars and PHW guidance on responding to the health need of asylum seeker and refugees • Initial assessment following arrival and ideally within 24 hours. • Comprehensive 'Blue Book' health assessment • Health visitor drop-in sessions • Mental health support • Health screening for Blood Borne Viruses and Tuberculosis • GMS registration and provision via a Direct Enhanced Service including the catch up of scheduled immunisation • COVID-19/influenza vaccinations if required • Urgent Primary Care at RGH to provide urgent care appointments to reduce the pressure on GP practices.

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**

None identified by the Division				

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map

Evidence of Controls (mitigations to manage risk)	1st Line of Defence (Operational)	2nd Line of Defence (Organisational)	3rd Line of Defence (Independent)	Overall Assurance (RAG rated)	Gaps in Assurance

Weekly tactical meetings with Gwent Police and Newport City Council	**X** Meetings continue to take place and actions are recorded and tracked for progress				No gaps in assurance have been identified.
Wales Strategic Migrant Partnership Meeting		**X** Health Board representation secured at meetings and reporting by exception through monthly Divisional Assurance meetings to the Executive Risk Owner			No gaps in assurance have been identified.
Regular update reporting to Executive Committee as required.	**X** Items reserved on agendas in readiness for exception reporting				No gaps in assurance have been identified.
Internal HB policies procedures	**X** A specific Enhanced Service Level Agreement has been developed for asylum seekers with				No gaps in assurance have been identified.

	independent contractors and GMS colleagues				
Welsh Government has published Refugee and asylum seeker plan (nation of sanctuary) | GOV.WALES and there are several Welsh Health Circulars and PHW guidance on responding to the health need of asylum seeker and refugees			**X**		The Health Board would need to establish mechanisms to monitor and review compliance with external sources of legislation and guidance. The outcome of which should be reported regularly through the organisation.

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance.*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
To ensure the Health Board has effective mechanisms to monitor and review compliance with external sources of legislation and guidance, a Health Board wide programme structure will be established. It is proposed that this could be adapted from the	**William Beer/Chris O'Connor**	**Q1 2023**	**Escalation process in place however recognition that strengthened reporting and governance structures would benefit the position.**	

arrangements in place for the Ukrainian Resettlement programme. This will ensure that all services involved have the right resources in place (skills and capacity) to respond and that there is a collective, organisational responsibility for meeting the needs of this vulnerable group.				

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR027 Director of Public Health

KEY:		
Priority 1	• Every Child has the Best Start in Life	X
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	X
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	
	• Workforce & Organisational Development	X X
	• Finance	X
	• Digital, Data, Intelligence	
	• Estate	
	• Regional Solutions	
	• Governance	

Assurance/Oversight Committee: Patient, Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TOLERATE

Overall Level of Assurance (RAG):

	X	

Risk of: New COVID variants emerging
Due to: Significant and sustained spread of disease culminating in the effectiveness of COVID-19 vaccination and booster programme being compromised.
Likelihood of Current Occurrence: *4 = Likely - Will probably happen/recur but it is not a persisting issue*

Impact if Occurred: Potential impact on ability to staff services appropriately, also leading to widespread disease and harm in communities, eventually impacting on Health Board services, Primary, Secondary and Tertiary).

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X - risk appetite - moderate (cautious risk taking)		
				X – current score **X – target score**
				X – capacity score

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophi
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
5	***5***	***4***	***5***	***4***	***5***
25		***20***		***20***	

Justification for Risk Appetite and Risk Capacity Level & Target Score: *The risk appetite level for this risk is set at moderate level recognising that there are several factors related to this risk which are out of the Health Board control.*

The risk capacity is set at maximum (5x5)25 as this is the level at which the Health Board tolerated the risk when it was first identified.

	*The risk target score is in alignment with the current risk score; therefore, the Board is requested to **TOLERATE** this risk above risk appetite but in line with target score, recognising it is being managed within the capacity limits.* ***Risk Trend:** Maintained.* **Current Controls:** • Continuation of data, surveillance, and monitoring activities to inform any deterioration from 'Covid Stable' to 'Covid Urgent' (as per WG national policy), as could be triggered by emergence of a new variant and initiate standing up of IMT arrangements as necessary. • Development of Health Board Public Health Plan (to supersede the previous Pandemic Plan) • Health Board Vaccination Programme

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of* ***operational***, ***organisationa****l and* ***independent*** *assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

Criteria to consider*: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map					
Evidence of Controls (mitigations to manage risk)	**1st Line of Defence (Operational)**	**2nd Line of Defence (Organisational)**	**3rd Line of Defence (Independent)**	**Overall Assurance (RAG rated)**	**Gaps in Assurance**

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR004 Director of Public Health

KEY:		
Priority 1	• Every Child has the Best Start in Life	X
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	X
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	
	• Workforce & Organisational Development	X X
	• Finance	X
	• Digital, Data, Intelligence	
	• Estate	
	• Regional Solutions	
	• Governance	

Assurance/Oversight Committee: Audit, Risk and Assurance Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

		X

Risk of: Failure to comply with the Well Being of Future Generations Act

Due to: Inability to undertake the actions required to achieve compliance.

Likelihood of Current Occurrence: *4 = Likely - Will probably happen/recur but it is not a persisting issue*

Impact if Occurred: *Reputational, Financial, Workforce, Quality, Resilience, non-compliance could result in an over reliance on Health Board services for future population.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

			X – target score	
			X – current score	
		X - risk appetite - moderate (cautious risk taking)	**X – capacity score**	

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	Frequency:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
3	***4***	***2***	***4***	***1***	***4***
12		***8***		***4***	

Justification for Risk Appetite and Risk Capacity Level & Target Score: *The risk appetite level for this risk is set at moderate level recognising that there are several factors related to this risk which are out of the Health Board control but can provide opportunistic risk taking.*

	The risk capacity is set at (3x4)12 as this is the level at which the Health Board tolerated the risk when it was first identified. *The risk target score is (1x4)4 and reflects the Health Board's ambition to ensure objectives set out within the Act, become embedded and integral to all Health Board decision making.* *The Board is asked to note that although the risk is not currently being managed within its agreed risk appetite level, the agreed tolerance level for this risk can be flexed in consideration of the environment within which the Health Board is currently operating and taking into consideration the residual impact of the COVID pandemic.* ***Risk Trend:*** *Escalated February 2023.* **Current Controls:** • Programme Board in place to ensure the duties in the WBFGA are applied across the organisation. • Each Division has developed and agreed wellbeing objectives which have been signed off by Board and published. • Organisational wellbeing objectives and PSB(s) wellbeing objectives reflected within the IMTP and Divisional Plans

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
None identified by the Division				

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map					
Evidence of Controls (mitigations to manage risk)	**1st Line of Defence (Operational)**	**2nd Line of Defence (Organisational)**	**3rd Line of Defence (Independent)**	**Overall Assurance (RAG rated)**	**Gaps in Assurance**

Programme Board in place	**X** Programme Board meetings taking place.				Gaps identified in assurances - Post pandemic review of management arrangements necessary to assess current position.
Divisional well-being objectives in place	**X** Divisional plans contain well-being objectives.				Gaps identified in assurances - Post pandemic review of management arrangements necessary to assess current position.
PSB and organisational well-being objectives reflected in IMTP and Divisional plans	**X** IMTP records Health Board's well-being objectives. Progress in meeting well-being objectives publicly reported annually.	**X** IMTP Annual Report			Gaps identified in assurances - Post pandemic review of management arrangements necessary to assess current position.

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**

The post pandemic review, which is noted above, is intended to address current gaps in assurance regarding the effectiveness of existing controls.	**Stuart Bourne**	**March 2023**	Currently being undertaken by the ABUHB Public Health Team.	

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR012 Director of Public Health

KEY:		
Priority 1	• Every Child has the Best Start in Life	X
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	X
Priority 5	• Dying Well as part of Life	X
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	
	• Workforce & Organisational Development	X X
	• Finance	X
	• Digital, Data, Intelligence	
	• Estate	
	• Regional Solutions	
	• Governance	

Assurance/Oversight Committee: Partnerships, Population Health and Planning Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: Increased dependency on Health Board services in the longer term.

Due to: Inability to address health inequalities across the population including adequate access to appropriate Health Board Services

Likelihood of Current Occurrence: *4 = Likely - Will probably happen/recur but it is not a persisting issue*

Impact if Occurred: *Creation of demand in specific areas of Gwent, leading to inequity of service provision, stretched capacity in some areas, poor patient outcomes and experience, poorer financial outcomes, less ability to innovate, reputational damage.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

			X – target score	
	X - risk appetite – low -adverse to risk		**X – current score**	
			X – capacity score	

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
4	***4***	***3***	***4***	***1***	***4***
16		***12***		***4***	

	Justification for Risk Appetite and Risk Capacity Level & Target Score: *The risk appetite level for this risk is set at low/adverse to risk level due to the risk of poorer patient outcomes and experience.* *The risk capacity is set at (4x4)16 as this is the level at which the Health Board tolerated the risk when it was first identified.* *The risk target score is (1x4)4 and reflects the Health Board's ambition to ensure objectives and principles associated with becoming a 'Marmot region', are embedded and integral to all Health Board decision making for service delivery and prevention work.* ***Risk Trend:*** *Maintained.* **Current Controls:** • Sustainability Board established to monitor and report on all Primary Care GP Service sustainability. • New MDT model in place in a number of practices. • New model implemented in managed practices. • Work continues on managed practices, supported mergers and manager redistribution continues. • Oversight at Senior Management Team Meetings within Primary Care and Community Services. • Neighborhood Care Networks well established and plans in place and reviewed. • Continuous and regular monitoring of the development of 'Building a Fairer Gwent': Gwent Marmot Region at Committees, Executive Team and the Board.

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Gwent Marmot Region leadership event held on 21st Oct 2022.	**Director of Public Health**	**Oct 2022**	**Event held.**	
Gwent PSB draft Well-being Plan includes creating a fairer, more equitable and inclusive Gwent as one of two strategic objectives. The Well-being Plan also includes a specific step to 'Take action to address inequities, particularly in relation to health, through the framework of the Marmot Principles'. Plan to be approved by PSB in June'23.	**Director of Public Health**	**Jun 2023**	**In progress**	
PSB Well-being Plan delivery plan(s) to be informed by the findings of the Institute of Health Equity Gwent Marmot Region report.	**Director of Public Health**	**Jun 2023**	**In progress**	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of* ***operational***, ***organisationa****l and* ***independent*** *assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

Criteria to consider*: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map

Evidence of Controls (mitigations to manage risk)	1st Line of Defence (Operational)	2nd Line of Defence (Organisational)	3rd Line of Defence (Independent)	Overall Assurance (RAG rated)	Gaps in Assurance
Priorities for population health described in ABUHB plans		**X IMTP**			The extent to which services are provided according to need is unclear

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR025 Director of Workforce and OD

KEY:		
Priority 1	• Every Child has the Best Start in Life	X
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	
Priority 5	• Dying Well as part of Life	
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	
	• Workforce & Organisational Development	
	• Finance	
	• Digital, Data, Intelligence	
	• Estate	
	• Regional Solutions	X
	• Governance	X
		X

Assurance/Oversight Committee:

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

		X

Risk of: **A negative impact on absenteeism and could result in long term sickness with PTSD & other forms of emotional traumatisation.**

Due to: **Lack of mental and psychological staff preparedness**

Likelihood of Occurrence: *4 – Likely* **-** *Will probably happen/recur but it is not a persisting issue*

Impact if Occurred: High work-related industrial injury claims and compensation pay-outs. High sickness absence rates and impacts on financial backfill costs

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X – low risk appetite **X target score**		
		X current score **X capacity score**		

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Rare - Will probably never happen/recur	**Not for years**	**1**	**2**	**3**	**4**	**5**
2 Unlikely - Do not expect it to happen/recur but it is possible	**At least annually**	**2**	**4**	**6**	**8**	**10**
3 Possible - It might happen/recur occasionally	**At least monthly**	**3**	**6**	**9**	**12**	**15**
4 Likely - Will probably happen/recur, but is not a persisting issue	**At least weekly**	**4**	**8**	**12**	**16**	**20**
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	**At least daily**	**5**	**10**	**15**	**20**	**25**

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
4	***3***	***4***	***3***	***2***	***3***
12		***12***		***6***	

	Justification for Risk Appetite and Risk Capacity Level & Target Score: Risk appetite in this area is low in the interests of staff wellbeing, retention and an inability to safely staff the service capacity required to meet patient needs. ***Risk Trend:*** *Maintained.* **Current Controls:** • Monitoring Framework to support roll out of the People Plan • Monitoring delivery of the #PeopleFirst project through Executive Team reports, KPI sickness metrics underpinned by People Plan Delivery Framework. Engagement ongoing with divisional management teams • Monitoring of absence, reasons for absence and trends in referrals to Occupational Health and Employee Well-being Service through Workforce Performance Dashboard. • Dashboard reported to Executive Team, TUPF and LNC colleagues and People and Culture Committee with regular summary of Well-being and Occupational Health activity. • Quarterly Staff Well-being Surveys for staff in progress. • Ministerial Measure 24 -Demonstrate an annual improvement in the overall staff engagement score Ministerial measure 25: Demonstrate an annual improvement in the % of staff who report that their line manager takes a positive interest in their health and well-being. • Ministerial Measure No 27: Demonstrate a 12-month reduction trend in the % of sickness absence rate of staff. • Monitoring referrals to Employee Wellbeing Services

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Continue to work with other Health Boards and Trust in NHS Wales (recent work with WAST & Powys delivering well-being webinars).	**Sarah Simmonds**	**Ongoing**	Consider scale up collaborative opportunities for the region via Regional Partnership Board. RPB has recently agreed to offer £10K from the winter support fund this will help us fund additional Staff Counsellor time until end of March 23. Recent funded work with WAST & proposed work with Shared Services, HPMA Wales, and HEIW).	
Implement and progress new Integrated Psychological Well-being roles and peer support	**Sarah Simmonds**	**Ongoing**		

networks within divisions and hospital sites.				
Identify, training and develop Respect and Resolution advocates (similar to Mental Health first aiders)	**Sarah Simmonds**	**Ongoing**		
Train Mediators so there is team and organisational resilience and network.	**Sarah Simmonds**	**Ongoing**	New Mediators trained	
Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being	**Sarah Simmonds**	**Ongoing**	A new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being has been completed.	
Scope, design and deliver a programme of activity 'Healthy Working Day'.	**Sarah Simmonds**	**Ongoing**	Engagement with staff across different staff groups postponed to Feb/March 23 due to winter pressures	
Enhance our financial well-being offer	**Sarah Simmonds**	Initial documentation completed – ongoing updating	Information published below on 08 June 2022. Website signposts staff to: • Help Paying your Bills • Benefits, Grants and Tax Relief	

			• HMRC Support • Support from Councils • Staff discounts • Support on budgeting • Mental Health Support • Getting food on the table. Agreed as an interim to increase canteen subsidiaries on canteen food agreed.	
Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate.	**Sarah Simmonds**		**TBC**	
Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management.	**Sarah Simmonds**	**Ongoing**	Continue availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. Psychologists from the Wellbeing Service continue to offer expert	

			support to teams though this has needed to be rationalized to supporting Teams which are most likely to utilize the resource, not just those struggling.	
The Avoidable Employee Harm Programme was launched on 5th July 2022 initially focusing on HR processes it will then look to other formal processes that inadvertently cause harm to all those involved and the organisation. The training day that supported the launch has evaluated very well and organisations beyond ABUHB are keen to engage. Within ABUHB we have subsequently seen a >60% reduction in gross misconduct investigations.	**Sarah Simmonds**	**Ongoing**	Working with University partners, and national leaders (The Kings Fund) on participation and development of research projects aligned to Aneurin Bevan Wellbeing including: Avoidable Employee Harm and, Factors that inhibit middle managers to raise concerns. The Avoidable Employee Harm Programme was launched on 5th July 2022 initially focusing on HR processes it will then look to other formal processes that inadvertently cause harm to all those	

			involved and the organisation. The training day that supported the launch has evaluated very well and organisations beyond ABUHB are keen to engage. Within ABUHB we have subsequently seen a >60% reduction in gross misconduct investigations.	
Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19.	**Sarah Simmonds**	**Ongoing**	Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19. Interim Occupational Health provision agreed to improve sustainability within the service	
Reviewed Occupational Health provision and consider options to improve sustainability	**Sarah Simmonds**	**Ongoing**	**Activity** • 413 Pre-placement Health questionnaires receiving	

within the service, paper drafted			• 154 staff referrals into service • 56 appointments attended • 823 phone calls received • Top reasons for referrals: Stress and Anxiety, MSK and Psychological	
launch and assess Employee Wellbeing survey	**Sarah Simmonds**	**Ongoing**	The results of the survey show that staff wellbeing has fallen again slightly (when asked about fatigue and coping) since the spring 2022 survey. Whilst this is similar to many NHS organisations at this time, our executive and senior management teams will be using your feedback to inform the decisions they are making in relation to steps we can take now - and in the future - to improve our wellbeing offer for staff, and ultimately your experience of work.	

			At the same time, the survey also reported a significant number of those who completed it feeling a stronger sense of belonging. We will be working with divisions and teams to discuss how the survey findings relate to them and discuss strategies to support wellbeing.	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

Criteria to consider: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?

Assurance Map

Evidence of Controls (mitigations to manage risk)	1st Line of Defence (Operational)	2nd Line of Defence (Organisational)	3rd Line of Defence (Independent)	Overall Assurance (RAG rated)	Gaps in Assurance
People plan Performance dashboard		Monthly sent to senior management			No gaps in assurance identified
People plan tracker		Monthly reporting to the WOD senior Management team			No gaps in assurance identified
People Plan updates		Quarterly reports to the People and Culture Committee			No gaps in assurance identified
Divisional Strategies to support Wellbeing based on survey results	**TBC**				Meetings with Divisions ongoing
Reports to Trade Union Partnership					No gaps in assurance identified

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance.*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Meet with Divisions to review and update strategies with key issues highlighted from results of wellbeing survey	Adrian Neal	June 2023	Meetings with Divisions Management Teams are ongoing. They have all received direct feedback from the December 2022	

			survey and are engaged in the design and distribution of the Summer 2023 Survey.	

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR021 Director of Workforce and OD

KEY:		
Priority 1	• Every Child has the Best Start in Life	X
Priority 2	• Getting it Right for Children and Young Adults	X
Priority 3	• Adults in Gwent Live Healthily and Age Well	X
Priority 4	• Older Adults are Supported to Live Well and Independently	
Priority 5	• Dying Well as part of Life	
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	
	• Workforce & Organisational Development	X
	• Finance	
	• Digital, Data, Intelligence	X
	• Estate	X
	• Regional Solutions	X
	• Governance	

Assurance/Oversight Committee:

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

		X

Risk of: Inability to comply with the Welsh Language Standards as a result of the Welsh Language (Wales) Measure 2011, which will mean that Welsh speakers will not be able to receive services in their language of choice.

Due to: Ensuring Welsh Language is considered in all aspects of the business of the organisation.

Likelihood of Occurrence:

Impact if Occurred: *Failure to meet compliance with the Welsh Language Act 2011, reputational damage, public confidence.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X Low risk appetite **X target score**		
		X current score **X capacity score**		

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
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3 Possible - It might happen/recur occasionally	**At least monthly**	**3**	**6**	**9**	**12**	**15**
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5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	**At least daily**	**5**	**10**	**15**	**20**	**25**

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
4	***3***	***4***	***3***	***2***	***3***
12		***12***		***6***	

	Justification for Risk Appetite and Risk Capacity Level & Target Score: There will need to be sustained effort to meet the standards set out. Risk appetite in this area is low in the interests of compliance with the Welsh Language Act. ***Risk Trend:*** *Maintained.* **Current Controls:** **The Welsh Language (Wales) Measure 2011 is the legislation that created the Welsh language standards.** Welsh language standards promote and facilitate the Welsh language and ensure that the Welsh language is not treated less favourably than the English language in Wales. • Monitoring Framework to support delivery of the People Plan 2022-25. • A Welsh Language Strategic Group which is an internal ABUHB group is in place. The role of this group is with the support from divisional representation, to mainstream the implementation of the standards. • Following the release of the new 'More Than Words' plan 2022-2027 by Welsh Government a paper went to board noting key actions for the Welsh Language Unit as well as KPI's for all other divisions. These will be communicated through meetings in the first quarter of 2023. • Monitoring of Job descriptions with Welsh as essential and desirable or learnt. • Internal auditing processes established - undertaken quarterly and reported to Strategic Group. • Mandating Welsh Language Competencies on ESR • Spot checks undertaken on documentation, phone lines, inspections on sites.

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Detailed action plan for the implementation of the standards to mitigate this risk.	Sarah Simmonds	Ongoing	Monitored through the Welsh Language Strategic Group	
Welsh Language Standards awareness activities including roadshows, training sessions, attendance at team and departmental meetings, attendance at Health Board events such as conferences, community events, joint community and staff language awareness training	Sarah Simmonds	Ongoing	A series of roadshows carried out around HB sites. Involvement in Nurse leadership, HCSW conference, leadership development programme.	
To develop a series of protocols and guidelines meet the requirements of the Standards	Sarah Simmonds	Ongoing	Many protocols have been developed with further protocols developed as required. Where appropriate	

			training and workshops are provided for groups or individuals.	
Work collaboratively with other Health Boards and Public Sector bodies to learn lessons, share best practice and develop all Wales challenges	Sarah Simmonds	Ongoing	New Welsh language managers network established to undertake this work (Dec 2022). ABUHB representative is the current vice chair.	
Continual revision and updating of the Welsh Language homepage with useful links and additional resources for staff	Sarah Simmonds	Ongoing	Sits as a responsibility of a member of staff within the Welsh language unit and is a standing agenda item on monthly team meetings	
Continued communication and engagement activities through a series of Frequently Asked Questions, national and local Welsh Language campaigns and the PartnerIaith network	Sarah Simmonds	Ongoing	Partneriaith networks continues to engage with Welsh language speakers. The FAQ's on Welsh pages of 'pulse' are monitored and updated. New mandatory course on Welsh language awareness launched 10th of March.	
To agree new arrangements and an SLA with BCUHB for translation services due	Sarah Simmonds	Ongoing	BCUHB are ready to begin SLA and contract has ended with bilingual Cardiff however awaiting	

to concerns raised regarding the quality of the current external provider			confirmation from procurement before being able to complete.	
Deliver a Welsh Language recruitment training scheme	Sarah Simmonds	Ongoing	Bilingual skills strategy is active, and workshops carried out with recruitment managers to ensure understanding and implementation.	
Introduce a revised Welsh Language Awareness training package	Sarah Simmonds	March 23	New module launched on ESR and is mandatory as of 10th of March.	
Ensure a robust and sustainable internal translation service	Sarah Simmonds	Ongoing	Internal translation service is established and is undertaking key project work to supplement that of the SLA	
Systematic review of Workforce & OD policies and frameworks to mainstream the Welsh Language in key policies and initiatives	Sarah Simmonds	Ongoing as policies reviewed in line with renewals procedure and timelines	All recruitment and HR policies are reviewed to ensure compliance. Policy for use of Welsh internally is undergoing review at present.	
Promote specific activities provided through the medium of Welsh so that Welsh	Sarah Simmonds	Ongoing	Engaging with community Welsh language networks to advertise activities	

speakers may choose to use them			through PartnerIaith network.	
Develop guidelines for agencies, contractors, and providers stating the requirements regarding the use of the Welsh Language in every business arrangement with the Health Board	Sarah Simmonds	Ongoing	Will review these during 2023.	
Redevelopment of Health Board's Language Skills Strategy and assessment matrix for assessing Welsh Language skills for vacant positions	Sarah Simmonds	Ongoing	Bilingual skills strategy is active, and workshops carried out with recruitment managers to ensure understanding and implementation.	
Provision of Welsh Language Mentor activities to ensure that performance, efficiencies and economies of scale are realised	Sarah Simmonds	Ongoing	Will be within the work stream of new Welsh Language Support Officer (starting May 2023)	
Develop improvement plans to ensure that services provided electronically for patients and the public, or which demand the use of Information Technology	Sarah Simmonds		Working in collaboration with DHCW to ensure that the Welsh language is embedded in any new technology created.	

for their administration are available to the same standard in Welsh and in English.				
Publish strategy review to evaluate 5-year Welsh Language Clinical Consultation plan – measures to sustain achieved actions over the past 5-year period and actions for the next 5-year period	Sarah Simmonds	September 22	Review has been penned and approved by director of WOD. On agenda of next Welsh language strategic group before going to Board	
Working collaboratively with Recruitment colleagues to populate a local level library of translated Job Descriptions.	Sarah Simmonds	Ongoing	This library now contains 150 fully bilingual Job Descriptions. Action plan to translate most widely used job descriptions as a priority	
Digital accredited and informal Welsh Language training packages	Sarah Simmonds	March 23	Packages are being offered to staff	
Develop a suite of written and digital resources for clinicians to raise awareness of the importance of the 'active offer' principle	Sarah Simmonds	Ongoing	On Welsh language unit homepage.	

Face-to-face workshops conducted with Welsh Language secondary school students	Sarah Simmonds		A calendar of workshops is in place with the support of Careers Wales with both Welsh language schools and colleges as well as Welsh learners.	
Continue communication and engagement activities through national campaigns (e.g., St David's Day, Dydd Miwsig Cymru, Diwrnod Shwmae, etc.).	Sarah Simmonds		Activities are being run collaboratively with other Health Boards in order to maximise their impact and share resources and ideas.	
Establish communication with hospital site leads to ensure active offer is displayed	Sarah Simmonds	Ongoing	In progress. Communication has been sent to leads to arrange meetings.	
More than just words – Develop ESR module and monitoring of Welsh language abilities on ESR	Sarah Simmonds	Ongoing	Compliance against self certification of Welsh language skills increased to 75% by end of 2022/23 reporting period, a significant increase from previous year. Module around More Than Just Words live as of 10th March 2023 and is mandatory for all staff.	

Develop a map of Welsh language abilities across the Health Board	Sarah Simmonds	Ongoing	Mapping exercise in process.	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

Criteria to consider: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?

Assurance Map

Evidence of Controls (mitigations to manage risk)	1st Line of Defence (Operational)	2nd Line of Defence (Organisational)	3rd Line of Defence (Independent)	Overall Assurance (RAG rated)	Gaps in Assurance
Report risks to People and Culture Committee Annual report, monitoring against targets and compliance against standards and complaints					No gaps in assurance have been identified.

Workforce monitoring Framework support People Plan reported monthly to WOD divisional day		Items reserved on agendas in readiness for exception reporting			No gaps in assurance have been identified.
Reporting structure locally to ensure actions are implemented		Meetings continue to take place and actions are recorded and tracked for progress			No gaps in assurance have been identified.
Welsh Language Strategic Group (Community of Practice) established across Wales to share good practice			Health Board Representation secured at meetings		No gaps in assurance have been identified.
Reporting framework in place for Welsh Language Commissioner			In place and reporting		No gaps in assurance have been identified.
WG monitoring framework – More than just words			In place and reporting		No gaps in assurance have been identified.
Internal Audits to map compliance		Regular audits undertaken on documentation and calls to ensure compliance			No gaps in assurance have been identified.
SLA in place to support translation of documentation/internal translation		Review and monitor translation capacity and activity			No gaps in assurance have been identified.

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance.*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Provision of Welsh Language Mentor activities to ensure that performance, efficiencies and economies of scale are realised	Sarah Simmonds	June 2023	New member of staff appointed to commence in May 2023 who will lead on the PartnerIAITH network.	
Establish communication with hospital site leads to ensure active offer is displayed	Sarah Simmonds	May 2023	Communication sent to identified leads to arrange mechanisms to ensure compliance	

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR041 Director of Workforce and OD

KEY:		
Priority 1	• Every Child has the Best Start in Life	
Priority 2	• Getting it Right for Children and Young Adults	
Priority 3	• Adults in Gwent Live Healthily and Age Well	
Priority 4	• Older Adults are Supported to Live Well and Independently	
Priority 5	• Dying Well as part of Life	
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	
	• Workforce & Organisational Development	X
	• Finance	
	• Digital, Data, Intelligence	
	• Estate	
	• Regional Solutions	
	• Governance	

Assurance/Oversight Committee:

Risk Decision (4Ts):

Overall Level of Assurance (RAG):

		X

Risk of: Failure to sustain current levels.

Due to: Industrial action following 2022/23 pay round and ballots.

Likelihood of Occurrence:

Impact if Occurred: *Adverse impacts on delivery of care for patients across acute and non-acute settings and non-compliance with safe staffing principles and standards.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X low risk appetite level	**X target score**	
				X current score
				X Capacity score

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
5	***5***	***4***	***5***	***2***	***4***
25		***20***		***8***	

	Justification for Risk Appetite and Risk Capacity Level & Target Score: Low level of risk appetite in relation to potential patient safety risks. ***Risk Trend:*** *Maintained.* **Current Controls:** • Section 234A of the Trade Union and Labour Relations (Consolidation) Act 1992; and • CODE OF PRACTICE Industrial Action Ballots and Notice to Employers • Under section 231 and 231A of the 1992 Act a union must, as soon as reasonably practicable after holding an industrial action ballot, take steps to inform all those entitled to vote18, and their employer(s), of the number of individuals entitled to vote in the ballot; the number of votes cast in the ballot. • Trade union partnership meetings • Business Continuity Processes - Redeployment Principles and Risk Assessment agreed. • Health Care Standards - Section 7 staffing and resources. • Operational planning, led by Director of Operations, to respond to implications of strikes action in other NHS organisations.

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**

Adopt a clear communications strategy	**Sarah Simmonds**	Completed and further updates provided	Industrial Action Guidance reviewed and implemented across Wales	
Services Business continuity plans in place	**Director of Operations**	Ongoing	• Operational planning, led by Director of Operations, to respond to implications of strikes action in other NHS organisations. • Emergency planning networks across Wales to consider emergency planning response. • Unknown position regarding future strike action based on revised pay offer	
All Wales training sessions provide by legal and risk to support industrial action	NWSSP and Health Boards		• National Workforce Group in regular contact to review and share lessons learnt from strike action.	
Ensure early identification of mandated Statutory, and	Director of Operations		Identified	

core critical clinical services				
Trade union provides a list of the categories of employee to which the affected employees belong, figures on the number of employees in each category, figures on the numbers of employees at each workplace, the total number of affected employees. Such information will enable the employer to readily deduce the total number of employees affected, the categories of employee to which they belong, the number of employees concerned in each of those categories, the workplaces at which the employees concerned work and the number of them at each of these workplaces.	Sarah Simmonds		Dependant on ongoing ballot and unions	

Reducing impact on patients - Support for early supported discharge prior to industrial action	Medical Director, Nursing Director, Therapy Director	Ongoing review	Plans in place, ongoing review pending outcomes of ongoing ballots	
Trade Unions specifies: (i) whether the union intends the industrial action to be "continuous" or "discontinuous" (14); and (ii) the date on which any of the affected employees will be called on to begin the action (where it is continuous action), or the dates on which any of them will be called on to take part (where it is discontinuous action).	Sarah Simmonds/Affiliated Trade Unions	Ongoing review	Plans in place, ongoing review pending outcomes of ongoing ballots	
Establish WOD hub with emergency planning – • Ensure early identification of mandated Statutory, and core critical clinical services. • Review of business continuity plans	Sarah Simmonds/Director of planning	Ongoing review	In place pending outcomes of ballots and staff numbers and services affected	

• Map services and staff provision and impacts of industrial action. • Assess variable pay usage in case of work to rule applies. • Assess current vacancies. • Working with partners in Gwent on a system wide basis • Implementation of business continuity plans • Communication plans				

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

Criteria to consider: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?

Assurance Map					
Evidence of Controls (mitigations to manage risk)	**1st Line of Defence (Operational)**	**2nd Line of Defence (Organisational)**	**3rd Line of Defence (Independent)**	**Overall Assurance (RAG rated)**	**Gaps in Assurance**
People and Culture Committee	**Sarah Simmonds**	**Quarterly**			No gaps in assurance reported
National Workforce Group	**Sarah Simmonds**	Monthly meetings with WOD representatives			No gaps in assurance reported
Industrial Operational Planning group	**Director of Operations**	Ongoing			No gaps in assurance reported
Emergency planning networks	**Director of Planning**	Ongoing			No gaps in assurance reported

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance.*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
No gaps in assurance reported				

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR002 Director of Workforce and OD

KEY:		
Priority 1	• Every Child has the Best Start in Life	
Priority 2	• Getting it Right for Children and Young Adults	
Priority 3	• Adults in Gwent Live Healthily and Age Well	
Priority 4	• Older Adults are Supported to Live Well and Independently	
Priority 5	• Dying Well as part of Life	
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	
	• Workforce & Organisational Development	X
	• Finance	
	• Digital, Data, Intelligence	
	• Estate	
	• Regional Solutions	
	• Governance	

Assurance/Oversight Committee:

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

		X

Risk of: **Adverse impacts on delivery of care for patients across acute and non-acute settings and non-compliance with safe staffing principles and standards.**

Due to: Failure to recruit, retain and develop staff across all disciplines and specialities.

Likelihood of Occurrence: 5 – almost certain -
Impact if Occurred:

- *Failure to recruit to Primary Care and Secondary care workforce to meet service requirements.*
- *High vacancies potentially drive higher variable pay costs.*
- *Increased workloads, reduced staff morale, staff wellbeing,*
- *recruitment and retention.*
- *Adverse impacts on delivery of care for patients across acute and non- acute settings and noncompliance with safe staffing principles and standards*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

		X low risk appetite		

			X target score	
			X current score	X – capacity score

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
5	***5***	***5***	***4***	***4***	***4***
25		***20***		***16***	

Justification for Risk Appetite and Risk Capacity Level & Target Score: There will need to be sustained effort to recruit and retain due to ongoing turnover and National skills shortages. Long lead in times for training for several professional groups.

Low level of risk appetite in relation to potential patient safety risks. However, in acknowledging that the target score is (4x4) 16, the Health Board accepts that this risk will never be managed to a low level as recruitment and retention will always be a significant risk to service sustainability and patient safety.

Risk Trend: Trends over the past 6 months has remained at current risk level. The risk appeared on the risk register March 2017.

Current Controls:

- Monitoring Framework to support roll out of the People Plan.
- Workforce Dashboard to track activity – recruitment, turnover, sickness absence.
- Supply and demand tracker (Nursing).

	• Nurse Strategic Workforce Group. • Daily sickness monitoring reports. • People Plan tracker to support delivery of actions within the People Plan 2022-25. • Health Care Support Worker tracker. • Agency Reduction Plan approved June 2022 and supported by Programme Board. • Management of attendance through All Wales Management Attendance at Work Policy. • Health Care Standards - Section 7 staffing and resources. • Nurse Staffing Levels (Wales) Act 201625b/25c. • Filled and unfilled shifts reports (RN). • Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e., RCP. • Support agile working delivering through Agile Programme Board. • Measurements of Wellbeing through the ABUHB Staff Survey. • Occupational Health and Wellbeing dashboards report KPIs. • Development of new roles to support vacancies. • Recruitment KPI's. • IMTP Educational Commissioning.

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Staff attendance - Continuing support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work.	Sarah Simmonds	Ongoing		
Staff attendance Absence "hot spot" areas identified and plans in place to support.	Sarah Simmonds	Ongoing	Divisional Action plans in place. Sickness absence rates reduced from December's figures. Continuing support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work.	

Recruitment - Engagement with national recruitment campaigns such as BAPIO, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW for Junior Doctor.	Sarah Simmonds	Ongoing	In place	
Recruitment - Annual programme of Apprentice recruitment	Sarah Simmonds	Ongoing	In place with 2 cohorts for up to 20 places per cohort	
Recruitment – Overseas Nursing (All Wales)	Sarah Simmonds	Completed for 2022/23	In place and 2022/cohort recruited. Potential to extend recruitment for 2023/24	
Recruitment – Development of nursing strategy	Jennifer Winslade/Sarah Simmonds	Due to for completion March 23	In development and due to be presented to the Executive Committee	
Recruitment – Streamlining and improve recruitment timescales through recruitment modernisation programme (started Oct 22)	Sarah Simmonds	Ongoing	1st phase implemented	
Recruitment	Sarah Simmonds	Ongoing	In place	

Partnerships with employability schemes such as Kickstart and Restart.				
Recruitment : Actively working with Local Authorities to promote joint recruitment activities.	Sarah Simmonds	Ongoing	Draft joint initial recruitment form has been developed across LA's and being piloted. In terms of apprenticeships, research and papers presented to Gwent workforce Board. To commence initial pilot in Newport Mapped non-clinical routes for ABUHB and drafted report to support Gwent Workforce Strategy and recruitment initiative. Increased interns 22-23	
Retention: Development of career pathways (e.g., non-clinical to clinical).	Sarah Simmonds	Ongoing	HCSW group established to support education development of HCSW. HCSW education group in place Turnover currently for HCSW is 11.18%	
Retention: Retention engagement chat cafes providing information and support for key topics such as Agile Working, Learning	Sarah Simmonds	Ongoing	Regular retention Cafe's attendance at hospital sites to gain staff perceptions. Retention meetings	

and Development, Wellbeing Activity, Occupational Health and Complex HR			are planned for 24 Feb (NHH); 27 March. (St Cadocs); 20 April (YFF). Further ones throughout the year and details will be available on our intranet.	
Retention: Internal Exit interview group has been established with a view to 1) Increase the numbers of people completing the forms and 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts.	Sarah Simmonds	Ongoing	In place and reporting	
Agency reduction plan in place to monitor and review all agency, bank pay incentives supply and demand.	Sarah Simmonds	Ongoing	In place to reduce all off-contract agency RN and contract agency for HCSW and FM staff	
Development of alternative and new roles - Continued implementation of new roles such as Physician Associates, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP.	Sarah Simmonds	Ongoing	Physician Associates implemented in POCU and workshop March to assess the role of PA's in supporting sustainable workforce options. Compendium of New Roles captures all new roles and extended roles.	

			Reporting of new roles through IMTP process to HEIW and WG	
Primary Care workforce The Regional Integrated Fund (RIF) Workforce Programme is in development to support the wider health and social care staffing issues as required in Healthier Wales. Gwent Workforce Board is being tweaked to support scaling up of initiatives and pace.	Sarah Simmonds	Ongoing	Workshops held and TOR agreed, and updated attendees list First draft developed - Working together to create better lives	
Effective deployment of current staff - Programme Plan to introduce Workforce Medical E-Systems to support effective deployment of medical staff.	Sarah Simmonds	Ongoing	Functional Specification documents developed with non-functional specifications Integration Specification. In the process of inviting suppliers to tender	
Registration – Temporary register extended for 2 years to enable staff to return to practice.	Sarah Simmonds	Ongoing	No action from Health Board, regulation bodies to inform current staff on temporary register	
Retire and return - The Accessing NHS Pension Policy has been reviewed and provides the	Sarah Simmonds	Ongoing	In progress nationally	

opportunity for staff to re-engage in work following a 24-hour break as opposed to the 14-day break previously.				
Training - The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%-43%). This will increase the number of graduates coming out of training in 2022 and beyond which are required to support turnover and existing vacancies.	Sarah Simmonds	Completed for 2023	Educational commissioning figures agreed by Executive Committee February 16th, 2023, and submitted to HEIW	
Training - HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce. Including Primary Care Academy		Ongoing	Primary Care Academy posts in place	

Training - Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx) started with 3 cohorts in September 2022. Nursing Academy, Leadership Development program (entry level) and Leading People (advanced Level) programs fully booked		Ongoing	Over 30 members of staff have been accepted onto the latest Leading People programme starting in March. CDx programme in place with 48 staff undertaking the 10-month programme	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

Criteria to consider: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?

Assurance Map

Evidence of Controls (mitigations to manage risk)	1st Line of Defence (Operational)	2nd Line of Defence (Organisational)	3rd Line of Defence (Independent)	Overall Assurance (RAG rated)	Gaps in Assurance

Workforce and OD Performance dashboard	Sarah Simmonds	(Monthly reports vacancies, recruitment activity, workforce performance measures,			
People plan reports	Sarah Simmonds	Yes (People and Culture Committee) quarterly			
People Plan Delivery tracker	Sarah Simmonds	Monthly – reporting to WOD			
Recruitment KPI	Sarah Simmonds	Local time to monitoring of timescales	Shared service monitor KPI's per month		
Divisional recruitment plans for medical staffing	Divisions/Sarah Simmonds	Local divisional plans in place to support medical recruitment	Reporting through divisional assurance meetings		
Retention Group	Sarah Simmonds	Regular reports on reasons for leavers, attendance at retention events (monthly)			
Safer Staffing Medical Group	Stephen Edwards	Monitor implementation of Safer Staffing levels (due to be restarted with new TOR)			Assurance to be confirmed once new group established
Agency reduction Group	Sarah Simmonds	Monthly meetings chaired by Director of Workforce and OD – reports directly to Executive Committee			

Strategic Nursing group	Linda Alexander	Monthly tracker and recruitment reports			

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance.*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Safer Staffing Medical Group	**Stephen Edwards**	**May 2023**	Monitoring implementation of Safer Staffing levels. New group due to be restarted with new Terms of Reference developed.	

Potential Impact of Risk on IMTP Priorities:	Risk Reference and Executive Owner: CRR036 Director of Operations

KEY:		
Priority 1	• Every Child has the Best Start in Life	
Priority 2	• Getting it Right for Children and Young Adults	
Priority 3	• Adults in Gwent Live Healthily and Age Well	
Priority 4	• Older Adults are Supported to Live Well and Independently	X
Priority 5	• Dying Well as part of Life	
Enablers	• Experience, Quality & Safety	X
	• Partnership First	X
	• Research, Innovation, Improvement, Value	X
	• Workforce & Organisational Development	X
	• Finance	X
	• Digital, Data, Intelligence	X
	• Estate	X
	• Regional Solutions	X
	• Governance	X

Assurance/Oversight Committee: Patient Quality, Safety and Outcomes Committee

Risk Decision (4Ts): TREAT

Overall Level of Assurance (RAG):

	X	

Risk of: Clinically unsafe and inappropriate inter-site patient transfers and into communities.

Due to: Lack of availability of safe and appropriate transfer vehicles, staff and skill mix to facilitate the transfers.

Likelihood of Current Occurrence: 3 = Probable - Might happen or recur occasionally

Impact if Occurred: *Compounds the Health Board's inability to discharge into communities and negatively impacts the DToCs position. Poor patient/families and staff experience and outcomes. Potential financial implications and reputational/public confidence damage.*

Risk at a glance: *Plot the APPETITE, CAPACITY, TARGET and CURRENT scores on the below chart. If the current score sits outside of appetite, target and capacity, a proposal to tolerate the risk is required.*

				X – target score
		X – low risk appetite – adverse to risk		
				X – current score
				X – capacity score

Risk Scoring: *The following criteria should be followed when assessing the scoring of the inherent, current and target levels of the risk:*

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:	**Frequency:**	**1 Negligible**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophi**
1 Rare - Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely - Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Possible - It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Likely - Will probably happen/recur, but is not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain - Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Assessment:

Inherent Risk Level *before any controls/mitigations implemented, in its initial state.*		***Current Risk Level*** *after initial controls/mitigations have been implemented*		***Target Risk Level*** *after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.*	
Likelihood	***Impact***	***Likelihood***	***Impact***	***Likelihood***	***Impact***
4	***5***	***3***	***5***	***1***	***5***
20		***15***		***5***	

	Justification for Risk Appetite and Risk Capacity Level & Target Score:
	The risk appetite for this risk is set at a low level, which confirms that the Health Board is averse to seeking risks in this area. The rationale for this is to minimise harm to patients.
	
	The risk capacity level for this area is 20 as this is the level at which the risk has been tolerated previously before mitigations were put in place. This
	
	*The target risk score for this area is (1x5)5. Actions identified throughout this report aim to provide a pathway through which the Health Board could achieve the target score. Therefore, the Board is asked to **TREAT** this risk above the appetite, noting it is currently scored below the capacity level.*
	
	Current Controls:
	
	• Ministerial direction on 6 goals of urgent and emergency care and Health Board Programme to achieve the objectives set out within.
	• Contractual obligations between the Health Board and WAST.
	• Same Day Emergency Care Model implemented at GUH.
	• Local handover improvement plan being coordinated by Corporate Operations including:
	  ○ Refresh Full Capacity Protocol (Q3 2022)
	  ○ Review of HALO/PFC role in ED (Q4 2022)
	  ○ Over 65 Pathways (Q1 2023)
	  ○ SDEC (Q4 2022)
	  ○ Scheduling of Urgent Care @ RGH MAU (Q4 2022)
	  ○ Flow Centre APP (Q4 2022)
	  ○ PRU Business Case continuation (Q3 2022)
	  ○ Discharge Pathways (Q3 2022)
	  ○ SAFER Principles(Q3 2023)
	  ○ Consistent MDT Board Rounds (Q1 2023)
	  ○ Provision of an extra 1000 community beds pan Wales by Winter 2022 (Q3 2022)

Action Plan: *Based on the SMART methodology, how will the Health Board ensure the management of the risk is as effective as possible? What further actions will be taken to manage the risk down to an acceptable level or if target level is already achieved, how will we maintain the position?*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN CONTROL				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**
Handover Improvement Plan actions & timelines added.	**Steve Bonser**	**Achieved**	**Governance arrangements added to demonstrate measurement and management of WAST contracts. Number of Inter-Site vehicles and skill mix added to highlight appropriateness of ambulance type and clinician available to safely transfer patients between sites.**	

Sources of Assurance: *To demonstrate the means through which the Health Board can assure itself that there are adequate controls in place to effectively manage the risk, the below assurance map has been devised. It aims to provide the overall assurance we can place in areas of **operational**, **organisational** and **independent** assurance. These are then Red, Amber, Green (RAG) rated to demonstrate the level of confidence the Health Board has in each area of assurance. For clarity, Red would indicate no assurances available, Amber would indicate limited sources of assurance available, and Green would indicate a satisfactory level of assurance with clear evidence that the risk is being managed effectively. Where there are gaps in assurance, the Health Board will produce clear plans to address the gaps.*

***Criteria to consider**: How is the risk currently being managed? What policies and procedures are we following to actively manage the risk [Operational]? Is there legislation in place to support the risk [Organisational]? Are there governance arrangements in place to support the actions being undertaken to manage the risk [Organisational] Are there any internal, external, independent advisory or inspectorate reports to support the strength of the controls [Independent]?*

Assurance Map					
Evidence of Controls (mitigations to manage risk)	**1st Line of Defence (Operational)**	**2nd Line of Defence (Organisational)**	**3rd Line of Defence (Independent)**	**Overall Assurance (RAG rated)**	**Gaps in Assurance**
Internal Health Board policies and procedures in place.		**X**			**Regular review of policies and procedures**
Operational criteria and checklists for patients to be transferred.	**X**				
Handover improvement plans.	**X**				**Further testing of improvement plans to demonstrate improvements.**

Action Plan to Address Gaps in Assurance: *Outline the plans the Health Board will put in place to address the gaps identified in assurance*

RISK MANAGEMENT ACTION PLAN TO ADDRESS GAPS IN ASSURANCE				
Action	**Responsible Officer**	**Deadline**	**Progress**	**Implementation Status (RAG)**

Further testing of improvement plans against performance data to demonstrate improvement.	**Steve Bonser**	**Q2 2023**	**Ongoing**