Risk Ref	Risk (for more detail see individual risk entries)	Included on BAF	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Jan-21	Trend	Target Risk Score	Risk on page no...
684	Lack of agreed replacement programme for radiology equipment across UHB	*	Carruthers, Andrew	Service/Business interruption/disruption	6	4x4=16	5×4=20	↑	2×3=6	3
1032	Delivery of Q3/4 Operating Plan - Timely access to assessment and diagnosis for Mental Health and Learning Disabilities clients	**	Carruthers, Andrew	Safety - Patient, Staff or Public	6	N/A	4×4=16	→	3×4=12	6
855	Risk that UHB's non-covid related services and support will not be given sufficient focus	5	Moore, Steve	Quality/Complaints/Audit	8	3x4=12	4×4=16	↑	2×4=8	9
750	Lack of substantive middle grade doctors affecting Emergency Department in WGH.	**	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4x4=16	4×4=16	→	2×4=8	12
1017	Delivery of Q3/4 Operating Plan - Test, Trace and Protect Programme being able to quickly identify & contain local outbreaks	**	Shakeshaft, Alison	Safety - Patient, Staff or Public	6	3×5=15	3×5=15	→	2×5=10	15
129	Ability to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda patients	*	Carruthers, Andrew	Service/Business interruption/disruption	6	4x3=12	4×3=12	→	4×3=12 Accepted	18
628	Fragility of therapy provision across acute, community and primary care services	2	Shakeshaft, Alison	Safety - Patient, Staff or Public	8	4x4=16	3×4=12	↓	3×4=12	22
291	Lack of 24 hour access to Thrombectomy services	*	Carruthers, Andrew	Quality/Complaints/Audit	8	3x4=12	3×4=12	→	2×2=4	26
117	Delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery	*	Carruthers, Andrew	Safety - Patient, Staff or Public	6	2x5=10	2×5=10	→	2×5=10	29
634	Overnight theatre provision in Bronglais General Hospital	*	Carruthers, Andrew	Safety - Patient, Staff or Public	6	2x5=10	2×5=10	→	1×5=5	33
635	No deal Brexit affecting continuity of patient care	6	Thomas, Huw	Service/Business interruption/disruption	6	4x3=12	3x2=6	↓	2x2=4	36
853	Risk that Hywel Dda's response to COVID-19 will be insufficient to manage demand.	5	Moore, Steve	Safety - Patient, Staff or Public	6	1x5=5	1×5=5	→	1×5=5	40

Assurance Key:

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

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

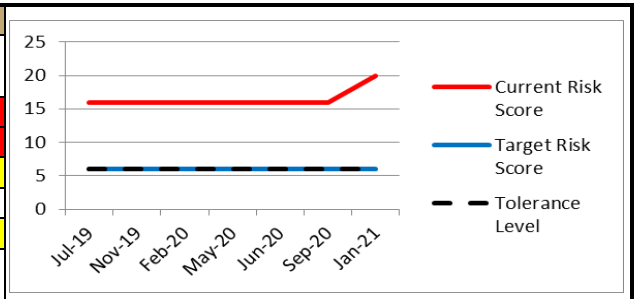
NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you

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

Date Risk Identified:	Jan-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jan-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Feb-21

Risk ID:	**684**	**Principal Risk Description:**	There is a risk radiology service provision from breakdown of key radiology imaging equipment (specifically MRI in WGH, insufficient CT capacity UHB-wide and the general rooms in Bronglais). This is caused by equipment not being replaced in line with RCR (Royal College of Radiographers) and other guidelines. This could lead to an impact/affect on patient flows resulting from delays in diagnosis and treatments, delays in discharges, increased waiting times on cancer pathways, increased staffing costs to minimise the impact on patients when breakdowns occur and increased number of breaches over 8 weeks due to increased downtime.
Does this risk link to any Directorate (operational) risks?	644		

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



Rationale for CURRENT Risk Score:

The UHB's stock of imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites which has a significant impact on the UHB's ability to meet its RTT target and impact to patients can include delays in diagnosis and treatment. Presently equipment downtime is frequently up to a week which can put significant pressures on all diagnostic services. Whilst activity has decreased due to COVID, scanning of COVID patients requires more time than non-COVID patients, which will become an issue as requests for diagnostics for non-COVID patients increase as other services resume. Commissioning of agreed equipment has also been delayed as a result of COVID and this remains dependent external factors. Radiology has been asked to increase its service provision to other Directorates which it is currently unable to provide due to limitations on current equipments.

Rationale for TARGET Risk Score:

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports.Some funding has been secured from AWCP for some replacements but does not cover all outdated equipment nor the future requirements. # Escalation process in place for service disruptions/breakdowns.	Limitation of spare parts for some older equipment leading to extended outages. This issue may be componded by Brexit. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Delayed commissioning of new MRI Scanner in WGH and agreed funding for replacement CT due COVID-19.	Review and strengthen site business continuity plans with individual site leads to ensure robust response to breakdown.	Evans, Amanda	Completed	Site leads in process of developing up-to-date and robust business continuity plans which will operationalise procedures following breakdowns. Site leads have met with the business continuity team to agree on the process of updating plans. Due to operational pressures this needs further time to fully complete.
		Work with planning colleagues about sourcing capital funding through DCP and AWCP.	Evans, Amanda	~~30/06/2019~~ 01/04/2020 31/12/2020 31/03/2021	Funding for one scanner has been agreed with plans submitted to WG for the replacement of four CT scanners that are approaching end of life. Still ongoing.
		Develop plan in line WG Operating Framework for Q1 to deal with COVID and non-COVID patient flows and potential backlog.	Evans, Amanda	Completed	Submit to Bronze Acute Group by 18/05/20.
		Monthly project meeting to discuss commissioning of agreed equipment with estates, planning and manufacturers.	Evans, Amanda	~~31/12/2020~~ 30/08/2021	Commissioning equipment is dependent on lockdown measures in and outside of UK and contractor availability to undertake work. Some equipment has already been commissioned, however still awaiting completion of project on MRI in WGH.

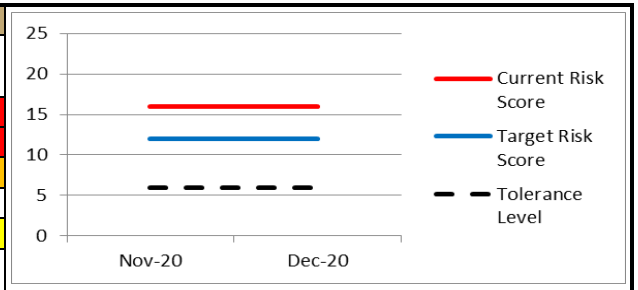
		Additional CT resource due to delay in funding from WG	Evans, Amanda	Completed	Additional CT resource obtained from NHS England in the form of a demountable unit . Resource to be shared with SBUHB. Now operational. Further additional CT secured in the form of a mobile van for two weeks in December 2020.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Reduction of waiting times to under 6 weeks by Mar22. Reduction in overtime costs to nil by Mar22.	Monthly reports on equipment downtime and overtime costs	1st			Radiology Equipment SBAR - Executive Team - Mar19 Further updates CEIMT February 2020 Further updates CEIMT September2020	Lack of process of formal post breakdown review.	Formalise post breakdown review process to ensure lessons are learnt and improvements implemented following the most impactful breakdowns.	Evans, Amanda	Completed	RSM has discussed with site leads and further work is underway. Equipment and risk information is included in regular site lead meetings . Performance reviews include downtime Administrator coordinating issues and response
	IPAR report overseen by PPPAC and Board bi-monthly	2nd								
	Internal Review of Radiology Service Report (Reasonable Rating	3rd								
	WAO Review of Radiology - Apr17	3rd								
	External Review of Radiology - Jul18	3rd								

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Dec-20
Strategic Objective:	Delivery of the Quarter 3/4 Operating Plan	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Jan-20

Risk ID:	**1032**	**Principal Risk Description:**	There is a risk the length of time MH&LD clients (specifically ASD, memory assessment and psychology services for intervention) are waiting for assessment and diagnosis will continue to increase during Q3/4. This is caused by new environmental (due to social distancing measures) constraints to undertake required face-to-face assessments and patients' reluctance to attend clinics due to the risk of COVID. This could lead to an impact/affect on increasing delays in accessing appropriate diagnosis and treatment, delayed prevention of deterioration of conditions and delayed adjustments to educational needs.
Does this risk link to any Directorate (operational) risks?			

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



Rationale for CURRENT Risk Score:

Referrals for ASD have continued throughout the pandemic at approximately the same level as pre-Covid. The service were experiencing significant waiting times as a result of demand levels. Due to the constraints to undertake the required face to face assessments, the implementation of social distancing and, in some instances patients reluctance to attend clinics due to the risk of Covid, has an impact on the services' ability to see the same volume of service users as they were previously able to. In addition, the estate footprint does not necessary lend itself to accommodate the social distance requirements and in some instances is not therapeutically beneficial.

Rationale for TARGET Risk Score:

The Directorate is aiming to restore pre-Covid levels of assessment and intervention.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Use of IT/virtual platforms such as AttendAnywhere when appropriate. Clinical prioritisation regarding assessment and treatment of service users by engaging in a dynamic process of reviewing waiting lists in line with any other referrals that may be received in respect of that service user. Additional funding provided for recruitment however national shortage of required skills. Services are in contact with individualss to provide information regarding community support, well being at home and guidance should their situation deteriorate.	Social distancing measures reducing the available space/offices that can be used to meet clients face-to face. To ensure all individuals are being contacted periodically through the wait for assessment/treatment to monitor any alteration in presentation.	Assess and source further IT requirements.	Carroll, Mrs Liz	31/03/2021	Heads of Service to identify any additional IT requirements to facilitate face-to-face assessments/consultations.
		Identify alternative venues/space to hold clinics.	Carroll, Mrs Liz	31/03/2021	Working with the Estates department and exploring options with external partners.
		Head of Service to operationalise	Carroll, Mrs Liz	31/12/2020	Director to set up Task & Finish Group to focus on referral to treatment and diagnostic assessments to ensure consistency across the service with regards to managing those awaiting a service through a quality outcome and patient experience lens. Service user/carer input will be sought as part of the development of this.
		Appointment of Service Delivery Manager.	Carroll, Mrs Liz	31/03/2021	Appointment has now been made for Service Delivery Manager and this work will commence in January 2021 following them taking up post.
		Services will be in contact with individuals to provide information regarding community support, well being at home and guidance should their situation deteriorate.	Carroll, Mrs Liz	Completed	This process has been enacted.

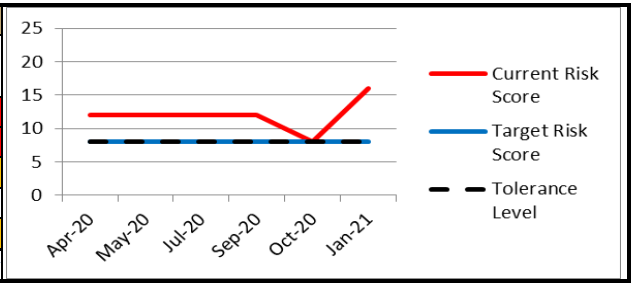
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Welsh Government performance indicators along with internal monitoring arrangments will be used to ensure the actions are having the desires effect or whether there is more that needs to be done.	Management monitoring of referrals	1st				System to improve analysis of patient experience	There are outcome measure in place within Psychological Therapies following intervention with a plan to develop a Task and Finish group to look at themes and areas which may require further improvement.	Carroll, Mrs Liz	31/03/2021	This will be taken forward by the new Service Delivery Manager for Psychological Therapies when appointed.
	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd								
	MH&LD QSE Group overseeing patient outcomes	2nd								

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

Executive Director Owner:	Moore, Steve	**Date of Review:**	Jan-21
Lead Committee:	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Feb-21

Risk ID:	**855**	**Principal Risk Description:**	There is a risk that the UHB's non-covid related services and support will not be given sufficient focus. This is caused by Our ongoing operational response and the implementation of a COVID mass vaccination programme. This could lead to an impact/affect on poor patient outcomes and experience, increase in complaints, increased follow-ups, delays to treatment, increase in financial deficit, increase scrutiny by regulators/inspectors.
Does this risk link to any Directorate (operational) risks?			

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



Rationale for CURRENT Risk Score:
With a winter surge in COVID demand, which currently significantly exceeds the peak seen in spring 2020, coinciding with usual winter pressures and the rapid roll out of a Mass Vaccination Programme, the risk score has been increased to 4 x 4 = 16. All but essential services have been suspended with staff redeployed and only the most urgent surgery is being undertaken on a case by case basis.

Rationale for TARGET Risk Score:

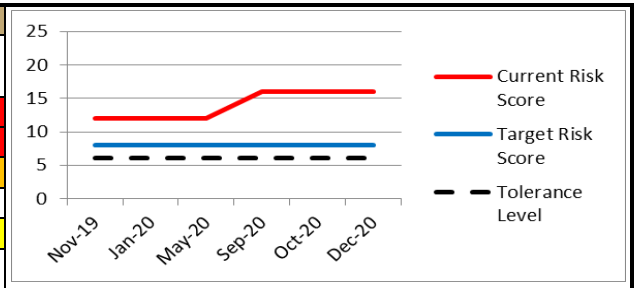
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Ethics Panel established and asked to consider issues related to the care of non-COVID-19 patients. Clinicians are making case by case risk based decisions for high risk/vulnerable patients. All urgent and emergency work continuing at present. All available capacity being utilised at the Werndale to support cancer and urgent planned care activity. Revised Strategic Plan Requirement issued by Gold to Tactical on 27/04/20 to include non-COVID planning. The Winter Plan sets out arrangements for non-COVID services during winter ensuring focus is maintained on these services during a challenging winter period. Transformation Steering Group established. Quarterly planning process to ensure essential services are maintained and other services are cautiously restored as progress of the pandemic allows.	Plan required to restart services.	A prioritised risk based plan to re-establish and maintain services for Quarter 1 has been requested from Tactical by Gold Command.	Carruthers, Andrew	Completed	Gold Command Group approved the Operational Framework Quarter 1 at its meeting on 18May20 noting this was submitted in draft form to Welsh Government on the same date. Board will be asked to approve plan on 28May20.
		Develop a quarterly approach to planning to maintain essential services and retain flexibility and adaptability to changes in community transmission rates of COVID-19.	Carruthers, Andrew	Completed	To be established through the Command and Control Structure
		Develop Quarter 2 plan in response to WG Q2 Operating Framework for Gold Group.	Carruthers, Andrew	Completed	Completed. Q2 Delivery Plan submitted to WG on 03/07/20. Board will receive plan retrospectively at Jul20 Board Meeting in Public. Delivery of Q2 plan to be undertaken by PPPAC.
		Develop Quarter 3&4 plan in response to WG Winter Preparedness Framework and Gold Command requirements.	Carruthers, Andrew	Completed	Completed - awaiting ratification by Board at its Public Meeting on 26 November 2020

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
None identified.	Command and Control Structure developing and approving plans to re-establish and maintain essential services	2nd			Responding to the COVID-19 pandemic - Board (Nov20)	No performance measures. Internal and External Audit Plans in 20/21 are being reviewed to incorporate review of organisational response to COVID-19.	Develop KPIs following development and approval of plan to restart services.	Carruthers, Andrew	31/07/2020	The UHB is in the process of asking the medical advisory board to give us their view on international best practice in monitoring the population impact of this issue which will inform the KPIs we track.
	Board oversight of revised quarterly plans	2nd								

Date Risk Identified:	Jun-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Dec-20
Strategic Objective:	Delivery of the Quarter 3/4 Operating Plan	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Jan-21

Risk ID:	**750**	**Principal Risk Description:**	There is a risk unavoidable delays in the treatment of patients in Emergency Department (ED) at WGH. This is caused by a lack of substantive middles grade and high reliance on agency locum cover, which is not always available. This could lead to an impact/affect on patient care through prolonged stays in ED and delays in transferring to specialty, delays in diagnosis and treatment, poorer outcomes, and increased ambulance off load delays. Further impacts include inability to run a full rota and a decreased level of supervision of junior doctors, as well as deterioration in Tier 1 performance for 4 hours waiting time in A&E, and increased pressure on WGH financial position through use of agency at an enhanced time.
Does this risk link to any Directorate (operational) risks?	229		

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



Rationale for CURRENT Risk Score:

WGH should have 7 middle grade doctors to fill rota. at prsent we have 3 in substantives posts, 1 who can not work nights and 1 has handed in their notice. We have 2 on boarding, with 1 long term NHS locum and 2 on agency plus 3 locums being used ad hoc. There is a possibility that the 7th post may revert to a ANP post to cover the shortfall. The rota remains under constant review and management as the department are fully reliant on temporary staff. The risk has therefore increased to 16 based on 3 substantive & 1 long term zero hours doctors being in place. Unfortunately, only 3 of these doctors work a full rota, including nights. This places additional pressure on the system.
22.10.20. Only 1 post left for on boarding. 1 post has been filled, but at present they are customizing to the NHS program so are not on the Rota. Other posts are still out to advert, with active interviews being held regularly.
24.12.20 3 posts left to appoint into. Recruited doctors have withdrawn. 1 new appointment due to start beginning of January but will need to customize the NHS program so will not be on the Rota immediately. Other posts are still out to advert, with active interviews being held regularly.

Rationale for TARGET Risk Score:

It is anticipated that the completion of the recruitment process of 3 middle grade posts will provide some stability to the department. The contingency plan, which is currently under development, will ensure that robust procedures are in place in the event that the middle grade rota cannot be filled.

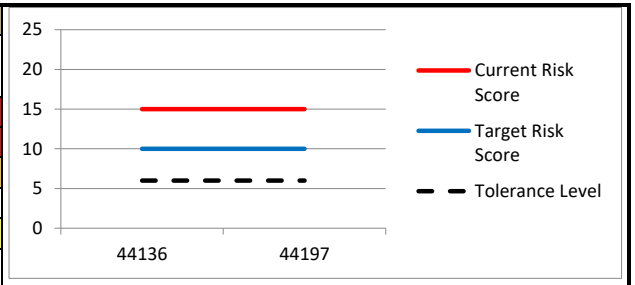
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Daily review of team strengths by rota co-ordinators and service manager unscheduled care. Issues identified escalated to GM and SDM. Recruitment program on-going to fill gaps and recruit into vacant posts. Medacs agency filling whenever possible with long term locums. Continuous monitoring of the team strengths to ensure consultant and senior support and supervision. Links with other Health Board sites (HDUHB & SBUHB) to outline current pressures and any opportunities to cross cover and to assess overall medical staffing position across HDUHB Weekly Urgent Response Group review rotas for the next six months.	Contingency plan for when middle grade shift is uncovered. Inability to recruit middle grade doctors at WGH.	Develop contingency plan to respond to incidences when middle grade rotas cannot be filled in WGH ED.	Cole-Williams, Janice	~~30/09/2019~~ 07/11/2020	Draft procedure under review. Plan A drafted and circulated. Unable to provide ED with ad hoc paediatric middle grade or consultant cover when ED middle grade position is uncovered. Therefore, Plan B currently being drafted.
		Complete the recruitment of 4 middle grade doctors.	Cole-Williams, Janice	~~31/12/2019~~ 07/11/2020	1 Post out to advert. Others offered but candidates are overseas. delays in transporting to the UK due to the Coronavirus pandemic and related travel restrictions.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
A&E 4hr waiting times (<95%) A&E 12hr waiting times (0 target) Number of ambulance handovers over one hour (0 target) Incidents level 4 or 5	Daily review of rotas	1st			* Executive Committee - Jul19 * In-committee Board - Jul19	None identified.				
	Daily review of incident reports	1st								
	Local governance meeting monthly	1st								
	Tier 1 target performance reviewed at Business Planning and Performance Committee	2nd								

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Shakeshaft, Alison	**Date of Review:**	Jan-21
Strategic Objective:	Delivery of the Quarter 3/4 Operating Plan	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Feb-21

Risk ID:	**1017**	**Principal Risk Description:**	There is a risk that the UHB will not be able to identify local outbreaks of COVID-19 rapidly and take appropriate action promptly. This is caused by the local population being unable to access timely tests for COVID-19 through the Test, Trace and Protect Programme (all testing of general public is undertaken through the DHSC (UK Department of Health and Social Care laboratory) where capacity has previously been outmatched by a significant rise in demand for testing, limiting availability of testing). This issue has now resolved but could recur. There has also previously been issues with poor turnaround times (TATs) for result reporting.Whilst this has been also resolved, This could lead to an impact/affect on taking action quickly enough to contain the spread of localised outbreaks of COVID-19 and preventing transmission to vulnerable members of the community, inability to protect NHS services through increased hospital admissions and depletion of workforce from staff self-isolating.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:

Several months ago, the DHSC laboratory capacity was outmatched by a significant rise in demand for testing, resulting in the previously agreed Wales capacity being capped. This resulted in the public being unable to book testing locally, if at all, and delays of up to 10 days in the availability of test results, when tests were undertaken. This had serious implications for the Test, Trace and Protect Programme. There was a significant increase in the number of calls and emails to the Health Board to resolve issues that were mainly out of our control. Access to testing has now resolved with no delays in accessing tests and sufficient testing capacity available. TATs have also deteriorated previoulsy but are currently good.

Rationale for TARGET Risk Score:

It is unlikely that this risk will be brought within tolerance due to the UK testing system (through to booking and results availability is out of HB and WG control. We have seen several period of poor performance linked with high levels of UK demand on the system which could reoccur.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Operational Testing Delivery Plan for the coming 6 months based on demand modelling and assumed testing capacity across both the Welsh and UK Department of Health and Social Care (DHSC) systems. Plenty of testing capacity in the system. Plan updated on 10 November 2020. Issued clear communications to staff, partners, schools and the public to	Over recent months, the DHSC laboratory capacity has been outmatched by a significant rise in demand for testing, resulting in the previously agreed Wales capacity being capped.	Continuous review of the Operational Testing Delivery Plan in place to ascertain the sustainability of an in-house testing provision for Hywel Dda population	Shakeshaft, Alison	~~31/12/2020~~ 28/02/2021	Ongoing review relating to changes in demand for testing.

issued clear communications to staff, partners, schools and the public to reinforce messaging to reduce the amount of inappropriate testing requests being made. Testing for all symptomatic individuals, including members of public and critical workers is available in Aberystwyth, Aberaeron, Carmarthen, Llanelli and Haverfordwest via the UK portal. Additional testing sites, not open to general public access, for pre-operative and pre-treatment testing e.g. prior to chemotherapy and for critical health and social care staff delivered by Health Board staff using the welsh laboratory network. Work underway to further expand Health Board delivered testing to reduce reliance on the UK system, which is out of our control. Testing Team in place with daily meetings to discuss and resolve any issues in the system. LumiraDx machines have been introduced in EDs/MAUs for rapid testing of symptomatic admissions.	being capped. Turnaround Times (TATs) performance through the DHSC model has been extremely poor previously but improved over the past month. All such requests for testing via the UK model is booked via the UK portal and capping testing slots is not within UHB control. PHW laboratory capacity has previously been limited but has recently increased with further plans in place to increase this significantly over next month. To date the majority of community testing has been by the DHSC testing system.	Currently recruiting additional staff to increase community testing through the PHW system to circa30%	Shakeshaft, Alison	~~31/12/2020~~ 28/02/2021	Work is progressing.
		Consider appropriate use of POCT when it becomes available	Shakeshaft, Alison	31/12/2020	Paper to be discussed at Formal ET on 27/01/2021 in respect of routine testing of asymptomatic patient-facing HB staff to commence on a small scale from 1 February 2021. Wider roll-out dependent on the introduction of a digital solution for results recording and reporting and feed to CRM for contact tracing.

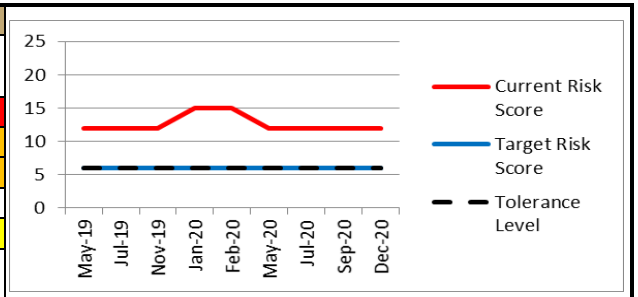
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**		
Weekly turnaround time results (100% within 24 hours) 100% Access to test within 24hours	Testing Team monitors booking, delivery and analysis of local testing on a daily basis	1st			Included in Covid Board paper - Nov20 & Jan21
	Regular reports to Public Health Gold Cell and Gold Command on TTP	2nd			
	COVID Updates to Board include updates on testing	2nd			

Gaps in ASSURANCES				
Identified Gaps in Assurance:	**How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
Audit Wales Review on TTP due Dec20				

Date Risk Identified:	Apr-17	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Dec-20
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Feb-21

Risk ID:	**129**	**Principal Risk Description:**	There is a risk disruption to business continuity of the Hywel Dda Out of Hours (OOH) Service. This is caused by a lack of available of labour supply as GPs near retirement age and pay rate differentials across Health Boards in Wales impact the UHB's ability to recruit in the mid-long term. In the short term, any lifting of COVID-19 lock down measures (all clinicians are currently working as holidays and foreign working are temporarily unavailable to them) as well as possible impacts on in-hours provision is likely to result in a fragile workforce position once again. This could lead to an impact/affect on a detrimental impact on patient experience and the unscheduled care pathway.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×3=15
Current Risk Score (L x I):	4×3=12
Target Risk Score (L x I):	4×3=12
26/11/2020 - Board 'Accept' Target Risk	
Tolerable Risk:	6
Trend:	



Rationale for CURRENT Risk Score:

The COVID pandemic combined with the temporary overnight service changes has brought some respite to the service fragility, and this is reflected in the current risk score. Stability in the Carmarthen rota is now being seen but it coincides with destabilisation within Pembrokeshire. This, combined with any lifting of lock down/infection control related absence or impact on in-hours provision is highly likely to rapidly result in further deterioration of the current position.

Rationale for TARGET Risk Score:

Service rota positions remain variable with continued shortfalls in clinical cover variably affecting service provision. Despite the Carmarthen base rota now being stable, shortfalls in Pembrokeshire and Ceredigion have become evident- and this is further compounded by the need for staff to take leave. Medium term actions are still required, especially in terms of Winter planning and service modernisation. As soon as the present situation allows, work to develop a long term plan for OOH Services must recommence in order to reduce this risk on a permanent basis so to ensure the out of hours service provision is not interrupted. Worforce and service redesign requirements flagged as part of IMTP.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# GP's rotas across the 3 counties are now managed centrally via the administration team based in Haverfordwest # Dedicated GP Advice sessions in place at times of high demand (mostly weekends). # Remote working telephone advice clinicians secured where required. # Additional remote working capacity has been secured to assist clinicians who may be shielding/ isolating to continue to support operational demand. # Ongoing workforce support from 111 programme team in addressing OOH fragilities in place. # Health Professional feedback form in use between clinicians, service management and 111 (WAST) leads. # WAST Advance Paramedic Practitioner (APP) resource continued. # Rationalisation of overnight bases in place since March 2020 appear successful in supporting wider service delivery in current model. # Worforce and service redesign requirements flagged as part of IMTP.	The ability to influence workforce participation remains limited due to the lack of contractual agreements (reliance on sessional staff). At present the staffing remains challenging despite a stable rota now being agreed at the Carmarthen base- there are shortfalls in Pembrokeshire and Ceredigon that are affecting service provision throughout the 7 day operating period. The current situation is likely due destabilise further due to the current COVID-19 situation, and so need for formalised workforce plan and redesign is still required - reflected in IMTP submission. In relation to service demand, activity	Ensure Transforming Clinical Services Programme incorporates a long term, viable plan for OOH.	Rees, Gareth	~~30/09/2020~~ 31/12/2021	As of January 2020 the development of a detailed redesign plan is underway but the timescale has yet to be identified. Feb 2020- this work is continuing to progress and work on medium term resolution has now commenced. March 2020- Working group stood down due to Covid-19 commitments June2020- Requests to restart working group are subject to re-prioritisation. Dec2020- inclusion in new IMTP process, awaiting decision on how to progress with service change. Delayed by Covid-19.
		Development of home working provision for GPs.	Rees, Gareth	Completed	Completed and evolving.

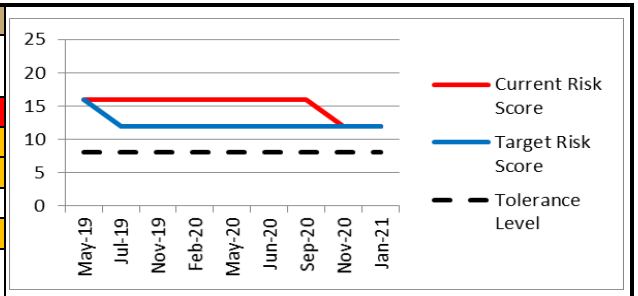
	In relation to service demand, activity is increasing and this further influences the risk-position, complicated by the inability to see red flow patients in an Out of Hours setting. The focus on delivery of care via the telephone advice method is the significant factor in not increasing risk at this time (80% of consultations is now dealt with on the phone)- but any further reduction in capacity is likely going to require an increase in the risk level as the service goes through the winter period.	Implement a change to the pathway in PPH Minor Injury Unit as authorised by Executive Team 06/11/19	Davies, Nick	Completed	ET approval gained following discussions with affected GP groups. Further engagement with affected staffing groups has been completed. New provisional dates agreed by engagement on 07/01/20. On target for rationalisation of night base cover from 09 March 2020
		Investigate potential external alternatives to current workforce position.	Davies, Nick	Completed	The Service is working with shared services and the 111 programme to develop a GP Hub where locum sessions can be accessed centrally to support service provision. This is similar to the Covid GP Hub and is supported by GP Wales. Access to this workforce stream (coordinated by GP Wales/111 project team) is anticipated to be available by end of December 2020

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Bi-monthly IPAR. National Standards and Quality Indicators-submitted monthly to WG. Issues raised, and performance Matrix reviewed, at National OOH forum (bi-monthly, attended by WG).	Daily demand reports to individuals within the UHB	1st			QSEAC OOH Update Sep19 & Feb20 QSEAC - Peer review - Feb20 QSEAC- Review of risk 129 - Oct20 ET- Risk to OOH business continuity - Sep19 ET- OOH resilience - Nov19 & Jan20 BPPAC Quarterly monitoring Nov19 BPPAC - update on the OOH Services peer review paper Dec19 BPPAC - OOH service design Feb20	Lack of meaningful performance indicators.	Assess NHS 111 performance metrics to understand how they may influence Hywel Dda OOHs performance, and if a viable alternative - which may support improvement in shift fill.	Davies, Nick	Completed	New 111 Wales performance metrics are being prepared and will soon be circulated for review.
	Weekly sitreps/Weekend briefings for OOH	1st								
	Monitoring of performance against 111 standards	1st								
	Monthly report to Joint Operations Group (WAST, 111 team & 111 Health Boards)	2nd								
	BPPAC monitoring	2nd								
	QSEAC monitoring	2nd								
	Issues raised, and performance Matrix reviewed, at National OOH forum (bi-monthly, attended by WG)	3rd								
	WG Peer Review Oct 19	3rd								

Date Risk Identified:	Sep-18	**Executive Director Owner:**	Shakeshaft, Alison	**Date of Review:**	Jan-21
Strategic Objective:	2. Working together to be the best we can be	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Mar-21

Risk ID:	**628**	**Principal Risk Description:**	There is a risk that patients in need of therapy services do not receive them in a timely period or do not receive the required level or intensity. This is caused by gaps or fragile staffing levels in the therapy service provision across acute, community and primary care settings from historical under-resourcing, exacerbated by recurrent savings targets, vacancies and recruitment/retention issues due to national shortages. There is the additional challenge that COVID-19 has placed upon workforce models due to staff shielding, reactive redeployment and physical distancing. This could lead to an impact/affect on patient outcomes, longer recovery times, increased length of stay, a reduction in performance against performance targets including 14 week waiting time, non-compliance with clinical guidance, and potential adverse impact on patient safety/harm.
Does this risk link to any Directorate (operational) risks?		yes	

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



Rationale for CURRENT Risk Score:

#Therapy service provision across acute, community and primary care continue to be challenging, as described in the cause section, but have improved following additional resourcing (Major Trauma, Nutrition, Rehabilitation, Lymphoedema, Dementia, MSK) , workforce redesign and over recruitment of Band 5 graduates (Physiotherapy, OT, Podiatry & S&LT).

#Impact to service provision by COVID-19 pandemic and rehabilitation requirements have added an additional challenge to workforce models, but have also enabled the roll out at scale of digital and virtual consultations.

#Across therapy services, current demand is largely being met for new patient referrals, apart from those clinical areas where physical delivery of hands on treatment is impacted by the demands of physical distancing and IP&C requirements. Further work is underway to understand the potential additional demand for rehabilitation for those directly affected by the pandemic or indirectly by the interruption of access to routine service provision.

Rationale for TARGET Risk Score:

The target risk score has been assessed as 12 as although priority areas have been agreed and progressed, the risk will not be completely addressed in the coming year. A sustainable therapy workforce solution aligned to the Health and Care Strategy has been agreed. The following high impact/workforce priority areas were prioritised within the Annual Plan for focus during 2020/21: older people (incorporating frailty and stroke); improving self-management (including pulmonary rehabilitation and diabetes); therapists as first point of contact in primary care (including musculoskeletal, older people and irritable bowel syndrome); Major Trauma Plan. An additional requirement will be the delivery of the COVID-19 Rehabilitation Framework, and work is underway to identify the impact of this locally. A sustainable solution is currently in place 14 week waiting time target, with additional support required for Occupational therapy and Podiatry as a result of IP&C requirements. Therapy services will continue to pursue practical, prudent and incremental workforce solutions to improve patient care, outcomes and experience, and to ensure sustainably funded models are identified through whole-system review and potential shifting of resource from elsewhere in the health and care system.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Individual service risks identified and discussed at a range of fora; i.e. QSEAC, OQSESC, Performance Reviews and Therapy Forum. # Priority areas agreed in the 2020/21 Annual Plan, to increase capacity in key areas identified in plan. Additional Capacity created in MSK service # Locum staff utilised where appropriate, funded from within core budget (2 vacancies required to fund 1 Locum) # Short-term contracts/additional hours within budget used to cover maternity leave. # Training of support staff to safely deliver delegated tasks. # Over-recruitment of Newly Qualified Staff / B5 staff where appropriate and approved by the Clinical Director to mange foreseeable and predictable staffing level capacity gaps. # Local solutions include review of each vacant post to make them attractive, including skill mix review, early advertisements for new graduates. # Student streamlining of B5 graduates from June 2021 # Prioritisation of patients is undertaken through triage and risk assessment by therapy services. # Use of Digital Platforms to support agile working and remote access # Continued training of the Malcomess Care Aims Framework for MDT/Therapy Service.	Inability to secure funding for all developments identified in 20/21 annual plan. Shortage in some clinical specialities of qualified and specialist staff nationally Rurality of HDdUHB has historically limited applications to some posts. Unplanned service development due to short term or opportunistic funding. Lack of cohesive approach to workforce planning across therapy services. Reactive deployment of Therapy workforce to support surge or Covid Pandemic response.	Developing robust plans to evidence improved patient outcomes and experience through reprovision of resource from elsewhere in the health and care system aligned with strategic direction of the HB. This is a significant, long term piece of work, which will need to run alongside strategic development through the Health and Care Strategy. This will include skill mix review such as new HCSW and Advan	Reed, Lance	~~31/03/2020~~ 31/03/2021	Plans under development. Funding already secured for developments in pulmonary rehab, dementia, lymphoedema and to support some increase in front door/acute therapy input including plans to address malnutrition. Continued operational and strategic engagement with DoTHS, DOO, HoS, CDs and GMs to address COVID-19 response and to service developments that would release resource and savings from the wider health and care system through increased therapy provision, including areas of pathway re-design. WG funding for Therapy Assistant Practitioner HCSW role to support workforce model changes.
		Ensure process for robust workforce planning is in place to inform HEIW in respect to future graduate numbers required by the UHB/Region, which are aligned to the Health and Care Strategy workforce plan.	Shakeshaft, Alison	Completed	Long-term piece of work informed by action above on an annual basis. Lead in time of 3 years to benefit from graduate programme.
		Pursue opportunities to attract local people into therapy careers in the HB, eg 'grow your own' schemes, apprenticeship programmes, development of career pathways from HCSW to graduate, development of local graduate training programme.	Reed, Lance	~~31/03/2020~~ 31/03/2021	Commitment given to extend apprenticeship scheme to AHPs, agreed from 2020. Variety of HCSW training modules for level 3 and 4 developed and being implemented. HEIW review to commission local training provision for Physio & Occupational Therapy Undergraduate Training locally.

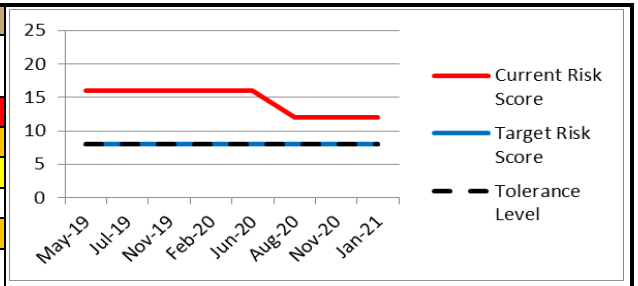
		Develop robust workforce plans that align to stroke, major trauma and neurology and COVID-19 rehabilitation service needs to maximise workforce opportunities.	Shakeshaft, Alison	~~31/03/2020~~ 31/03/2021	Plan being developed as part of Therapy 3 Year Plan 2021/23 to include extended and 7 day working.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Maintenance of 14 week waiting times for therapy services. Clearance of backlog for pulmonary rehabilitation, with 100% achievement of 14 week maximum wait by Dec21. Improved compliance with minimum standards for stroke therapy care by Q2 2021/22 (Dec21). Improved staffing ratios for priority areas by Dec21.	Management monitoring of breaches of 14 week waiting times	1st			Briefing on current position - QSEAC: Risk 628 - 06.10.2020 Briefing on Therapy Staffing - HDCHC Services Planning Committee 14.12.20					
	Exceptions to achieving 14 week waiting times reported via IPAR to PPPAC	2nd								
	Monitored nationally via SSNAP and monitored via Stroke Steering Group & RCP Annual Report with recommendations produced	2nd								
	External Peer Reviews, Delivery Unit Reviews & national audits, eg Diabetes paediatric audit - action plans developed	3rd								

Date Risk Identified:	Oct-17	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jan-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Mar-21

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

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



Rationale for CURRENT Risk Score:

Mechanical intervention for Stroke is available at North Bristol NHS Trust (NBT) (and Walton Centre NHS Foundation Trust for Bronglais Hospital). The service has expanded to a 7 day service 8am-8pm, cut off for patient arriving at NBT is 6pm. We still do not have 24/7 service, any patients presending after the cut off pint will not be accepted by NBT.

Rationale for TARGET Risk Score:

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

Mechanical intervention for Stroke is now available at Bristol (and Walton for Bronglais. The service in NBT has expended to 8am-8pm however we still do not have 27/7 service.The risk for out of hours would stay the same.

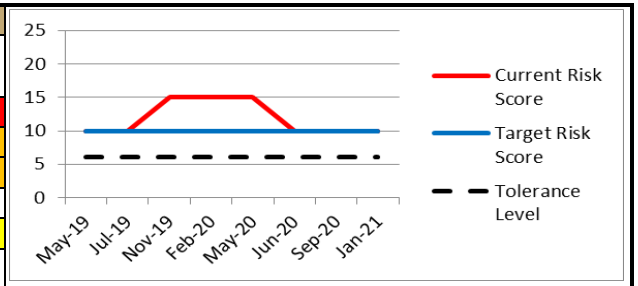
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
WHSSC have commissioned a service in North Bristol. Below is a link for the thrombectomy pathway with Bristol. It has the referral criteria and pathway. They are developing an imaging pathway as well. https://www.nbt.nhs.uk/clinicians/services-referral/stroke-service-clinicians/stroke-thrombectomy-service-clinicians. New all wales Thrombectomy group has been set up to discuss issues and to finalise pathway. HDUHB patients can now access Bristol Thrombectomy services 7days a week. They will provide a service from 8am-8pm. the patient must arrive at Southmead by 6pm. Incident reviewing in place.	All patients must have a CT and CTA performed before referral with a diagnosis of a large vessel occlusion. Timely investigations that are required to support transfers for thrombectomy not supported 24/7 on all sites. Work is ongoing to ensure that CT Angiography is available in all Hywel Dda units to provide the necessary diagnostic investigations prior to transfer to a specialist neuroscience centre.	Develop and review the Thrombectomy pathway, throughout the Health Board.	Andrews, Bethan	Completed	Review of thrombectomy pathway undertaken, no facility to procure ad hoc services from North Bristol or Stoke. National Stroke Implementation Group have worked with WHSSC to commission an all Wales Thrombectomy service with North Bristol NHS Trust for Welsh patients. North Bristol Trust has issued a
		Development of pathway and protocols for the referral of stroke patients within each of the Hywel Dda Acute Hospitals to suitable neuroscience in England.	Mansfield, Simon	Completed	Briefing paper and protocols developed for the direct commissioning of ad hoc thrombectomy services from English Neuroscience units.
		Negotiate short-term commissioning arrangements with neuroscience units.	Teape, Joe (Inactive User)	Completed	Completed - however unable to secure new commissioning arrangements whilst WHSSC work to commission all Wales service
		Work with WHSSC to ensure all Wales thrombectomy service is commissioned.	Teape, Joe (Inactive User)	Completed	A service is now available from Bristol 9 to 5 Monday to Friday. However no service out of hours, therefore this action stays open. There is a plan for Bristol to be available from Sep20 to be 9-5, 7 day a week service.

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

Date Risk Identified:	Feb-11	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jan-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Mar-21

Risk ID:	**117**	**Principal Risk Description:**	There is a risk avoidable patient harm or death and serious deterioration in clinical condition, with patients having poorer outcomes. This is caused by the delay in transfers to tertiary centre for those requiring urgent cardiac investigations, treatment and surgery. This could lead to an impact/affect on delayed treatments leading to significant adverse clinical outcomes for patients, increased length of stay, increased risk of exposure hospital acquired infection/risks, impaired patient flow into appropriate tertiary cardiac pathways with secondary care CCU and cardiology beds exceeding capacity and inhibiting flow from A&E/Acute Assessment wards.
Does this risk link to any Directorate (operational) risks?			

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



Rationale for CURRENT Risk Score:

The UHB has previously experienced delays in transferring patients to Swansea Bay UHB (SBUHB) tertiary service for a range of cardiac investigations, treatments and surgery. The historic risk specifically associated with transfer delays for N-STEMI patients (NICE: 'within 72 hours' reduced on development of the NSTEMI Treat & Repatriate service. The risk is further reduced given a reduced level of demand (reduced acute hospital presentation, reduced referrals from Primary Care, reduced Cardiology Outpatient activity) on account of Covid-19. The Cardiology Service has identified 'reduced patient presentation/Primary Care referral' and 'reduced Cardiology Outpatient activity' as two separate risks to manage this change.

Rationale for TARGET Risk Score:

The target score was reduced to 10 in March 2019 on account of the anticipated benefits of the Regional N-STEMI 'Treat & Repat' arrangement. The service initiated in January 2019 saw a reduction in transfer wait from an average of 10.7 to 3 days by April 2019. Between April and July 2019 waiting times increased to an average of approximately 5.8 days and is reflected in the increased current risk score of 15. Update on January 2021 waiting time position currently awaited from SBUHB.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# All patients are risk scored by cardiac team at SBUHB on receipt of patient referral from HDUHB and discussed at weekly Regional MDT. # Medical and nursing staff review patients daily and update the Sharepoint referral database as appropriate to communicate and escalate changes in level of risk/priority for patients awaiting transfer. # Bi-monthly operational meeting with Swansea Bay UHB (SBUHB) to monitor activity/patient flow and address associated risks/issues. # Weekday telephone call between SBUHB Cardiology Coordinator and all 4 hospital Coronary Care Units (CCUs) to review patients awaiting transfer, in particular the progress on identified work-up actions. # NSTEMI Treat & Repatriate service in place since January 2019 providing 6 ring-fenced beds at PPH supporting timelier transfer for BGH and WGH patients to SBUHB for angiography/coronary revascularisation. # Cardiology SDM engaged with Regional planning in support of improvements in coronary angiography capacity across South West Wales. # Cardiology SDM engaged with ARCH/Regional planning in support of improvements in pacing capacity across South West Wales.	Lack of capacity in tertiary centre to manage a range of specialised cardiac investigations, treatments and surgery. Limited available data and business intelligence to support daily monitoring/escalation of waiting times across all sites for the full range of cardiac investigations, treatments and surgery. Lack of cardiac catheter capacity in HDUHB to reduce reliance on tertiary centre angiography. Lack of theatre / pacing workforce capacity in HDUHB to reduce reliance on tertiary centre pacing. Lack of CT Coronary Angiography capacity in HDUHB to reduce reliance on in-house and SBUHB angiography.	Develop SBAR to scope the benefits and feasibility of increasing in-house CT Coronary Angiography (CTCA) capacity. As a less invasive/lower risk diagnostic, this will release and prioritize in-house and tertiary 'standard' Coronary Angiography capacity for those patients who require it and thereby reduce waiting list.	Smith, Paul	~~31/01/2019~~ 01/03/2021	Cardiology Clinical Lead and SDM currently working with in-house CTCA Steering Group to support SBAR development. SDM linking with SBUHB as part of Regional plans for CTCA and standard Coronary Angiography.
		Develop long term Regional Cardiology Plan.	Carruthers, Andrew	~~30/09/2019~~ 31/12/2021	Decision taken not to establish a regional Cardiac Network/ Collaborative. Development of long term regional plan now being overseen by Joint Regional Planning and Delivery Forum and Committee and ARCH workstreams. Cardiology Clinical Lead / SDM are engaged with these workstreams, but progress impeded in recent months due to COVID and meetings stood-down.
		Develop business case to support the long-term sustainability of the N-STEMI 'Treat & Repat' service, in particular for the following cost elements: • the transportation costs to ensure early transfer of patients to Morriston for same day cardiac catheter treatment and same day repatriation to HDdUHB; and • Consultant co-ordination/advice on the HDdUHB patients referred to the regional centre, t	Smith, Paul	Completed	Long-term funding now in place for PPH N-STEMI 'Treat & Repat' service - this service is now established and this action is now complete.

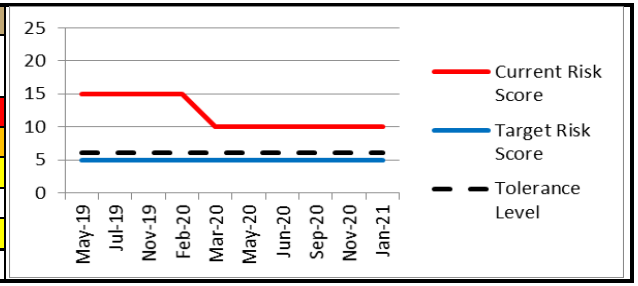
	Address issues identified regarding needed improvements to referral processes as reported in August JRPDC paper: • the internal communication and transfer processes within HDdUHB are a critical part of the success of the treat and repatriate pathway; and • Secondary care Cardiology referrals now have Consultant to Consultant discussion ahead of the electronic referral being made.	Smith, Paul	Completed	Current controls working well. SharePoint system and daily weekday coordination calls between Morriston Hospital and 4 HDUHB hospital sites working well.
	Develop more robust reporting of data and business intelligence to support daily monitoring/escalation of waiting times across all sites for the full range of cardiac investigations, treatments and surgery.	Smith, Paul	Completed	Currently piloting system at GGH for roll-out across all 4 hospital sites. In-house system monitored by Cardiology SDM works well in supporting escalation of prolonged waits to Morriston Cardiac Centre.
	Develop business case to outline and evidence benefits of increasing in-house pacing capacity in 2019/20 as part of a broader plan to repatriate the pacing LTA from SBUHB.	Smith, Paul	~~31/10/2019~~ 01/04/2021	Pacing SBAR (Aug '19) approved by Execs in Sept '19 supporting repatriating Simple Bradycardia Pacing (LTA) from SBUHB. Initial plan to phase repatriation from Spring 2020 impeded by COVID. Cardiology Clinical Lead / SDM currently working to return service capacity to baseline to support LTA repatriation plan. Fortnightly Task & Finish Group is focusing on securing workforce capacity at Withybush Hospital to develop pacemaker implant service as part of repatriation plan.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance indicators for Tier 1 targets.	Daily/weekly/monthly/ monitoring arrangements by management	1st				Lack of oversight at the Board and Committees.	Review reporting arrangements of emergency and elective waits.	Carruthers, Andrew	~~01/10/2018~~ 01/03/2021	Up to date cardiac waiting list data recently received from SBUHB. Further request made to SBUHB for Jan/Feb 2020 waiting list position for comparative purposes. Cardiology Clinical Lead and SDM currently reviewing data. Comparative analysis of 2020/2021 waiting list data for review/discussion/escalation at Feb '21 HDUHB Cardiologist Meeting. SDM to discuss with SBUHB to ensure monthly reporting of waiting list data to support improved monthly HDUHB monitoring.
	Audit of N-STEMI referral undertaken by Clinical Lead show average wait of 5.8 days - currently being reviewed for February 2021 position	1st								
	Executive Performance Reviews	2nd								
	IPAR Performance Report to BPPAC & Board	2nd								
	Monthly oversight by WG	3rd								

Date Risk Identified:	Sep-18	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jan-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Mar-21

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

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	3×5=15
Current Risk Score (L x I):	2×5=10
Target Risk Score (L x I):	1×5=5
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:

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

Rationale for TARGET Risk Score:

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

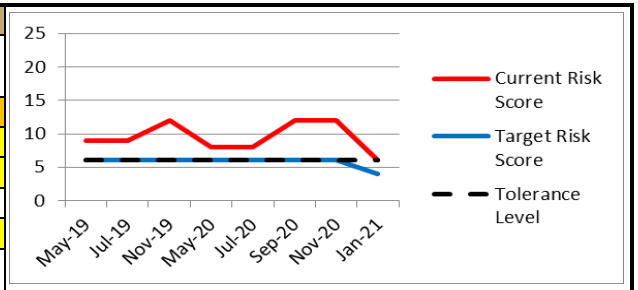
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Resident Operating Department Practitioners (OPD) Team 24/7 anaesthetic cover on site (obstetrician and consultant anaesthetist). All families are informed by the Maternity Service at Bronglais Hospital of the services available at the hospital and that they will be a Continual Risk Assessment throughout pregnancy for the suitability of the Mother to deliver at BGH. Maternity staff are trained to deal with emergencies, with protocols in place for transfer out to appropriate centre is issues are identified. Principle of removal of on-call compensatory rest approved by Executive Team.	Not having 24/7 resident theatre team.	Establish funding for 24/7 resident theatre team.	Teape, Joe (Inactive User)	Completed	Funding approved by Executive Team. Implemented new rota Oct19.
		Advertise and appoint to expanded theatre Team following agreement on funding.	Hire, Stephanie	Completed	Every vacancy is advertised although applicants can be limited. Exploring options for bulk shifts with on-contract agencies agency.
		Agreement with theatre teams (employee relations) for removal of compensatory rest. Formal 90 day OCP for Scrub and Band 3 circulatory staff to commence 16/01/19.	Carruthers, Andrew	~~30/11/2018~~ 14/06/2019 31/03/2020 30/09/2020 31/12/2020 31/03/2021	OCP completed for SCRUB and Band 3 team. Aim is to issue outcome by end of Sep20 with implementation by Dec20. Impact of Covid response has delayed finalising and communicating the conclusion of the hearing. It has also delayed the review of the risk assessment by OQSEAC. A single item agenda QSEAC is scheduled for 28th January to review the risk assessment. Following that, the hearing conclusion can be finalised and issued.
		E-roster build to support the new resident on call theatre team rota	Barker, Karen	Completed	Complete - e-roster is in place.
		Develop a formal implementation plan for the new staffing arrangements.	Barker, Karen	Completed	Establishment confirmed and work patterns in place. Recruitment ongoing.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
No of incidents reported where 30 minute response target is missed.	Maternity Services governance systems review of incident reports	1st			Executive Team - Jul18 Executive Team - Dec18 ARAC - Jun19	None identified.				
	Management audit of cases presented to QSEAC	2nd								
	Discussions with WG Chief Nursing Officer & UHB Medical & Nursing Director	3rd								

Date Risk Identified:	Sep-18	**Executive Director Owner:**	Thomas, Huw	**Date of Review:**	Jan-21
Strategic Objective:	6. Sustainable use of resources	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Mar-21

Risk ID:	**635**	**Principal Risk Description:**	There is a risk of disruption to patient care across acute, community, primary and mental health services in Hywel Dda despite the transition period for the UK's departure from the EU ended on 31 December 2020. This is caused by the agreed deal not providing comprehensive coverage, which could lead to delays in the supply chain (clinical consumables, components and medicines). There are also issues relating to the settled status scheme which may affect the ability of the Health Board to recruit and retain staff in the lead up to the 30 June deadline for that scheme. The transition from European Health entitlements to the Global Health Reciprocal Agreements which are being negotiated by the UK Government may also affect the recovery of costs relating to certain patients visiting the UK. This could lead to an impact/affect on patients being unable to access appropriate and timely treatment through the unavailability, or delay, of critical consumables, components and medicines, the UHB being unable to maintain safe and effective levels of staffing across acute and community care, financial loss and adverse publicity/reduction in stakeholder confidence and increased mortality and ill-health across our population.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	3×4=12
Current Risk Score (L x I):	3x2=6
Target Risk Score (L x I):	2×2=4
Tolerable Risk:	6
Trend:	



Rationale for CURRENT Risk Score:
Based on current assessments, the impact of continuing issues are likely to be sporadic, and not systematic. While potentially significant, the risk score can therefore be reduced post 31 December. Consequently, both the likelihood and the impact have reduced from 4 x 3 to 3 x 2. The target risk for this should also reduce given the new circumstances, from 2 x 3 to 2 x 2.

Rationale for TARGET Risk Score:
The target risk has been reduced from 2 x 3 to 2 x 2 given the new circumstances arising from the deal agreed on 24 December 2020.

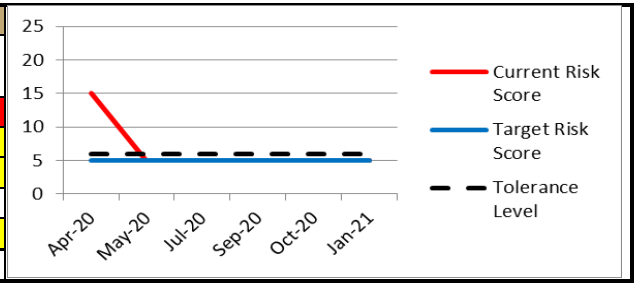
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
* Brexit Steering Group established to manage the consequences of Brexit and its interface with partners. * Wider governance infrastructure in place - of note the Dyfed Powys LRF Brexit Group (due to reconvene) and Welsh Government led groups. * Risk assessments and business continuity plans feed into a dynamic risk summary document which continues to track on-going risks and controls assurance with business continuity. * Work within Workforce and OD to identify EU nationals and resolve data gaps in ESR has been largely completed (98%). Workforce Brexit Plan developed. * Staff Brexit Intranet page developed as single point of information plus a closed Facebook Group for EU staff. * Sitrep process at local, regional and national level for reporting and escalating impacts of consequences of Brexit (currently stood down). * Staff bulletins issued to inform and raise awareness.	Full understanding of potential impacts and implications for the UHB due to the unknown final outcome of Brexit.	Ongoing dynamic review of the UHB's operational Brexit risk assessment and mitigating action to provide assurance that these remain current and that no new risks have been identified.	Thomas, Huw	Ongoing	Completed.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
None identified.	Response submitted on 19Nov18 to Andrew Goodall letter of 05 October stating approach to be taken by Health Boards confirming progress	1st			No recent papers.	Further sources to be identified when risk is fully understood.				
	Response submitted to Wales Audit Office letter notifying of intention to undertake an initial baseline of arrangements by 30Nov19	1st								
	Response submitted to the Health, Social Care and Sport Committee, Welsh Government request for written evidence of Brexit preparations by 20/06/19	1st								
	Response submitted to request from Welsh NHS Confederation in relation to providing support to vulnerable patients by 30/07/19	1st								
	Emergency Planning Team to review UHB no deal Brexit arrangements and associated BCPs	1st								
	Executive oversight of Brexit arrangements and BCPs	2nd								
	Review of Exercise planned for Jan19	3rd								
	WAO Review of Brexit Preparedness	3rd								

Date Risk Identified:	Apr-20	**Executive Director Owner:**	Moore, Steve	**Date of Review:**	Jan-21
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Feb-21

Risk ID:	**853**	**Principal Risk Description:**	There is a risk that the UHB's response to COVID-19 will be insufficient to address peak in demand terms of bed space, workforce and equipment and consumables. This is caused by an increased demand for services above the level secured. This could lead to an impact/affect on difficult triaging decisions for our clinicians, poor quality and safety for patients and an inability to accommodate every patient that needs us.
Does this risk link to any Directorate (operational) risks?			

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



Rationale for CURRENT Risk Score:
Impact of the risk recognises the significant clinical risk of the risk if it becomes reality. At present, based on estimated COVID demand and the planning undertaken to respond to COVID-19, the likelihood of this risk has been reduced from 3 to 1. Likelihood is based on actual experience of the progress of the pandemic, our winter preparedness plan (which sets out in detail our local arrangements to ensure capacity is sufficient), improvements in our modeling and WG planning assumptions regarding the likely transmission rate in Wales.

Rationale for TARGET Risk Score:
Target score has been met.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
A strong Command & Control structure has been implemented and judged fit for purpose by our assigned Military Liaison Officer. Planning numbers have been clearly communicated from Gold to Tactical and Bronze groups at the earliest opportunity. An Ethics Panel has been established to consider the challenges ahead and provide guidance. QSEAC will scrutinise PPE and areas of concern such as oxygen supply and ventilators. Modelling cell established to provide regular forecasts of the progress of the pandemic at local level. Functional capacity forecasting tool provides time to respond to changes in forecasting. Field hospital capacity has now been secured for the Q3/4 period and is sufficient to accommodate patients up to the peak level of configuration set out by Welsh Government. A workforce plan to support this is being finalised including additional recruitment (which is currently underway). Comprehensive Prevention and Response Plan agreed with the 3 local authorities to ensure Track, Trace and Protect (TTP) is effective in reducing transmission rates.	Inability to directly control lift of lockdown measures.				

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
None identified.	Response to COVID-19 reviewed by Command and Control Structure	2nd			Responding to the COVID-19 Pandemic Board Report - Apr20, May20, Jun20, Jul20 & Sep20	Internal and External Audit Plans in 20/21 are being reviewed to incorporate review of organisational response to COVID-19.				
	Board oversight of response to COVID-19	2nd								