Risk Ref	Risk (for more detail see individual risk entries)	Included on BAF	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Sep-20	Trend	Target Risk Score	Risk on page no...
628	Fragility of therapy provision across acute, community and primary care services	*	Shakeshaft, Alison	Safety - Patient, Staff or Public	8	4x4=16	4x4=16	↔	3x4=12	3
750	Lack of substantive middle grade doctors affecting Emergency Department in WGH.	*	Carruthers, Andrew	Safety - Patient, Staff or Public	6	3x4=12	4x4=16	↑	2x4=8	6
684	Lack of agreed replacement programme for radiology equipment across UHB	*	Carruthers, Andrew	Service/Business interruption/disruption	6	4x4=16	4x4=16	↔	2x3=6	8
810	Poor quality of care within the unscheduled care pathway	*	Carruthers, Andrew	Safety - Patient, Staff or Public	6	3x4=12	3x4=12	↔	3x4=12	12
855	Risk that UHB's non-covid related services and support will not be given sufficient focus	**	Moore, Steve	Quality/Complaints/Audit	8	3x4=12	3x4=12	↔	2x4=8	16
91	Insufficient number of Consultant Cellular Pathologists to meet 14 day timescale set out in the new Single Cancer Pathway	*	Carruthers, Andrew	Safety - Patient, Staff or Public	6	3x4=12	3x4=12	↔	2x4=8	18
291	Lack of 24 hour access to Thrombectomy services	*	Carruthers, Andrew	Quality/Complaints/Audit	8	N/A	3x4=12	↔	2x4=8	21
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	4x3=12	↔	2x3=6	23
733	Failure to meet its statutory duties under Additional Learning Needs and Education Tribunal Act (Wales) 2018 by Sept 2021	*	Shakeshaft, Alison	Statutory duty/inspections	8	4x4=16	3x4=12	↓	2x3=6	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	2x5=10	↔	2x5=10	30
634	Overnight theatre provision in Bronglais General Hospital	*	Carruthers, Andrew	Safety - Patient, Staff or Public	6	2x5=10	2x5=10	↔	1x5=5	33
635	No deal Brexit affecting continuity of patient care	*	Thomas, Huw	Service/Business interruption/disruption	6	4x2=8	4x3=12	↑	2x3=6	35
853	Risk that Hywel Dda's response to COVID-19 will be insufficient to manage demand.	**	Moore, Steve	Safety - Patient, Staff or Public	6	1x5=5	1x5=5	↔	1x5=5	37

* Health Board objectives 20/21 to be confirmed.

** Delivery of the QTR 2 Operating Plan

Assurance Key:

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

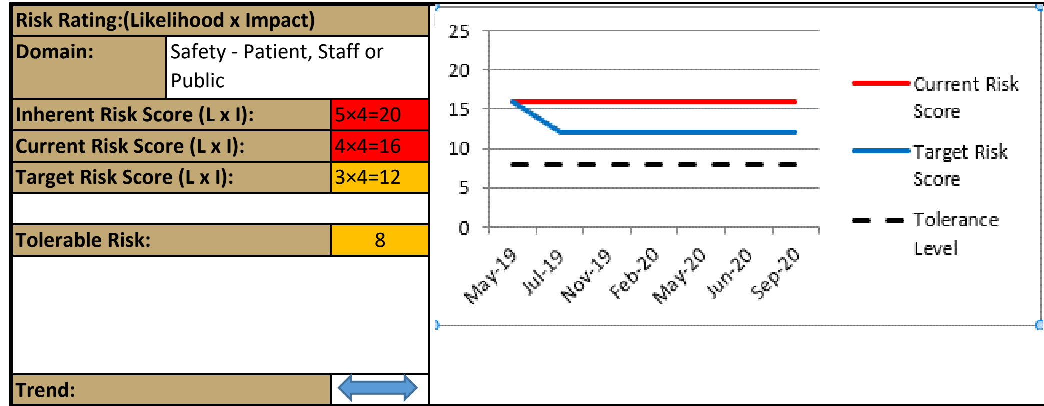
Key - Assurance Required		*NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you*
(blue)	Detailed review of relevant information	
(pink)	Medium level review	
(purple)	Cursory or narrow scope of review	

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

Date Risk Identified:	Sep-18	Executive Director Owner:	Shakeshaft, Alison	Date of Review:	Sep-20
Strategic Objective:	Health Board objectives 20/21 to be confirmed.	Lead Committee:	Quality, Safety and Experience Assurance Committee	Date of Next Review:	Oct-20

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 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, 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 14 week waiting time and non-compliance with clinical guidance, with a potential adverse impact on patient safety/harm.
Does this risk link to any Directorate (operational) risks?			yes

Risk Rating:(Likelihood x Impact)	
Domain:	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):	3×4=12
Tolerable Risk:	8
Trend:	⬄



Rationale for CURRENT Risk Score:

There are significant gaps in the therapy service provision across acute, community and primary care, the reasons for this are described in the cause section. Impact to service provision by COVID-19 pandemic and rehabilitation requirements will add an additional challenge to workforce models. Across all therapy services, current demand does not align to current capacity and whilst this is being managed as far as possible by the controls in place, it is not sustainable.

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 have been identified within the Annual Plan for focus during 2020/21: older people (incorporating frailty, dementia and stroke); improving self-management (including pulmonary rehabilitation and diabetes); therapists as first point of contact in primary care (including musculoskeletal, older people and irritable bowel syndrome); Major Trauma Plan. An additional requirement will be the delivery of the COVID-19 Rehabilitation Framework. A sustainable solution is also required to maintain the 14 week waiting time target. These areas of development will require practical, prudent and incremental workforce solutions to improve patient care, outcomes and experience, and sustainable funding models will be required through whole-system review and shifting of resource from elsewhere in the health and care system.

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

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**
Inability to secure funding for all developments identified in 20/21 annual plan. Shortage of qualified staff nationally and rurality of HDdUHB historically limits applications to some posts. Unplanned service development opportunities. Lack of cohesive approach to workforce planning across all therapy services. 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 Advanced Practice roles. Restart of service delivery following Covid 19 will also create additional demand across the traditional areas in addition to the rehabilitation needs associated with COVID-19.	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.

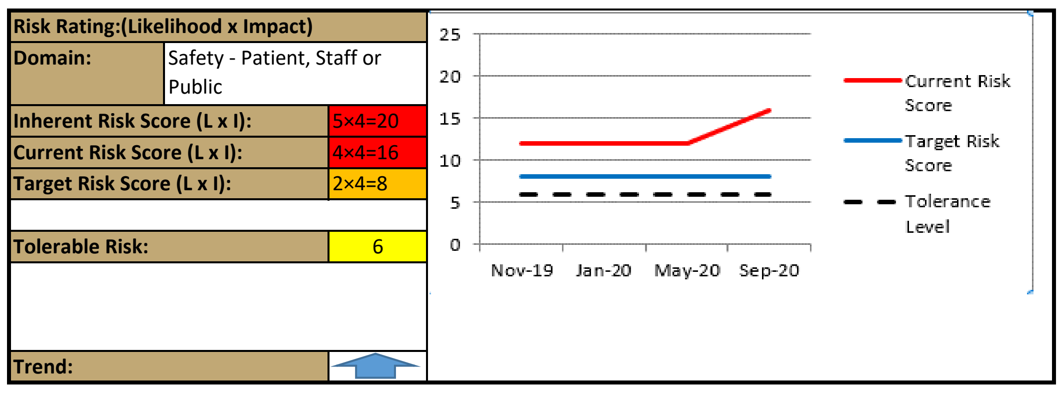
		Develop robust workforce plans that align to stroke, major trauma and neurology and COVID-19 rehabilitation service needs to maximise workforce opportunities.	Shakeshaft, Alison	~~31/03/2020~~ 31/03/2021	Plan being developed as part of Therapy 3 Year Plan 2021/23 to include extended and 7 day working.

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				Reporting improved compliance with the Dementia Action Plan, including increased diagnostic rates.				
	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:	Jun-19	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Sep-20
Strategic Objective:	Health Board objectives 20/21 to be confirmed.	Lead Committee:	Quality, Safety and Experience Assurance Committee	Date of Next Review:	Oct-20

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 rates.
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 present 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.

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.	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.

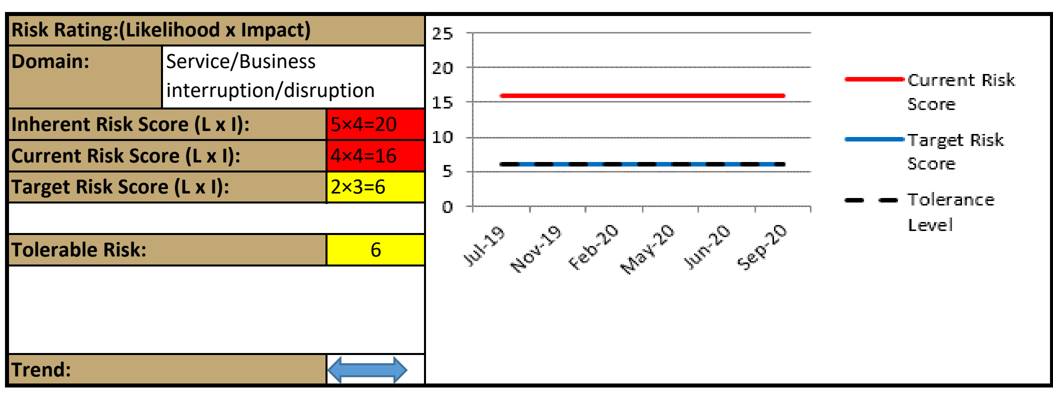
Links with other Health Board sites (HDUHB & SBUHB) to outline current pressures and any opportunities to cross cover and to assess overall medical staffing position across HDUHB Weekly Urgent Response Group review rotas for the next six months. 1 x long term locum in place (2 left July 2020). Escalation procedures in place. July 2020 - rotas have now separated as number of inpatients have increased and general medical teams have a larger inpatient & medical take to support.		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:	Jan-19	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Sep-20
Strategic Objective:	Health Board objectives 20/21 to be confirmed.	Lead Committee:	Quality, Safety and Experience Assurance Committee	Date of Next Review:	Oct-20

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):	4×4=16
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 can be 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.

Rationale for TARGET Risk Score:

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

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

Gaps in CONTROLS

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

# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place	Limitation of spare parts for some older equipment leading to extended outages. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. 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	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.
# Disaster recovery plan in place. # CT Scanner including fluoroscopy room and WGH MRI included on all Wales Capital Programme (AWCP)(not yet agreed)and AWCP secured for replacing the BGH MRI. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports. 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.		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	Commissioning equipment is dependent on lockdown measures in and outside of UK and contractor availability to undertake work.
		additional CT resource due to delay in funding from WG	Evans, Amanda	30/10/2020	Additional CT resource obtained from NHS England in the form of a demountable unit . Resource to be shared with SBUHB. Due to be installed 18th September operational in October

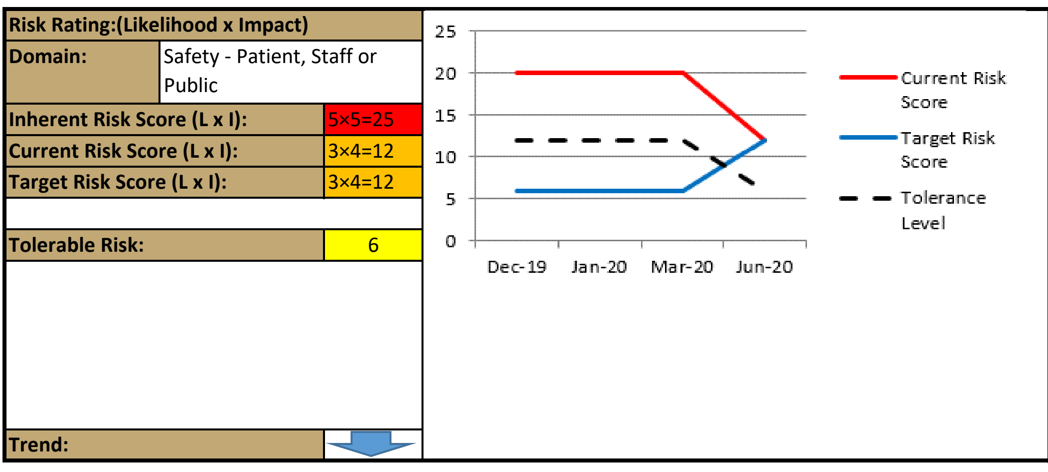
ASSURANCE MAP					Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance	Current Level			Identified Gaps in Assurance:	How are the 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-19	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Jun-20
Strategic Objective:	Health Board objectives 20/21 to be confirmed.	Lead Committee:	Quality, Safety and Experience Assurance Committee	Date of Next Review:	Aug-20

Risk ID:	810	Principal Risk Description:	There is a risk of avoidable harm to patients and poor quality of care within the unscheduled care pathway. This is caused by ambulance delays for patients waiting at home for an ambulance (as a result of ambulances being delayed outside hospitals), overcrowding within Emergency Departments (EDs) from poor patient flow, inability to adequately staff EDs and surge facilities to cope with demand, and deconditioning of patients who are spending too long in an acute hospital setting. This could lead to an impact/affect on patients who will experience significant clinical deterioration, delays to diagnostics and treatment, and poorer outcomes, increased incidents of a serious nature, inability to recruit and retain clinical staff, adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators.
Does this risk link to any Directorate (operational) risks?			

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



Rationale for CURRENT Risk Score:
The current risk has significantly reduced during the COVID period, potentially influenced by reduced demand for emergency care at our ED facilities. Ambulance delays have reduced to their lowest recorded level since July 2017. Where delays occur at the present time, these predominantly relate to the challenges of ensuring patients with known / suspected COVID symptoms are cared for in the most appropriate environment for their (and other patients') needs. The risk is not completely resolved as pressure on non-COVID GREEN capacity continues on some sites and the situation remains under review.

Rationale for TARGET Risk Score:
Across the UK there is a significant challenge across the unscheduled care system. The target score of 12 is based on the planned work to help prevent the return of extreme pressures in the post COVID-19 period.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)
Comprehensive daily management systems in place to manage unscheduled care risks on daily basis including multiple daily multi-site calls in times of escalation. # Reviews of patients admitted to surged areas to ensure patient acuity and dependency is monitored and controlled. # Surge beds continue as per escalation and risk assessment of site demand and acuity. A daily review of the use of surge beds via patient flow meetings to facilitate step down of beds. # Discharge lounge takes patients who are being discharged. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites. # Discharge planning is a core part of the inpatient documentation & is commenced prior to admission in the A&E Department once the decision to admit is made & included in ward rounds. # Regular training on discharge planning and complex care management is provided to ward based staff through Community Discharge Liaison teams, Social services and the Long Term Care Team support. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Escalation plans for acute and community hospitals. # Annualised delivery plans aligned to Transforming Clinical Services. # Annual winter plans developed to manage increased activity. # Joint workplan with Welsh Ambulance Services NHS Trust. # 111 implemented across Hywel Dda. # Transformation fund bids in relation to crisis response being implemented across the system.

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**
Lack of available inpatient beds to meet ED admissions Delays in discharge of medically fit patients Consistent approach to implementation of Red2Greed and SAFER patient bundles Lack of agreement of discharge standards with partners Workforce issues create an ongoing demand/capacity imbalance. Inability to improve current unscheduled care system due to high reliance on temporary staff. Inability to manage within current unscheduled care capacity continues to cause problems for elective programmes of work. Resilience of out of hours remains a significant challenge.	Redesign of services in unscheduled care through Transforming Clinical Services Programme.	Kloer, Dr Philip	31/03/2028	A Healthier Mid and West Wales: Health and Care Strategy was approved by the Board in Nov18. Since approval, significant work has been undertaken to plan for the delivery phase.
	Clusters through their IMTPs will consider system wide changes that support the provision of seamless care to patients	Paterson, Jill	31/03/2022	Defined plans will be developed as part of the planning process for 2021/22.
	Implementation Plan to be developed and delivered by UHB following the review on 'Amber' ambulance 999 calls	Bishop, Alison	31/03/2021	The USC system plan will encompass any actions to be delivered in partnership with primary care and WAST colleagues.
	Development and delivery of Unscheduled Care Programme including frailty plan, older people plan, Red2Green, SAFER bundles, PJ paralysis, last 1000 days.	Carruthers, Andrew	31/03/2021	Work progressing and is on target. USC System plans have been developed on a county level, next steps are peer review and agreement of outcome measures. Work is also underway with fortnightly meetings to review unscheduled care improvement plans.
	Develop winter plans for 2020/21.	Carruthers, Andrew	30/11/2020	To be developed and presented to Board for approval in Nov20.
	A refreshed approach based on the 4 nationally agreed 'Discharge to Assess/Recover' (D2RA) pathways to be developed and approved with each local authority and will be implemented as part of the Unscheduled Care 3 year plan.	Carruthers, Andrew	~~30/11/2019~~ 31/03/2023	Agreed approach with Local Authorities at Winter Summit in Dec19.

Action	Lead	By When	Progress
Implement transformation schemes funded through transformational funding through Regional Partnership Board to support implementation of TCS over next 10 years.	Carruthers, Andrew	31/03/2021	Submission successful in securing £11.9m. Groups now working on implementing three approved programmes and embedding into county plans. Weekly IEG meetings are pushing the pace.
Redesign of the out of hours system across HDUHB	Carruthers, Andrew	31/03/2021	Temporary closures of overnight rotas at 2 bases from 09Feb20.
Review of A&E model across the south of the Health Board	Kloer, Dr Philip	~~30/06/2020~~ 30/06/2021	As part of the Transforming Hospitals programme a complete review of the A&E model given current staffing constraints is being implemented.

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. A suite of unscheduled care metrics have been developed to measure the system performance.	Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st				What's the hold up? Discharging patients in Wales - Wales Audit Office Toolkit Assurance Report - ARAC - Oct19 IPAR - Board & BPPAC (bi-monthly) Winter plan 2019-20 - Finance Committee and Board - Nov19					
	Daily performance data overseen by service management	1st									
	Delivery Plans overseen by Unscheduled Care Improvement Programme	2nd									
	Bi-annual reports to PPPAC on progress on delivery plans and outcomes (and to Board via update report)	2nd									

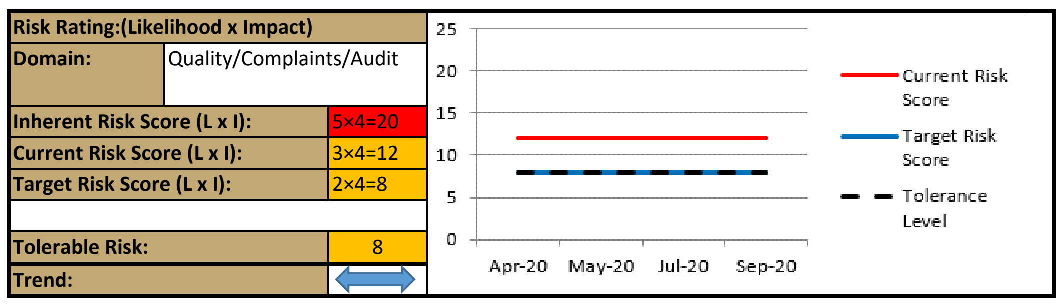
	Item	Line of defence									
	Executive Performance Reviews	2nd									
	IPAR Performance Report to PPPAC & Board	2nd									
	WAST IA Report Handover of Care	3rd									
	11 x Delivery Unit Reviews into Unscheduled Care	3rd									
	Delivery Unit Report on Complex Discharge	3rd									

Date Risk Identified:	Apr-20
Strategic Objective:	Delivery of the QTR 2 Operating Plan

Executive Director Owner:	Moore, Steve	Date of Review:	Sep-20
Lead Committee:	Quality, Safety and Experience Assurance Committee	Date of Next Review:	Nov-20

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 corporate and operational focus diverted to COVID-19 planning. 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):	3×4=12
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	8
Trend:	



Rationale for CURRENT Risk Score:

In the early stage of the pandemic, to prevent deterioration urgent patients and those needing cancer, rheumatological and other services continued to receive care and processes were in place to maintain this. Impact of the risk is based on the fact that harm will be done if the risk materialises. Quarterly planning process now established and expansion/restarting of non-COVID services is being implemented.

Rationale for TARGET Risk Score:

Revised Planning Guidance Requirement issued by Tactical to Bronze will lead to a prioritised risk based plan to restart services that have been scaled back or suspended.

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

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.

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
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

Winter Pressures Plan will set out plans for non-COVID services during winter ensuring focus is maintained on these services during a challenging winter period. Establish Transformation Steering Group. Quarterly planning process to ensure essential services are maintained and other services are cautiously restored as progress of the pandemic allows.		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.

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 (Apr20&May20)	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								

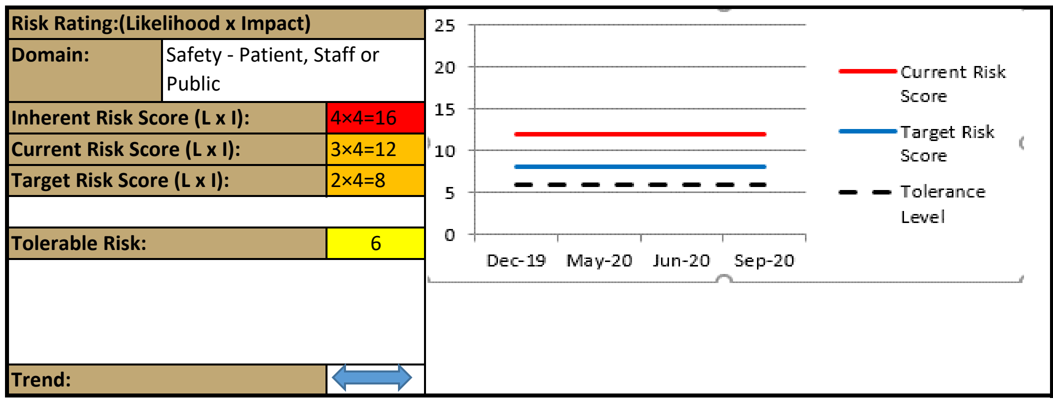
Appendix 3

Date Risk Identified:	Mar-11
Strategic Objective:	Health Board objectives 20/21 to be confirmed.

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Sep-20
Lead Committee:	Quality, Safety and Experience Assurance Committee	Date of Next Review:	Nov-20

Risk ID:	91	Principal Risk Description:	There is a risk of avoidable clinical deterioration of cancer patients waiting for diagnosis within the Single Cancer Pathway (SCP). This is caused by a significant number of vacant Consultant cellular pathologist posts(currently 3.0WTE vacant positions out of 9.0WTE establishment) to enable the timely analysis of tissue samples where there is suspected cancer within the 14 day timescale set out within the new SCP. This could lead to an impact/affect on patients having poorer outcomes from delays in the commencement of treatment, reliance on locums, delays to decision-making at MDTs (multidisciplinary Team), inability to treat patients within the timescales in the SCP, increased complaints and claims and increased scrutiny from Welsh Government.
Does this risk link to any Directorate (operational) risks?	96		

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



Rationale for CURRENT Risk Score:

There is a national recruitment issue in relation to consultant cellular pathologists. There is a current gap of 3.0WTE Consultant cellular pathologist posts, (out of 9.0WTE established posts) in Hywel Dda, however one substantive Consultant Cellular Pathologist has given notice to finish in Dec20. If the service fail to recruit, it will need to secure a locum, potentially above agency price cap. This significantly impacts the UHB's ability to meet timescales set out in the new single cancer pathway. The vacancy budget is being used to fund additional sessions and ILOL claims by the current substantive staff, however this is not sufficient to meet required timescales or enable the service to attend MDTs to review cancer cases. The service is also unable to source agency consultant cellular pathologist locums within the All Wales Framework due to the current price cap.

Rationale for TARGET Risk Score:

The service is actively trying to recruit into the remaining vacant posts. The service currently have 3 substantive and 3 NHS locums, 2 of which require CESR, with 3 vacancies remaining. Whilst this does not fully address the shortfall, it will provide capacity for cellular pathologist consultant representation at MDTs to review cancer cases. The long term plan is to develop a regional cellular pathology and immunology service with Swansea Bay UHB and Public Health Wales. A strategic outline case (SOC) has been submitted through ARCH to Welsh Government with a response awaited, however this is likely to be delayed as a result of COVID-19.

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

Consultant Cellular Pathologists centralised to Glangwili General Hospital (GGH) site. Tissue processing centralised to GGH site. Consultant Cellular Pathologists are undertaking additional sessions to maintain workload in house to ensure turn around times are maintained. Additional 6 sessions provided by current 3.0WTE substantive consultants (will reduce to 2.0 WTE working an additional 4 sessions from Dec20)	National shortage of available consultant cellular pathologists. Inability to secure locum consultant cellular pathologists within All Wales Framework. Inability to develop new staffing model whilst significantly understaffed(and 2 consultants working from home due to COVID-19).	Full implementation of digital pathology solutions to enable scanning of tissue samples to help reduce delays in analysis.	Stiens, Andrea	~~31/03/2021~~ (TBC)	Phase 2 of project has developed and tested the Hub and spoke concept - this phase closed in Nov 2019. Phase 3 has just started with a business case that will support national scale up, infrastructure and data storage solution currently being developed. Date of completion for Phase 3 will depend on approval and funding from WG.

Prioritisation of suspected cancer cases over routine tissue samples.

Actively working with medical staffing to recruit to vacant posts.

Action	By Who	By When	Progress
Implementation of regional service through the ARCH project.	Stiens, Andrea	~~31/03/2024~~ 30/09/2020	Strategic Outline Case (SOC) approved by Hywel Dda UHB, Swansea Bay UHB and Public Health Wales, has been submitted to Welsh Government (WG) for scrutiny and the UHB is awaiting WG approval. This will be delayed due to COVID-19.
Commence the modernisation of the technical workforce through recruitment of staff trained in dissection.	Stiens, Andrea	~~31/12/2019~~ 31/03/2020 31/03/2021	Progress may be limited until regional model is adopted. This will be delayed due to COVID-19.

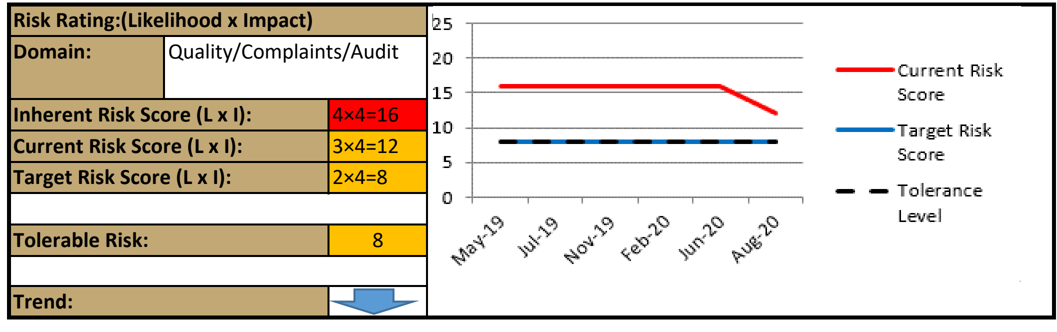
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level		
None identified.	Review of KPIs at Monthly Pathology Strategy Group meeting	1st			QSEAC -Feb19 & Apr19 & Feb20 (planned) Op QSE SC - May19
	External Quality Assessments by Consultant Staff - issues picked up through supervision	1st			

Gaps in ASSURANCES				
Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
Lack of independent assurance of service	Submit application for pre-assessment visit accreditation (UK Accreditation Scheme) re compliance with ISO 15189 Laboratory Standards)	Stiens, Andrea	~~31/03/2020~~ 30/09/2020	Rigorous accreditation process requires a pre-assessment visit which is unlikely to be before Sep20.

Date Risk Identified:	Oct-17	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Aug-20
Strategic Objective:	Health Board objectives 20/21 to be confirmed.	Lead Committee:	Quality, Safety and Experience Assurance Committee	Date of Next Review:	Oct-20

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):	2×4=8
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). However this service is only available Mon to Fri 9-5pm therefore there is still a risk during out of hours. During the COVID -19 situation there has been no significant changes to the pathway. All 4 sites have been able to transfer patients when required.
Some HDUHB sites still have delays in 24/7 CT Angiography. All 4 sites have Mon-Sun 9-5 CT angiography. There is a plan for Bristol to be available from Sep20 to be 9-5, 7 day a week service.

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. However this service is only available 9am to 5pm (at Bristol) Mon to Fri. 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. A HDUHB Thrombectomy group will be established(to be arranged). There is a plan for Bristol to be available form Sep20 to be 9-5, 7 day a week service.	Timely investigations that are required to support transfers for thrombectomy not supported 24/7 on all sites. Work is ongoing to ensure that CT Angiography is available in all Hywel Dda units to provide the necessary diagnostic investigations prior to transfer to a specialist neuroscience centre.	Develop and review the Thrombectomy pathway, throughout the Health Board.	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 Thrombectomy check list and

		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.

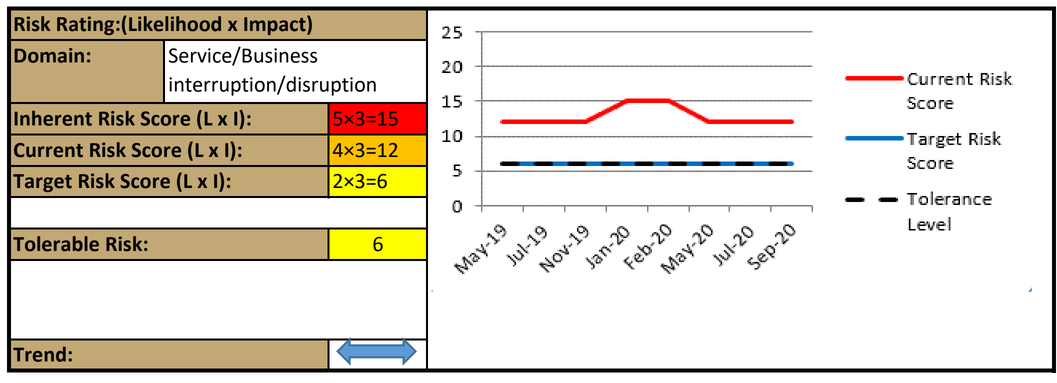
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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:	Apr-17
Strategic Objective:	Health Board objectives 20/21 to be confirmed.

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Sep-20
Lead Committee:	Quality, Safety and Experience Assurance Committee	Date of Next Review:	Nov-20

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):	2×3=6
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. Demand is variable as are remaining workforce shortfalls - also reflected in the current assessment. 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. In the event of a significant COVID outbreak, there are more staff who will be unavailable to work, further exacerbating the situation, in addition to those already absent having been identified through risk assessment. Given the ongoing issues as described, the need for service modernisation continues and is likely to be instrumental in long-term service security.

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. The project management office has been supporting service leads in this area prior to the Pandemic. A date has yet to be secured in relation to reconvening the working group.

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	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	Ensure Transforming Clinical Services Programme incorporates a long term, viable plan for OOH.	Rees, Gareth	30/09/2020	Project Management Office (PMO) has convened a working group to develop short to medium term
		Development of home working provision for GPs.	Rees, Gareth	Completed	Completed and evolving.

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. # Ongoing recruitment of clinicians has resulted in 14 appointments (sessional or bank basis) in the last 4 months. # Rationalisation of overnight bases in place since March 2020 appear successful in supporting wider service delivery in current model. # A new approach to engage with the GP network was held in terms of a workshop in Oct19 - further workshops to be held in 2020, but re-arrangement is affected by COVID-19 restrictions. # Programme Management Office (PMO) project to assess service and workforce redesign is presently on hold due to the COVID-19 situation.	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 - support from PMO to achieve this has been obtained and a working group will reconvene as soon as conditions allow- timescale yet to be confirmed. In relation to service demand, activity is increasing (3860 contacts in August 2020- on a par with January expectation)and this further	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

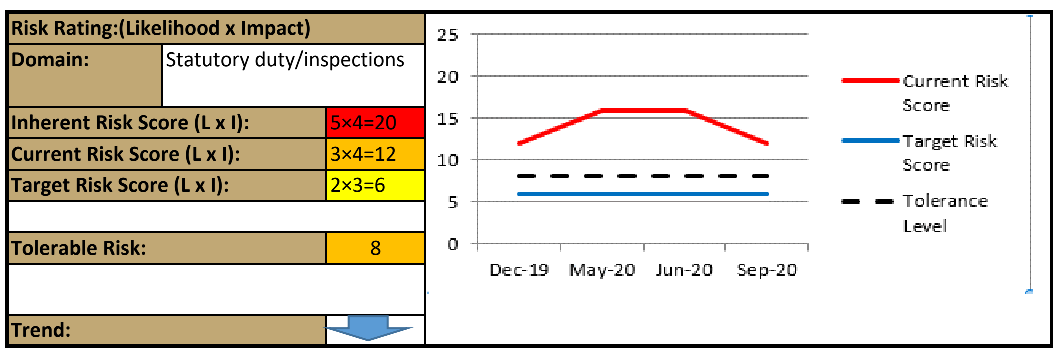
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
	Weekly sitreps/Weekend briefings for OOH	1st			QSEAC- Review of risk 129- (prepared Sep20) ET- Risk to OOH business continuity - Sep19 QSEAC OOH Update Sep19 ET- OOH resilience - Nov19 BPPAC - update on the OOH Services peer review paper	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.
	Monitoring of performance against 111 standards	1st								

	Executive Performance Reviews	2nd			Dec19 BPPAC Quarterly monitoring Nov19 QSEAC OOH Update Feb20 ET - OOH resilience Q3 monitoring Jan20 QSEAC - Peer review - Feb20 BPPAC - OOH service design Feb20					
	BPPAC monitoring	2nd								
	QSEAC monitoring	2nd								
	WG Peer Review Oct 19	3rd								

Date Risk Identified:	May-19	Executive Director Owner:	Shakeshaft, Alison	Date of Review:	Sep-20
Strategic Objective:	Health Board objectives 20/21 to be confirmed.	Lead Committee:	Quality, Safety and Experience Assurance Committee	Date of Next Review:	Oct-20

Risk ID:	733	Principal Risk Description:	There is a risk of the Health Board not meeting fully its statutory duties under the Additional Learning Needs and Education Tribunal Act (Wales) 2018 by 1st September 2021. This is caused by a deficit in Information Management requirements to inform performance reporting and assurance, lack of service/department systems and processes, lack of staff awareness and understanding of the relevance of ALNET Act upon their practice, inability to fully meet requirements in relation to Welsh Medium provision and dispute resolution. This could lead to an impact/affect on complaints and tribunals, loss of reputation and possible judicial review.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Statutory duty/inspections
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	8
Trend:	



Rationale for CURRENT Risk Score:

"The ALNET Act (Wales) 2018 places new statutory duties on the Health Board. The full impact of these new statutory duties on individual services/departments/directorates is not fully understood as yet.
During the Q1 period of the COVID-19 pandemic, the preparations for the implementation were put on hold. However, the WG Education branch has been clear in its communication that the implementation of the ALNET Act on the 1st September 2021 remains a firm priority. More recently, as part of the Q2 framework, the preparations for the implementations of the ALNET Act have been resumed."

Rationale for TARGET Risk Score:

The focus of the actions is to prepare all relevant services/departments/directorates so that they can fulfil their duties under the Act or support the organisation in fulfilling its duties under the Act. However, the impact of the implementation of the Act will only become fully clear over time. Lessons will be learned from the implementation which will inform further actions which may reduce the target score to below tolerance level.

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**

# DECLO (Designated Education Clinical Lead Officer) appointed (one of the 4 new statutory duties) - 01/01/2019 # DECLO member of the All Wales DECLO Group # DECLO member of Regional ALN Transformation Leadership Group. # Hywel Dda ALN Implementation Group established - 01/04/2019 # Hywel Dda Readiness Survey completed - Spring 2019 # Hywel Dda ALN Implementation Plan (2019-2020) in situ. # Hywel Dda represented at the relevant regional ALN work streams (2019-2020) # Local systems in place to capture SEN, which may be transferable to ALN. # Strong local, operational working relationships with Local Authority Education Services, Social Services, Schools and Further Education Institutions.	A deficit in information management requirements to inform performance reporting. A lack of service/ department/directorate systems and processes to ensure adherence with the statutory requirements of the ALNET Act . A lack of staff awareness and understanding of the relevance of ALNET Act upon their practice.	Implement Regional Health ALN Implementation Plan (04/2020-08/2021), which includes actions to address the assurance gaps.	Vanderlinden, Natalie	~~31/08/2020~~ 31/08/2021	The original national implementation date of the ALNET Act on 01/09/2020 was revised to 01/09/2021 by the Welsh Minister for Education Kirsty Williams.

# Successful grant application from Regional Transformation Fund (2019-2020) to fund fixed term Business Support to assist with the implementation of the ALN Implementation Plan. # Project Support Manager - ALN appointed for 12 months. # Information raising session at OD Session of the Board and at Executive Team. # Growing understanding of the ALNET Act amongst senior leaders within the Health Board and its potential impact, which helps inform the implementation plan. # Integrated Regional ALN Transformation Plan (2020-2021) in situ # Successful grant application from Regional ALN Transformation Fund (2020-2021) to support the delivery of the Regional Health ALN Implementation Plan (01/04/2020 - 31/08/2020) # Review of ToR of HDdUHB ALN Operational Implementation Group. # Development of Guide for NHS staff on ALNET Act (09 2020)	Inability to fully meet requirements in relation to Welsh Medium provision and dispute resolution. Project Support Officer (started 09/12/2020) been deployed on 24/03/2020 in support of COVID-19.Returned on 22/06/2020 ALN Implementation Group stood down in support of Covid-19. Re-instated since 10/06/2020. Reduced capacity within Services/Departments/Directorates to focus on readiness for implementation due to current focus on Covid-19. Capacity and focus partially been re-instated (09 2020). Uncertainty of the impact of the conversion of Individual Education Plans and Statements into Individual Development Plans unto service resources.				

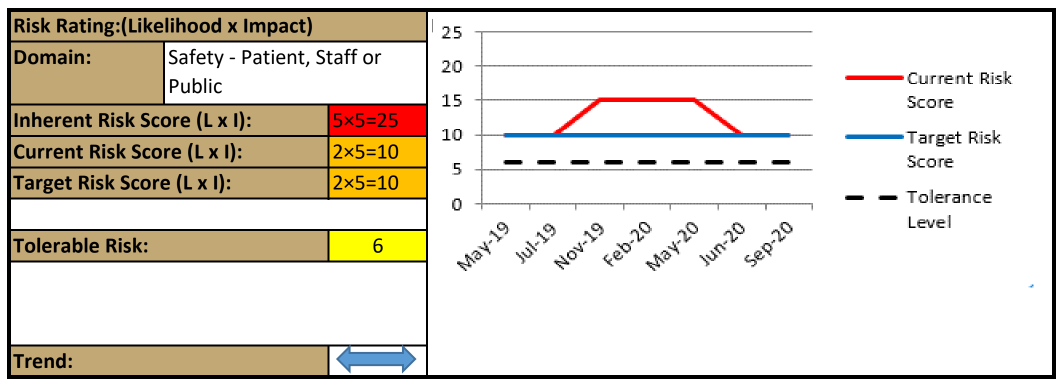
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
	Hywel Dda ALN Implementation Group monitors the progress against the actions within the Regional Health ALN Implementation Plan - 2020-2021	1st			Executive Team, ALN Act Implementation - 09 2019 Bronze Command - Community -	Performance and governance arrangements currently not in place to provide the necessary assurance that the organisation	Confirm key performance indicators	Vanderlinden, Natalie	~~31/08/2020~~ 31/08/2021	The original national implementation date of the ALNET Act on 01/09/2020 was revised to 01/09/2021 by the Welsh Minister for Education Kirsty Williams.

DECLO provides assurance on an exception basis to the Executive Team	1st			SBAR: SEN and ALN during CIVID-19 - June 2020	fulfils its duties under the Act.	Confirm key performance reporting arrangements	Vanderlinden, Natalie	~~31/08/2020~~ 31/08/2021	The original national implementation date of the ALNET Act on 01/09/2020 was revised to 01/09/2021 by the Welsh Minister for Education Kirsty Williams.
DECLO provides assurance to the Regional Transformation Lead and the Regional ALN Transformation Group	2nd					Confirm key quality, safety and experience indicators	Vanderlinden, Natalie	~~31/08/2020~~ 31/08/2021	The original national implementation date of the ALNET Act on 01/09/2020 was revised to 01/09/2021 by the Welsh Minister for Education Kirsty Williams.
Regional ALN Transformation Group monitors progress made against the actions within the ALN Health work stream plan 2019 -2020	1st					Confirm key quality, safety and experience assurance arrangements	Vanderlinden, Natalie	~~31/08/2020~~ 31/08/2021	The original national implementation date of the ALNET Act on 01/09/2020 was revised to 01/09/2021 by the Welsh Minister for Education Kirsty Williams.

Date Risk Identified:	Feb-11	Executive Director Owner:	Carruthers, Andrew	Date of Review:	Sep-20
Strategic Objective:	Health Board objectives 20/21 to be confirmed.	Lead Committee:	Quality, Safety and Experience Assurance Committee	Date of Next Review:	Nov-20

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 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 February 2020 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. # 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	Lack of capacity in tertiary centre to manage a range of specialised cardiac investigations, treatments and surgery. Lack of available data and business intelligence to support daily	Develop business case to outline and evidence the benefits of increasing in-house coronary angiography capacity in 2020/21 as	Smith, Paul	~~31/01/2019~~ 30/11/2020	Cardiology SDM is engaged with JRPDF concerning this development. SDM/Clinical Lead currently
		Develop long term regional plan.	Carruthers, Andrew	~~30/09/2019~~ 31/12/2020	Decision taken not to establish a regional Cardiac Network/ Collaborative. Development of long

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.	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 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 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.	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.

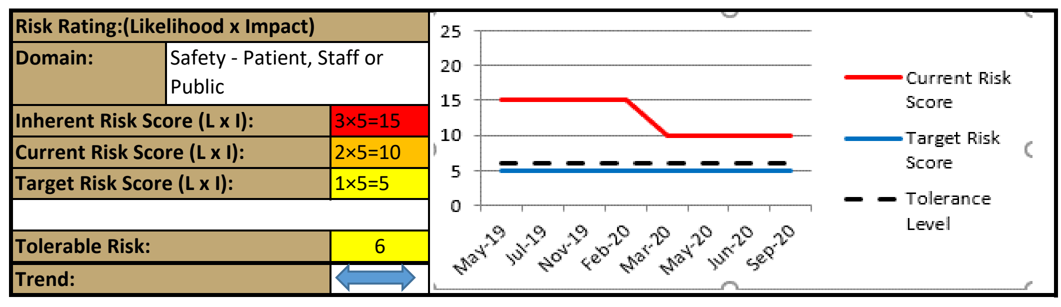
	Develop business case to outline and evidence benefits of increasing in-house pacing capacity in 2019/20 as part of a broader plan to repatriate the pacing LTA from SBUHB.	Smith, Paul	~~31/10/2019~~ 30/11/2020	Pacing SBAR (Aug '19) approved by Execs in Sept '19 supporting repatriating Simple Bradycardia Pacing (LTA) from SBUHB. Initial plan to phased repatriation from October/November 2019 impeded by HDUHBs pacing operational/capacity pressures (loss of 50% capacity at GGH site; loss of 33% Health-board-wide). SDM/Clinical Lead currently working to return service capacity to baseline following significant pacing reduction due to COVID. T&F Group currently meeting weekly to focus on needed actions.

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~~ 30/11/2020	Discussions continue with SBUHB for information on cardiac patients(on all pathways)to be provided to Hywel
	Audit of N-STEMI referral undertaken by Clinical Lead show average wait of 5.8	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:	Sep-20
Strategic Objective:	Health Board objectives 20/21 to be confirmed.	Lead Committee:	Quality, Safety and Experience Assurance Committee	Date of Next Review:	Oct-20

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	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.

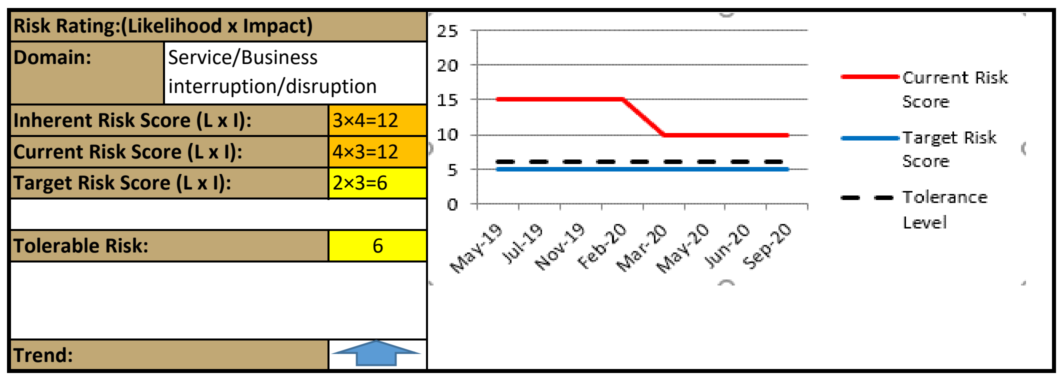
identified. Principle of removal of on-call compensatory rest approved by Executive Team.		Agreement with theatre teams (employee relations) for removal of compensatory rest. Formal 90 day OCP for Scrub and Band 3 circulatory staff to commence 16/01/19.	Carruthers, Andrew	~~30/11/2018~~ 14/06/2019 15/07/2019 31/03/2020 30/09/2020 31/12/2020	OCP completed for SCRUB and Band 3 team. Resolution of the process to remove compensatory rest days was paused during the COVID-19 and will form part of the Quarter 2 plan. Staff and union representatives have been informed. Aim is to issue outcome by end of Sep20 with implementation by Dec20.
		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:	Sep-20
Strategic Objective:	Health Board objectives 20/21 to be confirmed.	Lead Committee:	Quality, Safety and Experience Assurance Committee	Date of Next Review:	Nov-20

Risk ID:	635	Principal Risk Description:	There is a risk of a no-deal Brexit at the end of the transition period following the UK leaving the European Union (EU) on 31 January 2020. This is caused by a lack of clarity regarding UK position on Britain's exit from the EU in relation to the trade agreements (the basis of the future relationship with the EU and the foundations of the deal). This could lead to an impact/affect on patients being unable to access appropriate and timely treatment, the UHB being unable to maintain safe and effective levels of staffing, financial loss and adverse publicity/reduction in stakeholder confidence and increased mortality and ill-health across our population.
Does this risk link to any Directorate (operational) risks?			

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



Rationale for CURRENT Risk Score:

The UK left the EU on 31 January, 2020. Since then the UHB has been responding to the impact of the COVID-19 pandemic. The compounding effect of a Brexit no-deal scenario with winter plans, maintaining the Covid-19 response and the increasing concern regarding the fragility of the independent social care sector requires the likelihood to remain at 4 however the impact score to be increased to 3 to reflect the additional mitigating actions required at a national, regional and local level.

Rationale for TARGET Risk Score:

This will be affected by confirmation of Brexit outcome by UK Government. The UK government are continuing trade deal talks with the EU currently. However, the UK Government has ruled out any extension to the transition period and the UK will move to trading with the EU on World Trade Organisation rules from 2021 if no agreement is reached.

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. * Scoping exercise undertaken within Workforce to identify EU nationals and resolve data gaps in ESR. 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).	Full understanding of potential impacts and implications for the UHB due to the unknown final outcome of Brexit.	Completion of workforce scoping exercise and resolution of ESR data gap.	Gostling, Lisa	Completed	Completed - ESR data now 98% compliant.

* Staff bulletins issued to inform and raise awareness.			
	Complete a 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	21/10/2020	Work is underway.

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	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	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:	Sep-20
Strategic Objective:	Delivery of the QTR 2 Operating Plan	Lead Committee:	Quality, Safety and Experience Assurance Committee	Date of Next Review:	Nov-20

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:	Rationale for TARGET Risk Score:
Impact of the risk recognises the significant clinical risk of the risk 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, improvements in our modelling and WG planning assumptions regarding the likely transmission rate in Wales.	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	Inability to control lift of lockdown measures. To be reviewed at Gold Stocktake in Sep20.				

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 are sufficient to accommodate patients up to the peak level of configuration set out by Welsh Government.

Comprehensive Prevention and Response Plan agreed with the 3 local authorities to ensure Track, Trace and Protect (TTP) is effective in reducing transmission rates.

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	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									