Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ANSAWDD, DIOGELWCH A SICRHAU PROFIOD
QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	08 June 2021
TEITL YR ADRODDIAD: TITLE OF REPORT:	Corporate Risks Assigned to QSEAC
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Director of Operations Steve Moore, Chief Executive Officer Huw Thomas, Director of Finance Alison Shakeshaft, Director of Therapies & Health Sciences
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Wilson, Board Secretary Charlotte Beare, Head of Assurance and Risk

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

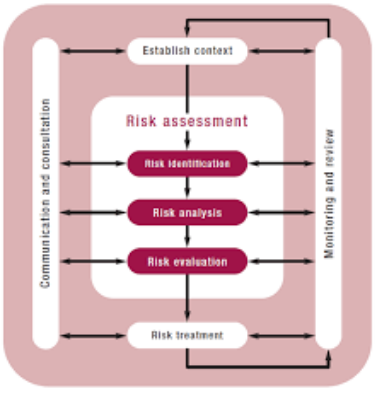
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Committee is asked to request assurance from Executive Directors that the corporate risks in the attached report are being managed effectively.

Cefndir / Background

Effective risk management requires a 'monitoring and review' structure to be in place to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place.



(Risk Management Process, ISO 31000)

The Board's Committees are responsible for the monitoring and scrutiny of corporate level risks within their remit. They are responsible for:

- Seeking assurance on the management of principal risks on the Board Assurance Framework (BAF)/Corporate Risk Register (CRR) and providing assurance to the Board that risks are being managed effectively and report areas of significant concern, for example, where risk appetite is exceeded, lack of action, etc.

- Reviewing principal and operational risks over tolerance and, where appropriate, recommend the 'acceptance' of risks that cannot be brought within Hywel Dda University Health Board's (HDdUHB) risk appetite/tolerance to the Board.
- Provide annual reports to Audit and Risk Assurance Committee (ARAC) on the effectiveness of the risk management process and management of risks within its remit.
- Identity through discussions any new/emerging risks and ensure these are assessed by management.
- Signpost any risks outside of its remit to the appropriate HDdUHB Committee.
- Use risk registers to inform meeting agendas.

These risks have been identified by individual Directors via a top down and bottom up approach and are either:

- Associated with the delivery of the Health Board objectives; or
- Significant operational risks escalated that are of significant concern and require corporate oversight and management.

Each risk on the CRR has been mapped to a Board level Committee to ensure that risks on the CRR are being managed appropriately, taking into account the gaps, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

The Board has delegated a proportion of its role of scrutiny of assurances to its Committees to make the most appropriate and efficient use of expertise. Therefore, Committees should also ensure that assurance reports relevant to the principal risks are received and scrutinised, and an assessment made as to the level of assurance it provides, taking into account the validity and reliability i.e. source, timeliness, methodology behind its generation and its compatibility with other assurances. This will enable the Board to place greater reliance on assurances, if they are confident that they have been robustly scrutinised by one of its Committees; and provide them with greater confidence regarding the likely achievement of strategic objectives, as well as providing a sound basis for decision-making. It is the role of Committees to challenge where assurances in respect of any component are missing or inadequate. Any gaps should be escalated to the Board.

The process for risk reporting and monitoring within the UHB is outlined at Appendix 1.

Asesiad / Assessment

The QSEAC Terms of Reference reflect the Committee's role in providing assurance to the Board that principal risks are being managed effectively by the risk owners (Executive Leads).

The Terms of Reference state that:

5.2 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action.

There are 10 risks currently aligned to QSEAC (out of the 21 that are currently on the CRR) as the potential impacts of the risks relate to the safety of patients, quality of services and patient outcomes. A summary of corporate risks can be found at Appendix 2.

Each of these risks have been entered onto a 'risk on a page' template, which includes information relating to the strategic objective, controls, assurances, performance indicators and

action plans to address any gaps in controls and assurances. These can be found at Appendix 3.

Changes since the previous report to QSEAC (2nd February 2021):
The Committee is requested to seek assurance from risk owners (Executive Directors) that each risk is being managed effectively and will be brought within the UHB tolerance.

Below is a summary of changes since the previous report to QSEAC:

Total number of risks	10	
New / escalated risks	0	*See note 1*
De-escalated/Closed risks	2	*See note 2*
Increase in risk score ↑	1	*See note 3*
Reduction in risk score ↓	1	*See note 3*
No change in risk score →	8	*See note 4*

Note 1 – New Risks
Since the previous report, no new risks have been added to the CRR and aligned to QSEAC.

Note 2 – Closed/De-escalated Risks
Since the previous report, two corporate risks aligned to this Committee have been closed.

Risk Ref & Title	Exec Lead	Closed/ De-escalated	Date	Reason
Risk 635 - No deal Brexit affecting continuity of patient care	Director of Finance	Closed	03/03/21	The Executive Team agreed to close this risk as the UK has now left the European Union and any residual issues or risks within the supply chain will be managed as part of the UHB's routine processes going forward.
Risk 1017 – Delivery of Q3/4 Operating Plan – Test, Trace and Protect Programme being able to quickly identify and contain local outbreaks	Director of Therapies and Health Science	Closed	21/05/21	This risk has been closed as the level of risk has been reduced to 5, reflecting the increased level of confidence in the system, which has been working well over a number of months. It is anticipated that previous issues are very unlikely to reoccur. The current risk score of 5 is within the tolerance level of 6 for a risk in the safety domain.

Note 3 – Increase/Decrease in Current Risk Score
Since the previous report to QSEAC in February 2021, there have been the following changes to current risk scores.

Risk Reference & Title	Executive Director	Previous Risk Score (Feb-21) (LxI)	Risk Score May-21 (LxI)	Date of review	Update
855 - Risk that the UHB will be unable to address the issues that arise in non-COVID-19 related services and support functions	Chief Executive Officer	**4x4=16**	**3x4=12** ↓	17/05/21	This risk has been reduced to 12 to reflect that levels of COVID-19 patients are at very low levels, and there has been a limited restart of some planned care services since April 2021. Work has also commenced on the waiting list support (Single Point of Contact) programme to support patients waiting for services. This has reduced the likelihood to a 3, giving a rating of 3 x 4 = 12. The likelihood will reduce further once the first tranche of recovery funding is deployed to overcome the UHB's capacity in all planned care services.
117 - Delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery	Director of Operations	**2x5=10**	**4x5=20** ↑	17/05/21	This risk has increased to reflect the increasing numbers of patients waiting for transfer from all 4 acute hospital sites due to the cessation of the 'treat and repatriate' service in 2020. This is further compounded by acute site pressures at Morriston Hospital – the risk likelihood has consequently been increased from 2 to 4 to reflect the current waiting times averaging 7.7 days. The Acute Coronary Syndrome (ACS)/ Non-ST Segment Elevation Myocardial Infarction (NSTEMI) 'treat and repatriate' service was established in January 2019 and

					provided 6 ring-fenced beds at Prince Phillip Hospital (PPH) and improved transfer times for Bronglais General Hospital (BGH) and Withybush General Hospital (WGH) patients in particular to address the historical delays experienced by HDdUHB in transferring patients to Swansea Bay University Health Board's (SBUHB) tertiary cardiac service for a range of cardiac investigations, treatments and surgery, in particular transfer delays for ACS/NSTEMI patients requiring tertiary centre angiography/coronary revascularisation within 72 hours of presentation to local secondary care hospital (NICE).

Note 4 - No change in risk score
There have been no changes in the following risk scores since they were reported to the previous meeting.

Risk Reference & Title	Executive Director	Previous Risk Score (Feb-21)	Risk Score May-21	Date of Review	Update
Risk 684 - Lack of agreed replacement programme for radiology equipment across UHB	Director of Operations	**5x4=20**	**5x4=20**	30/04/21	This risk has been recently reviewed by the Head of Service. The risk score remains at 20 as, although funding has been agreed for 2 out the 5 required CT scanners for HDdUHB, these will not be commissioned until the end of Q3 and Q4. Therefore, the benefits will not be realised and the likelihood of business disruption will not decrease until these are in place. Whilst some

					contingency has been provided by a scanner in a demountable unit, this does not provide full cover for acute care (not suitable for complex care). The replacement programme is still heavily reliant on funding from the All Wales Capital Programme.
Risk 1032 - Delivery of Q3/4 Operating Plan - Timely access to assessment and diagnosis for Mental Health and Learning Disabilities clients	Director of Operations	**4x4=16**	**4x4=16**	13/05/21	Referrals for Autism Spectrum Disorder (ASD) have continued throughout the pandemic at approximately the same level as pre-COVID-19. The service is 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-19, has an impact on the services' ability to treat the same volume of service users as they were previously able to. In addition, the estate footprint does not lend itself to accommodate the social distance requirements and in some instances is not therapeutically beneficial. Certain elements of some assessments, also being restricted due to other agencies, such as education, providing limited services. The Integrated Autism Service (IAS) is funded on a fixed term basis, which can make staff

					retention challenging in addition to having to train new incoming staff.
Risk 750 - Lack of substantive middle grade doctors affecting Emergency Department (ED) in WGH	Director of Operations	**4x4=16**	**4x4=16**	13/05/21	Despite improvement through locum staff being secured, the middle grade rota remains under constant review and management as the department are fully reliant on temporary staff. Despite ongoing recruitment, there are 4 vacant posts as previously recruited doctors have withdrawn. Discussions are underway in relation to the job description.
Risk 129 - Ability to deliver a GP Out of Hours (OOH) Service for HDdUHB patients	Director of Operations	**4x3=12**	**4x3=12**	14/05/21	The COVID-19 pandemic, combined with the temporary overnight service changes, has brought some respite to the service fragility, which is reflected in the current risk score. Stability in the Carmarthen rota is now being seen however, 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.
Risk 628 - Fragility of therapy provision across acute and community services	Director of Therapies and Health Science	**3x4=12**	**3x4=12**	12/05/21	Therapy service provision across acute, community and primary care continues to be challenging, as outlined in the risk description. However, there have been improvements following additional resourcing (Major Trauma, Nutrition,

					Rehabilitation, Lymphoedema, Dementia, Musculoskeletal (MSK), Winter Funding), workforce redesign and over recruitment of Band 5 graduates (Physiotherapy, Occupational Therapy, Podiatry, and Speech and Language Therapy). COVID-19 and rehabilitation requirements have affected service provision by adding an additional challenge to workforce models. However, this has 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 Infection Prevention and Control (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.
Risk 291 - Risk 291 – Lack of 24 hour access to Thrombectomy services	Director of Operations	**4x3=12**	**4x3=12**	11/05/21	Mechanical intervention for Stroke is available at North Bristol NHS Trust (NBT) and Walton Centre NHS Foundation Trust for Bronglais Hospital. The service has been expanded to a 7 day service, 8am-8pm,

					with a 6pm cut off point for patients arriving at NBT. The Health Board still does not operate a 24/7 service, and any patients presenting after the cut-off point will not be accepted by NBT.
Risk 634 - Overnight theatre provision in BGH	Director of Operations	**2x5=10**	**2x5=10**	21/05/21	Resolution of the process to remove compensatory rest days was paused during the COVID-19 pandemic. The Operational Quality, Safety and Experience Sub-Committee (OQSESC) met in January 2021 to review the risk assessment, and the hearing conclusion has now been issued by the Director of Operations, with implementation by end of Q2. Based on the risk assessment for option 3, the risk would be reduced to within the UHB tolerance and would be consistent with the model in place in Glangwili General Hospital (GGH). A readiness assessment is being prepared ahead of implementation for Executive sign off.
Risk 853 - Risk that HDdUHB's response to COVID-19 will be insufficient to manage demand	Chief Executive Officer	**1x5=5**	**1x5=5**	20/05/21	This risk reflects that the Health Board would not be able to manage an increase in demand in terms of bed space, workforce and equipment/consumables, and to reflect the potential quality and safety impacts. This risk remains within the Health Board risk tolerance as based on estimated COVID-19 demand and the

					planning undertaken to respond to COVID-19.

Argymhelliad / Recommendation

The Committee is requested to seek assurance that:

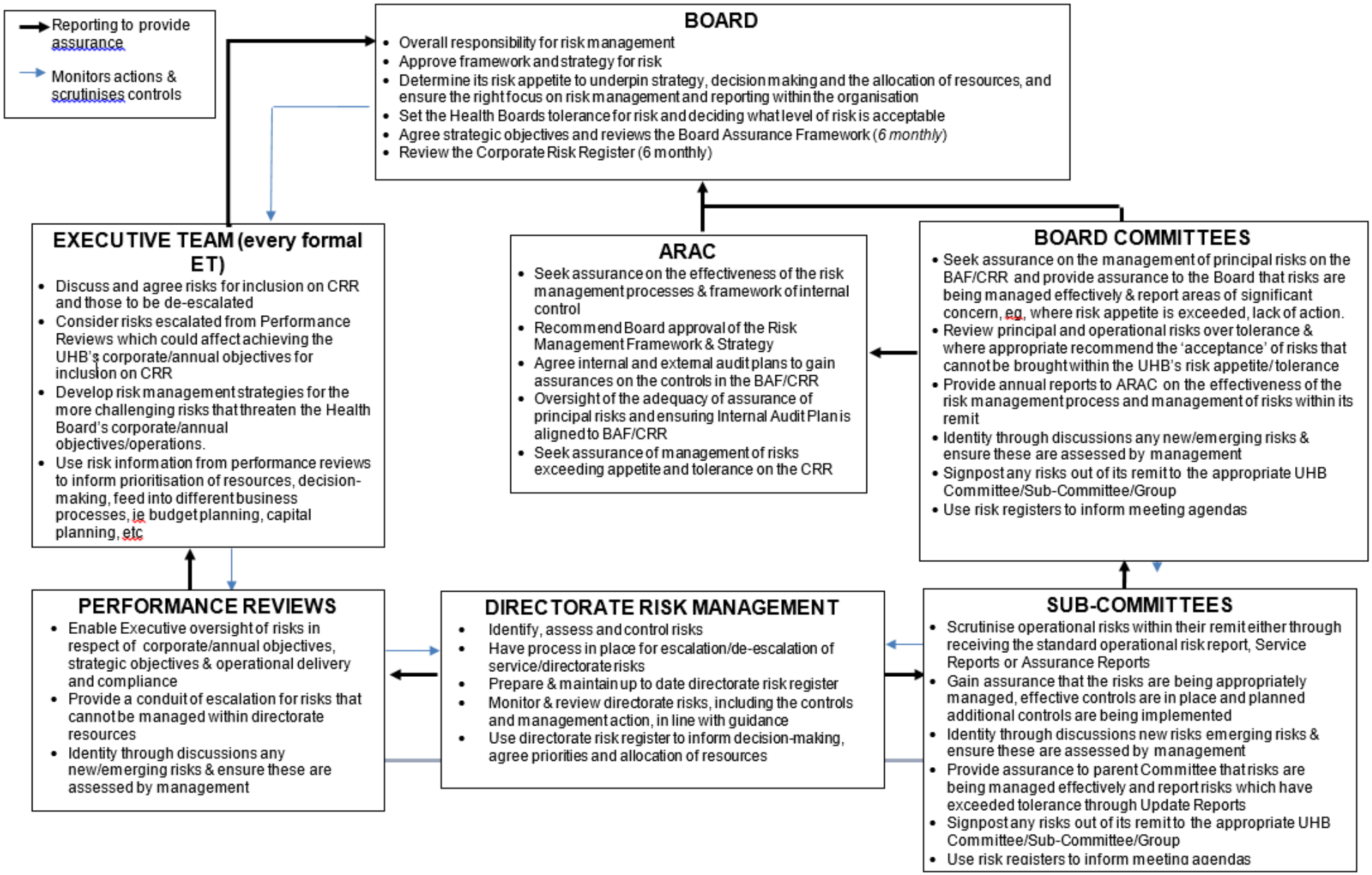
- All identified controls are in place and working effectively.
- All planned actions will be implemented within stated timescales and will reduce the risk further and/or mitigate the impact, if the risk materialises.
- Challenge where assurances are inadequate.

This in turn will enable the Committee to provide the necessary assurance to the Board, through its Committee Update Report, that the UHB is managing these risks effectively.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.2 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Contained within the report
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability

Effaith/Impact:	
Ariannol / Financial: **Ansawdd / Patient Care:** **Gweithlu / Workforce:** **Risg / Risk:** **Cyfreithiol / Legal:** **Enw Da / Reputational:** **Gyfrinachedd / Privacy:** **Cydraddoldeb / Equality:**	No direct impacts from the report, however, proactive risk management including learning from incidents and events contributes towards reducing/eliminating recurrence of risk materialising and mitigates against any possible legal claim with a financial impact. Poor management of risks can lead to loss of stakeholder confidence. Organisations are expected to have effective risk management systems in place and take steps to reduce/mitigate risks.

Appendix 1 – Committee Risk Reporting Structure



Risk Ref	Risk (for more detail see individual risk entries)	Included on BAF	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score May-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	5×4=20	5×4=20	→	3×4=12	3
117	Delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery	*	Carruthers, Andrew	Safety - Patient, Staff or Public	6	2×5=10	4×5=20	↑	2×5=10	6
1032	2021/22 Operating Plan Delivery - Timely access to assessment and diagnosis for Mental Health and Learning Disabilities clients	5	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×4=16	4×4=16	→	3×4=12	10
750	Lack of substantive middle grade doctors affecting Emergency Department in WGH.	**	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×4=16	4×4=16	→	2×4=8	13
129	Ability to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda patients	*	Carruthers, Andrew	Service/Business interruption/disruption	6	4×3=12	4×3=12	→	4×3=12 Accepted	16
628	Fragility of therapy provision across acute, community and primary care services	2	Shakeshaft, Alison	Safety - Patient, Staff or Public	8	3×4=12	3×4=12	→	3×4=12	20
855	Risk that the UHB will be unable to address the issues that arise in non-covid related services and support functions	5	Moore, Steve	Quality/Complaints/Audit	8	4×4=16	3×4=12	↓	2×4=8	24
291	Lack of 24 hour access to Thrombectomy services	*	Carruthers, Andrew	Quality/Complaints/Audit	8	3×4=12	3×4=12	→	2×2=4	27
634	Overnight theatre provision in Bronglais General Hospital	*	Carruthers, Andrew	Safety - Patient, Staff or Public	6	2×5=10	2×5=10	→	1×5=5	30
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	1×5=5	1×5=5	→	1×5=5	33

Key

* Operational Risk

** Delivery of the Quarter 3/4 Operating Plan

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Ma	Tends to be detailed
2nd Line	Corporate O	Less detailed but
3rd Line	Independen	Often less detail but truly

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

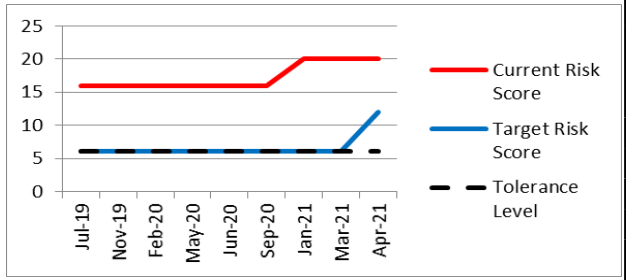
NB Assurance Map will tell you if you have

Key - Control RAG rating	
LOW	Significant concerns ove
MEDIUM	Some areas of concern o
HIGH	Controls in place assesse
INSUFFICIENT	Insufficient information a

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

Risk ID:	**684**	**Principal Risk Description:**	There is a risk radiology service provision from breakdown of key radiology imaging equipment (specifically insufficient CT capacity UHB-wide, and the general rooms and fluoroscopy room 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.

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):	3×4=12
Tolerable Risk:	6



Does this risk link to any Directorate (operational) risks?	644
Trend:	⟷

Rationale for CURRENT Risk Score:	**Rationale for TARGET 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 equipment, however the demountable CT-scanner will provide much needed resilience at GGH. The risk score remains at 20 as funding has been agreed for 2 out 5 required CT scanners for Hywel Dda, however these will not be commissioned until end of Q3 and Q4 therefore the benefits will not be realised and the likelihood will not decrease until these are in place. Whilst some contingency has been provided by a scanner in a demountable unit this does not provide full cover for acute care (not suitable for complex care).	Until a formal replacement programme in place, it will not be possible to bring this risk within tolerance and therefore the target score has increased to 15 as it should be possible that when the new equipment is commissioned, this will slightly reduce the risk. 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	**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. # WG Funding agreed for 2 x CT scanners (GGH & WGH) - to be commissioned by Dec21 and Mar22. # Additional CT secured in the form of a mobile van in December 2020.	Limitation of spare parts for some older equipment leading to extended outages. This issue may be compounded by Brexit. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Reliance on AWCP for replacement of equipment.	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 31/03/2023	Two business cases have been funded by WG. Further Business Cases for the further 3 CT scanners and or General Rooms (depending on priority) to be submitted in 2022/23.Submit updated paper to CEIMTSC to outline current priorities and funding requirements from DCP and AWCP.
		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~~ 31/03/2022	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. The commissioning of the 2 CT scanner has been added to project meeting.

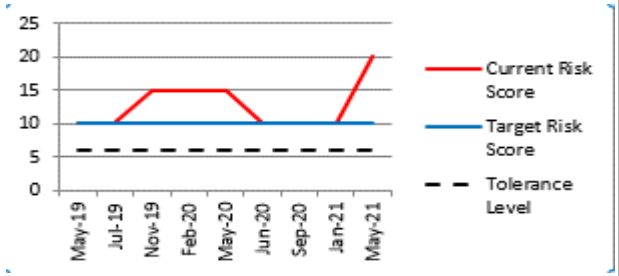
					Additional CT resource due to delay in funding from WG	Evans, Amanda	Completed	Additional CT resource obtained from NHS England in the form of a demountable unit . Resource to be shared with SBUHB. Now operational. Further additional CT secured in the form of a mobile van for two weeks in December 2020.

ASSURANCE MAP						Gaps in ASSURANCES			
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**	**Control RAG Rating (what the assurance is telling you about your controls**	**Latest Papers (Committee & date)**	**Identified Gaps in Assurance:**	**How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
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:	feb-11	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	mai-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	jun-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.

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



Does this risk link to any Directorate (operational) risks?

Rationale for CURRENT Risk Score:

The UHB has historically experienced delays in transferring patients to Swansea Bay UHB (SBUHB) tertiary cardiac service for a range of cardiac investigations, treatments and surgery, in particular transfer delays for ACS/NSTEMI patients requiring tertiary centre angiography/coronary revascularisation within 72 hours of presentation to local secondary care hospital (NICE). The ACS/NSTEMI Treat & Repatriate service established in January 2019 provided 6 ring-fenced beds at PPH and improved transfer times for BGH and WGH patients in particular. Cessation of the Treat & Repatriate service due to COVID acute site pressures at PPH in 2020 has seen a return to increased numbers of patients awaiting prolonged periods for transfer from all 4 acute hospital sites, which is further compounded by acute sites pressures at Morriston Hospital - the risk likelihood has consequently been increased from 2 to 4 to reflect current waiting times averaging 7.7 days.

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. Whilst the PPH 'Treat & Repat' service is currently suspended, it is anticipated that resumption of this approach would yield the same improvement.

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	**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. # 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. # 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. # Increased numbers of patients waiting / prolonged transfer delays are identified on daily Sitrep Calls and escalated by HDUHB Cardiology Clinical Lead / SDM to SBUHB Cardiology Clinical Lead / Cardiology Manager. # Reporting arrangements in place to monitor emergency and elective waiting times.	Lack of capacity in tertiary centre to manage a range of specialised 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. Suspension of PPH ACS/N-STEMI 'Treat & Repat' pathway in 2020.	Increase in-house CT Coronary Angiography (CTCA) capacity. As a less invasive/lower risk diagnostic, this will release and prioritize in-house and tertiary Percutaneous Coronary Angiography capacity for those patients who require it and thereby reduce transfer delays.	Smith, Paul	~~31/01/2019~~ 31/12/2021	SBAR development delayed due to COVID pressures. Cardiology Clinical Lead and SDM currently working with in-house CTCA Steering Group to support SBAR development.
		Develop long term Regional Cardiology Plan.	Carruthers, Andrew	~~30/09/2019~~ 31/12/2022	Decision taken not to establish a regional Cardiac Network/Collaborative in 2019. Development of long term regional plan for cardiology historically overseen by Joint Regional Planning and Delivery Forum and Committee and ARCH workstreams, but progress delayed/activity suspended during COVID. Cardiology Clinical Lead and SDM will engage with the ARCH Regional Cardiology Project' which resumes in June '21.
		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.

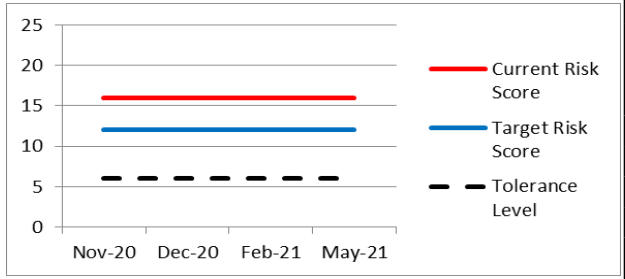
Address issues identified regarding needed improvements to referral processes as reported in August JRPDC paper: • the internal communication and transfer processes within HDdUHB are a critical part of the success of the treat and repatriate pathway; and • Secondary care Cardiology referrals now have 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.
Increase in-house cardiac pacing capacity as part of a broader plan to repatriate the pacing LTA from SBUHB.	Smith, Paul	~~31/10/2019~~ 31/12/2021	Pacing SBAR 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 to oversee refresh of SBAR/review of feasibility in support of repatriating this activity/pathway.
Re-establish HDUHB ACS/N-STEMI Treat & Repatriate Pathway	Smith, Paul	07.01.2021	Cardiology Clinical Lead/SDM currently drafting SBAR outlining a plan to support restoration of ACS Treat & Repatriate pathway to address current delays/immediate risks in the short-term.

					Review ACS/NSTEMI Pathway and longer term plans/requirements to achieve NICE NG185 ACS recommendations.	Smith, Paul	12.03.2021	Cardiology Pathway Transformation Project commencing June '21 to prioritise ACS pathway review in conjunction with current focus on ACS by Clinical Effectiveness Team and Value Based Healthcare Team.
					Increase in-house diagnostic Percutaneous Coronary Angiography. This will address current in-house capacity deficit due to patient social distancing as well as reduce reliance on tertiary pathway and thereby reduce transfer delays.	Smith, Paul	31/12/2021	SBAR development delayed due to COVID pressures. Cardiology Clinical Lead and SDM currently reviewing options to support SBAR development.
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	Completed	Now received on a regular basis from SBUHB and reviewed by Cardiology Clinical Lead/SDM
	Audit of N-STEMI referral undertaken by Cardiology Clinical Lead/SDM on quarterly basis.	1st								
	IPAR Performance Report to BPPAC & Board	2nd								
	Monthly oversight by WG	3rd								

Date Risk Identified:	nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	mai-21
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	jun-21

Risk ID:	**1032**	**Principal Risk Description:**	There is a risk that 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 2021/22. 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, as well as certain elements of some assessments being restricted due to other agencies, such as education, providing limited services at present. 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.

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



Does this risk link to any Directorate (operational) risks?

Trend: ⟷

Rationale for CURRENT Risk Score:	**Rationale for TARGET 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. Certain elements of some assessments also being restricted due to other agencies, such as education, providing limited services. Integrated Autism Service (IAS) is funded on fixed term basis which can make staff retention challenging along with having to train new incoming staff.	The Directorate is aiming to restore pre-Covid levels of assessment and intervention. This will be dependent on securing recurring funding for the IAS as well as having access to appropriate clinical venues and other agencies being able to undertaken their associated assessments.

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	**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 - 3 new staff have been recruited into the ASD team. Services are in contact with individuals to provide information regarding community support, well being at home and guidance should their situation deteriorate. Regular meetings with Women and Children's Service to strengthen interdepartmental working. Process in place to ensure individuals on waiting lists are being contacted periodically through the wait for assessment/treatment to monitor any alteration in presentation.	Social distancing measures reducing the available space/offices that can be used to meet clients face-to face. Certain elements of some assessments also being restricted due to other agencies, such as education, providing limited services. Continued lack of IT impacts on staff who have to work from home not having full accessibility. Estates issues ongoing with no access to clinical areas in some localities to see CYP and unable to access GP or LA sites thus restricting clinical sessions. Telephone assessments ongoing, virtual assessment offered but uptake not good for ASD client group.	Assess and source further IT requirements.	Carroll, Mrs Liz	Completed	Some further IT equipment has been received and distributed on a priority basis. The Directorate will now need to rationalise working from home/agile working in order to maximise the potential office/clinical space.
		Identify alternative venues/space to hold clinics.	Carroll, Mrs Liz	~~31/03/2021~~ 30/09/2021	Working with the Estates Department and exploring options with external partners. Regular meeting with Estates to look at accessing/leasing/enhancing the current MH estates with a view to increase MH estate footprint.
		Head of Service to operationalise	Carroll, Mrs Liz	~~31/12/2020~~ 30/09/2021	Directorate have been asked to participate in Health Board wide Task & Finish group. The Directorate will raise the importance of Service User/Carer input into this group to ensure the patient experience is represented to inform the outcome. Outcome measures will form part of this project.
		Appointment of Service Delivery Manager.	Carroll, Mrs Liz	Completed	Service Delivery Manager has now taken 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.

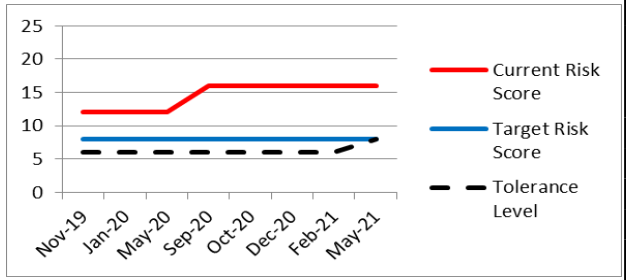
					Identify funding for Interim Clinical Psychologist lead post to assist with the waiting lists and service development.	Carroll, Mrs Liz	~~31/03/2021~~ 30/09/2021	Discussions taking place with Finance Business Partner to progress recruitment.
					Health Board is engaging in work with WG to benefit from additional support re waiting lists, demand and capacity planning and service mapping to meet the national standards and new Autism Code.	Carroll, Mrs Liz	~~30/04/2021~~ 30/09/2021	Health Board will be early pilot site providing an early offer for children and young people and their families, who otherwise would be referred for direct support to the NHS.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**			**Identified Gaps in Assurance:**	**How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
Welsh Government performance indicators along with internal monitoring arrangements will be used to ensure the actions are having the desires effect or whether there is more that needs to be done.	Management monitoring of referrals	1st				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	Completed	Directorate have been asked to participate in Health Board wide Task & Finish group. The Directorate will raise the importance of Service User/Carer input into this group to ensure the patient experience is represented to inform the outcome. Outcome measures will form part of this project.
	Monthly MH&LD Business Planning and Performance Group overseeing performance	2nd								
	MH&LD QSE Group overseeing patient outcomes	2nd								

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

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



Does this risk link to any Directorate (operational) risks?	229	**Trend:**	⟷

Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
WGH should have 7 middle grade doctors to fill rota. 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. 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. Update March: Still have 4 posts left to fill with ongoing recruitment. April, still have 4 post to fill with on going recruitment. May: still have 4 posts to fill with ongoing recruitment, discussions around Job description being held.	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.

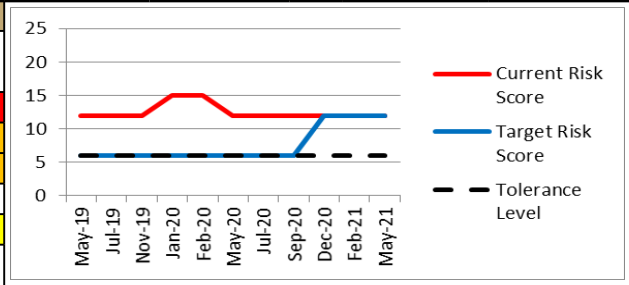
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that	**How and when the Gap 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. 1 x long term locum in place (2 left July 2020). Escalation procedures in place. March 2020 Middle grade rota merged with medical rota to strengthen workforce across 2 Emergency Departments. July 2020 - rotas have now separated as number of inpatients have increased and general medical teams have a larger inpatient & medical take to support.	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~~ 13/05/2021	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:	apr-17	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	mai-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	jul-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.

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:	⟷



Does this risk link to any Directorate (operational) risks?

Rationale for CURRENT Risk Score:	**Rationale for TARGET 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. Any further absence on out of hours provision is likely to rapidly result in further deterioration of the current position. As of May 2021 there has been no notable change/definite trend in the service fragility.	Service rota positions remain variable with continued shortfalls in clinical cover variably affecting service provision. Despite the Carmarthen base rota now predominantly 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 service modernisation. Work to develop a long term plan for OOH Services has now recommenced following Covid-19 and the settling in period of the new Service Delivery Manager, in order to reduce this risk on a permanent basis so to ensure the out of hours service provision is not interrupted. Workforce and service redesign requirements have been flagged as part of the 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	**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. # Workforce support from 111 programme team in addressing OOH fragilities available if required. # Health Professional feedback form in use between clinicians, service management and 111 (WAST) leads. # WAST Advance Paramedic Practitioner (APP) resource enhanced to provide more flexibility. # Rationalisation of overnight bases in place since March 2020, now subject to service review. # Workforce 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 Ceredigion that are affecting service provision throughout the 7 day operating period. Need for formalised workforce plan and redesign is still required - reflected in IMTP submission. In relation to service demand, activity appears to have stabilised but Covid continues to influence 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 stabilising the risk at this time (70-80%	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. Feb2021- Change in SDM, now subject to new focus. Still awaiting decision/direction on how to progress with service change. May 2021- Still awaiting decision/direction.
		Development of home working provision for GPs.	Rees, Gareth	Completed	Completed and evolving.
		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

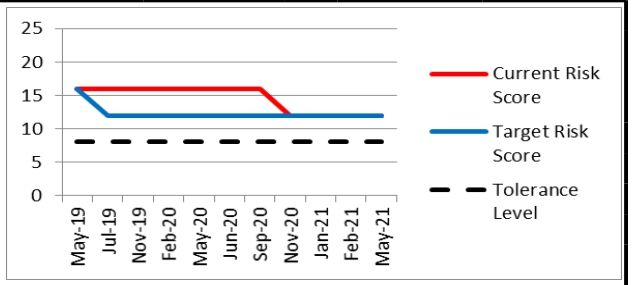
	of consultations is now dealt with on the phone)- but any reduction in capacity remains likely to require an increase in the risk level as the service delivery will be adversely affected.	Investigate potential external alternatives to current workforce position.	Davies, Nick	Completed	The Service is 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
		Review the rationalisation of overnight temporary service change.	Richards, David	~~31/05/2021~~ 30/09/2021	New SDM now in place. All operational staff are aware that this review is now underway as of February 2021. The review is being designed and will look at patient demand and experience, and service risks. As of May 2021 this is being actively reviewed with the Director of Operations. The consultations will now take place into June 2021 with outcomes to be reported to the relevant UHB Committees in September 2021.

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 QSEAC- Review of risk 129 Apr21 ET- Risk to OOH business continuity - Sep19 ET- OOH resilience - Nov19 & Jan20 BPPAC Quarterly monitoring Nov19 BPPAC - update on the	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.
	Twice a week sitreps and Weekend briefings for OOH	1st								
	Monitoring of performance against 111 standards	1st								
	Issues raised at fortnightly meeting with Primary Care Deputy Medical Director and Associate Medical Director	1st								
	Monthly report to Joint Operations Group (WAST, 111 team & 111 Health Boards)	2nd								
	PPPAC 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:**	mai-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:**	jun-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.

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



Does this risk link to any Directorate (operational) risks?	yes
Trend:	⟷

Rationale for CURRENT Risk Score:	**Rationale for TARGET 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, Winter Funding) , 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.	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	**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 21/22 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	Completed	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. HEIW AHP Streamlining to commence 2021

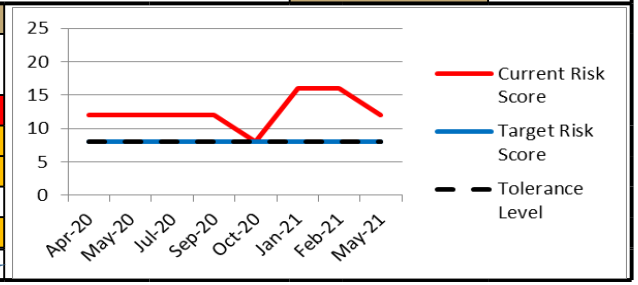
	Pursue opportunities to attract local people into therapy careers in the HB, eg 'grow your own' schemes, apprenticeship programmes, development of career pathways from HCSW to graduate, development of local graduate training programme.	Reed, Lance	Completed	Commitment given to extend apprenticeship scheme 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 Paper on Therapy Staffing - HDCHC Services Planning Committee 14.12.20 Briefing on Therapy Staffing - HDCHC Services Planning Committee 16.02.21					
	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:	apr-20	**Executive Director Owner:**	Moore, Steve	**Date of Review:**	mai-21
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	jul-21

Risk ID:	**855**	**Principal Risk Description:**	There is a risk that the UHB will be unable to address the issues that arise in non-covid related services and support functions. 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):	3×4=12
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	8
Trend:	



Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
With levels of COVID-19 patients at very low levels, a limited restart of some planned care services got underway in April. Work has also commenced on our waiting list support / SPOC programme to support patients waiting for our services. This has reduced the likelihood to a 3 giving a rating of 3 x 4 = 12. The likelihood will reduce further once the 1st tranche of recovery funding is deployed to overcome the HB's capacity in all planned care services.	

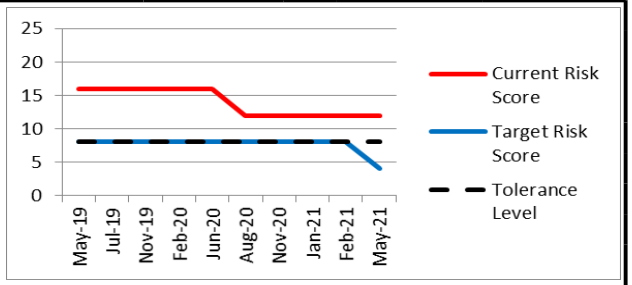
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do	**How and when the Gap in control be addressed** 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 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. Cancer Helpline in place for patients. 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. Waiting listing support/SPOC Programme rolling out to support patients waiting for our care. Additional funding for recovery recently announced - plans developed which will reduce the risk score looking forward.	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
		To establish a formal planned care recovery programme.	Moore, Steve	Completed	Developed as part of the Health Board's Annual Recovery Plan for 2021/22.
		To establish a communication hub to mitigate harm and complaints.	Rayani, Mandy	31/03/2023	A workstream has been established to initiate this work. Communications with patients has started.

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 asked the medical advisory board to give their view on international best practice in monitoring the population impact of this issue which will inform the KPIs we track. Nothing emerged from initial contact and no new indicators were developed. The UHB has continued to use existing indicators that the UHB has in place to measure the impact of patients waiting for treatment.
	Bi-monthly Covid-19 QSEAC	2nd								
	Weekly Formal Covid-19 Executive Team Assurance Meeting	2nd								
	Board oversight of revised quarterly plans	2nd								

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

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:	⟷



Does this risk link to any Directorate (operational) risks?

Rationale for CURRENT Risk Score:	**Rationale for TARGET 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 presenting after the cut off point will not be accepted by NBT.	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. March 21. There are ongoing meetings, to extend the service already offered. Ward staff will then be informed of the new process.

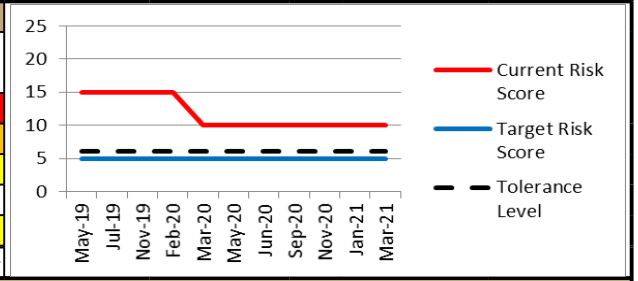
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that	**How and when the Gap 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.
		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:	sep-18	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	mai-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	jun-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.

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:	⟷



Does this risk link to any Directorate (operational) risks?

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.

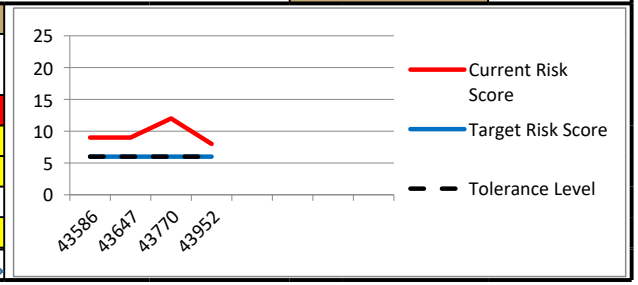
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do	**How and when the Gap in control be addressed** 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~~ ~~31/12/2020~~ ~~31/03/2021~~ 30/09/2021	OCP completed for SCRUB and Band 3 team. COVID has delayed finalising and communicating the conclusion of the hearing as well as the discussion of the risk assessment by OQSEAC. On 28Jan21, OQSEAC met to review the risk assessment, and now the hearing conclusion has issued by the Director of Operations, with implementation by end of Q2. Based on the risk assessment for option 3, the risk would be reduced to within the HB tolerance and would be consistent with the model in GGH. A readiness assessment is being prepared ahead of implementation for Executive sign off.
		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:	apr-20	**Executive Director Owner:**	Moore, Steve	**Date of Review:**	mai-21
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	jul-21

Risk ID:	**853**	**Principal Risk Description:**	There is a risk that the UHB's response to COVID-19 will be insufficient to address peaks 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 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, field hospital provision, 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	**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.	Inability to directly control lift of lockdown measures.				

ASSURANCE MAP						**Gaps in ASSURANCES**				
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance** (1st, 2nd, 3rd)	**Required Assurance** / **Current Level**	**Control RAG Rating (what the assurance is telling you about your controls**	**Latest Papers (Committee & date)**	**Identified Gaps in Assurance:**	**How are the Gaps in ASSURANCE will be addressed** Further action necessary to address the gaps	**By Who**	**By When**	**Progress**

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	Assurance being sought from councils regarding ability to access field hospitals when needed (specifically Carmarthen Leisure Centre Judo Hall)	Director of Operations requested to seek clarification and assurance regarding ability to access field hospitals when needed.	Carruthers, Andrew	30.06.2021	Director of Operations has been notified by Carmarthenshire County Council (CCC) that they request the return of Carmarthen Leisure Centre to reinstate as judo hall. CCC intention is that Health Board could regain access to it as FH ward within 3 to 4 weeks of it being requested. Field Hospital Team currently testing that time line to be assured that would be possible.
	Board oversight of response to COVID-19	2nd								