| Risk Ref | Risk (for more detail see individual risk entries) | Risk Owner | Domain | Tolerance Level | Previous Risk Score | Risk Score May-20 | Trend | Target Risk Score | Risk on page no... |
|---|---|---|---|---|---|---|---|---|---|
| 810 | Poor quality of care within the unscheduled care pathway | Carruthers, Andrew | Safety - Patient, Staff or Public | 6 | N/A | 4×5=20 | New risk | 3×4=12 | 3 |
| 628 | Fragility of therapy provision across acute, community and primary care services | Shakeshaft, Alison | Safety - Patient, Staff or Public | 8 | 4×4=16 | 4×4=16 | → | 3×4=12 | 7 |
| 684 | Lack of agreed replacement programme for radiology equipment across UHB | Carruthers, Andrew | Service/Business interruption/disruption | 6 | 4×4=16 | 4×4=16 | → | 2×3=6 | 10 |
| 733 | Failure to meet its statutory duties under Additional Learning Needs and Education Tribunal Act (Wales) 2018 by Sept 2020 | Shakeshaft, Alison | Statutory duty/inspections | 8 | N/A | 4×4=16 | New risk | 2×3=6 | 13 |
| 117 | Delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery | Carruthers, Andrew | Safety - Patient, Staff or Public | 6 | 3×5=15 | 3×5=15 | → | 2×5=10 | 16 |
| 91 | Insufficient number of Consultant Cellular Pathologists to meet 14 day timescale set out in the new Single Cancer Pathway | Carruthers, Andrew | Safety - Patient, Staff or Public | 6 | 3×4=12 | 3×4=12 | → | 2×4=8 | 21 |
| 750 | Lack of substantive middle grade doctors affecting Emergency Department in WGH. | Carruthers, Andrew | Safety - Patient, Staff or Public | 6 | 3×4=12 | 3×4=12 | → | 2×4=8 | 24 |
| 855 | Risk that UHB's normal business will not be given sufficient focus | Moore, Steve | Quality/Complaints/Audit | 8 | N/A | 3×4=12 | New risk | 2×4=8 | 26 |
| 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 | → | 2×3=6 | 28 |
| 634 | Overnight theatre provision in Bronglais General Hospital | Carruthers, Andrew | Safety - Patient, Staff or Public | 6 | 3×5=15 | 2×5=10 | ↓ | 1×5=5 | 31 |
| 635 | No deal Brexit affecting continuity of patient care | Jervis, Ros | Service/Business interruption/disruption | 6 | 4×3=12 | 4×2=8 | ↓ | 2×3=6 | 33 |
| 853 | Risk that Hywel Dda's Response to COVID-19 will be Insufficient to Manage Demand | Moore, Steve | Safety - Patient, Staff or Public | 6 | N/A | 1×5=5 | New risk | 1×5=5 | 36 |

**Assurance Key:**

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

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

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

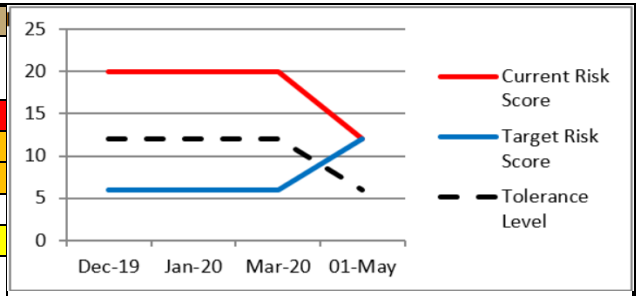
| Key - Control RAG rating | |
|---|---|
| **LOW** | Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks |
| **MEDIUM** | Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks |
| **HIGH** | Controls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

| | |
|---|---|
| **Strategic Objective:** | *The Health Board objectives for 2020/21 to be confirmed.* |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Carruthers, Andrew | **Date of Review:** | Jun-20 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | Aug-20 |

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

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




**Rationale for CURRENT Risk Score:**

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

**Rationale for TARGET Risk Score:**

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

| **Key CONTROLS Currently in Place:**<br>(The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed**<br>Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| # Comprehensive daily management systems in place to manage unscheduled care risks on daily basis including multiple daily multi-site calls in times of escalation.<br># Reviews of patients admitted to surged areas to ensure patient acuity and dependency is monitored and controlled.<br># Surge beds continue as per escalation and risk assessment of site demand and acuity. A daily review of the use of surge beds via patient flow meetings to facilitate step down of beds.<br># Discharge lounge takes patients who are being discharged.<br># The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles.<br># Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites.<br># Discharge planning is a core part of the inpatient documentation & is commenced prior to admission in the A&E Department once the decision to admit is made & included in ward rounds.<br># Regular training on discharge planning and complex care management is provided to ward based staff through Community Discharge Liaison teams, Social services and the Long Term Care Team support.<br># Delivery plans in place supported by daily, weekly and monthly monitoring arrangements.<br># Escalation plans for acute and community hospitals.<br># Annualised delivery plans aligned to Transforming Clinical Services.<br># Annual winter plans developed to manage increased activity.<br># Joint workplan with Welsh Ambulance Services NHS Trust.<br># 111 implemented across Hywel Dda.<br># Transformation fund bids in relation to crisis response being implemented across the system. | Lack of available inpatient beds to meet ED admissions<br><br>Delays in discharge of medically fit patients<br><br>Consistent approach to implementation of Red2Greed and SAFER patient bundles<br><br>Lack of agreement of discharge standards with partners<br><br>Workforce issues create an ongoing demand/capacity imbalance.<br><br>Inability to improve current unscheduled care system due to high reliance on temporary staff.<br><br>Inability to manage within current unscheduled care capacity continues to cause problems for elective programmes of work.<br><br>Resilience of out of hours remains a significant challenge. | Redesign of services in unscheduled care through Transforming Clinical Services Programme. | Kloer, Dr Philip | 31/03/2028 | A Healthier Mid and West Wales: Health and Care Strategy was approved by the Board in Nov18. Since approval, significant work has been undertaken to plan for the delivery phase. |
| | | Clusters through their IMTPs will consider system wide changes that support the provision of seamless care to patients | Paterson, Jill | 31/03/2022 | Defined plans will be developed as part of the planning process for 2021/22. |
| | | Implementation Plan to be developed and delivered by UHB following the review on 'Amber' ambulance 999 calls | Bishop, Alison | 31/03/2021 | The USC system plan will encompass any actions to be delivered in partnership with primary care and WAST colleagues. |
| | | Development and delivery of Unscheduled Care Programme including frailty plan, older people plan, Red2Green, SAFER bundles, PJ paralysis, last 1000 days. | Carruthers, Andrew | 31/03/2021 | Work progressing and is on target. USC System plans have been developed on a county level, next steps are peer review and agreement of outcome measures. Work is also underway with fortnightly meetings to review unscheduled care improvement plans. |
| | | Develop winter plans for 2020/21. | Carruthers, Andrew | 30/11/2020 | To be developed and presented to Board for approval in Nov20. |
| | | A refreshed approach based on the 4 nationally agreed 'Discharge to Assess/Recover' (D2RA) pathways to be developed and approved with each local authority and will be implemented as part of the Unscheduled Care 3 year plan. | Carruthers, Andrew | ~~30/11/2019~~ 31/03/2023 | Agreed approach with Local Authorities at Winter Summit in Dec19. |

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

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| Performance indicators for Tier 1 targets.<br><br>A suite of unscheduled care metrics have been developed to measure the system performance. | Medically optimised and ready to transfer patients are reported 3 times daily on situation reports | 1st | | | What's the hold up? Discharging patients in Wales - Wales Audit Office Toolkit Assurance Report - ARAC - Oct19<br><br>IPAR - Board & BPPAC (bi-monthly)<br><br>Winter plan 2019-20 - Finance Committee and Board - Nov19 | | | | | |
| | Daily performance data overseen by service management | 1st | | | | | | | | |
| | Delivery Plans overseen by Unscheduled Care Improvement Programme | 2nd | | | | | | | | |
| | Bi-annual reports to PPPAC on progress on delivery plans and outcomes (and to Board via update report) | 2nd | | | | | | | | |
| | Executive Performance Reviews | 2nd | | | | | | | | |
| | IPAR Performance Report to PPPAC & Board | 2nd | | | | | | | | |
| | WAST IA Report Handover of Care | 3rd | | | | | | | | |
| | 11 x Delivery Unit Reviews into Unscheduled Care | 3rd | | | | | | | | |
| | Delivery Unit Report on Complex Discharge | 3rd | | | | | | | | |

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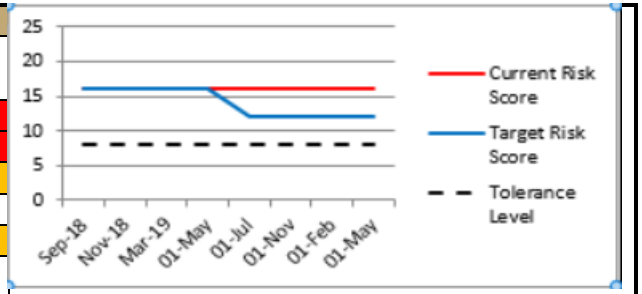
| **Strategic Objective:** | *The Health Board objectives for 2020/21 to be confirmed.* |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Shakeshaft, Alison | **Date of Review:** | Jun-20 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | Jul-20 |

| | | | |
|---|---|---|---|
| **Risk ID:** | **628** | **Principal Risk Description:** | There is a risk that patients in need of therapy services do not receive them or do not receive the required level of them. This is caused by gaps in the therapy service provision across acute, community and primary care settings from historical under-resourcing, exacerbated by recurrent savings targets, vacancies and recruitment/retention issues due to national shortages. There is the additional challenge that Covid19 has placed upon workforce models due to staff shielding, redeployment and physical distancing. This could lead to an impact/affect on patient outcomes, longer recovery times, increased length of stay, a reduction in performance against 14 week waiting time and non-compliance with clinical guidance, with a potential adverse impact on patient safety/harm. |
| **Does this risk link to any Directorate (operational) risks?** | yes | | |

| | |
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Safety - Patient, Staff or Public |
| **Inherent Risk Score (L x I):** | 5×4=20 |
| **Current Risk Score (L x I):** | 4×4=16 |
| **Target Risk Score (L x I):** | 3×4=12 |
| **Tolerable Risk:** | 8 |
| **Trend:** | ⟷ |




**Rationale for CURRENT Risk Score:**

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

**Rationale for TARGET Risk Score:**

The target risk score has been assessed as 12 as although priority areas have been agreed and progressed, the risk will not be completely addressed in the coming year. A sustainable therapy workforce solution aligned to the Health and Care Strategy has been agreed. The following high impact/workforce priority areas have been identified within the Annual Plan for focus during 2020/21: older people (incorporating frailty, dementia and stroke); improving self-management (including pulmonary rehabilitation and diabetes); therapists as first point of contact in primary care (including musculoskeletal, older people and irritable bowel syndrome); Major Trauma Plan. An additional requirement will be the delivery of the Covid 19 Rehabilitation Framework. A sustainable solution is also required to maintain the 14 week waiting time target. These areas of development will require practical, prudent and incremental workforce solutions to improve patient care, outcomes and experience, and sustainable funding models will be required through whole-system review and shifting of resource from elsewhere in the health and care system.

**Key CONTROLS Currently in Place:**

(The existing controls and processes in place to manage the risk)

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

| | | | | | |
|---|---|---|---|---|---|
| # Individual service risks identified and discussed at a range of for a; i.e. QSEAC, OQSESC, Performance Reviews and Therapy Forum.<br># Priority areas agreed in the 2020/2021 Annual Plan, to increase capacity in these areas.<br># Locum staff utilised where appropriate, funded from within core budget (2 vacancies fund 1 Locum)<br># Short-term contracts/additional hours within budget used to cover maternity leave.<br># Training of support staff to safely deliver delegated tasks.<br># Over-recruitment of Newly Qualified Staff were appropriate and approved by the Director to mange foreseeable future decrease in staffing levels.<br># Local solutions include review of each vacant post to make them attractive, including skill mix review, early advertisements for new graduates.<br># Prioritisation of patients is undertaken through triage and risk assessment by therapy service, using virtual and digital technology where possible.<br># Continued training of the Malcomess Care Aims Framework for MDT/ Therapy Services. | Inability to secure funding for all developments identified in 20/21 annual plan.<br><br>Shortage of qualified staff nationally and rurality of HDdUHB limits applications to some posts.<br><br>Unplanned service development opportunities.<br><br>Lack of cohesive approach to workforce planning across all therapy services. | 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, re-development of existing roles and Advanced Practice roles. Restart of service delivery following Covid 19 will also create additional demand across the traditional areas in addition to the rehabilitation needs associated with Covid 19. | Reed, Lance | 31/03/2021 | Plans under development. Funding already secured for developments in pulmonary rehab, dementia, lymphoedema and to support some increase in front door/acute therapy input including plans to address malnutrition. Continued operational and strategic engagement with DoTHS, Director of Operations, HoS, County Directors and GMs to address Covid 19 response and to service developments that would release resource and savings from the wider health and care system through increased therapy provision, including areas of pathway re-design. WG Funding for Therapy Assistant Practitioner HCSW role to support workforce model changes. |
| | | Ensure process for robust workforce planning is in place to inform HEIW in respect to future graduate numbers required by the UHB/Region, which are aligned to the Health and Care Strategy workforce plan. | Shakeshaft, Alison | Completed | Long-term piece of work informed by action above on an annual basis. Lead in time of 3 years to benefit from graduate programme. |
| | | Pursue opportunities to attract local people into therapy careers in the HB, eg 'grow your own' schemes, apprenticeship programmes, development of career pathways from HCSW to graduate, development of local graduate training programme. | Reed, Lance | 31/03/2021 | Commitment given to extend apprenticeship scheme to AHPs, agreed from 2020. Variety of HCSW training modules for level 3 and 4 developed and being implemented. HEIW review to commission local training provision for Physio & Occupational Therapy Undergraduate Training locally. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | Develop robust workforce plans that align to stroke, major trauma, neurology and Covid19 rehabilitation service needs to maximise workforce opportunities. | Shakeshaft, Alison | 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.<br><br>Clearance of backlog for pulmonary rehabilitation, with 100% achievement of 14 week maximum wait by Dec21.<br><br>Improved compliance with minimum standards for stroke therapy care by Q2 2021/22 (Dec21).<br><br>Improved staffing ratios for priority areas by Dec21. | Management monitoring of breaches of 14 week waiting times | 1st | | | | Reporting improved compliance with the Dementia Action Plan, including increased diagnostic rates. | | | | |
| | Exceptions to achieving 14 week waiting times reported via IPAR to BPPAC | 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 | | | | | | | | |

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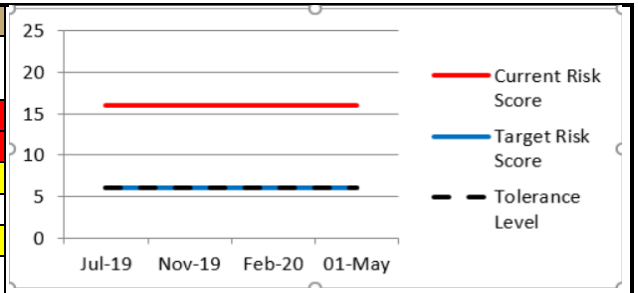
|---|---|
| **Strategic Objective:** | *The Health Board objectives for 2020/21 to be confirmed.* |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Carruthers, Andrew | **Date of Review:** | May-20 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | Jun-20 |

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

| | |
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Service/Business interruption/disruption |
| **Inherent Risk Score (L x I):** | 5×4=20 |
| **Current Risk Score (L x I):** | 4×4=16 |
| **Target Risk Score (L x I):** | 2×3=6 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟷ |




| **Rationale for CURRENT Risk Score:** |
|---|
| The UHB's stock of imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites which has a significant impact on the UHB's ability to meet its RTT target and impact to patients can include delays in diagnosis and treatment. Presently equipment downtime can be up to a week which can put significant pressures on all diagnostic services. Whilst activity has decreased due to COVID, scanning of COVID patients requires more time than non-COVID patients, which will become an issue as requests for diagnostics for non-COVID patients increase as other services resume. Commissioning of agreed equipment has also been delayed as a result of COVID and this remains dependent external factors. |

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

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

| **Gaps in CONTROLS** | | | | |
|---|---|---|---|---|
| **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed**<br>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.<br># The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service.<br># Regular quality assurance checks (eg daily checks).<br># Use of other equipment/transfer of patients across UHB during times of breakdown.<br># Ability to change working arrangements following breakdowns to minimise impact to patients.<br># Site business continuity plans in place.<br># Disaster recovery plan in place.<br># CT Scanner including fluoroscopy room and WGH MRI included on all Wales Capital Programme (AWCP)(not yet agreed)and AWCP secured for replacing the BGH MRI.<br># 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.<br># Escalation process in place for service disruptions/breakdowns. | Limitation of spare parts for some older equipment leading to extended outages.<br><br>Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites.<br><br>Delayed commissioning of new MRI Scanner in WGH and Fluoroscopy Room in GGH due COVID-19. | Review and strengthen site business continuity plans with individual site leads to ensure robust response to breakdown. | Evans, Amanda | Completed | Site leads in process of developing up-to-date and robust business continuity plans which will operationalise procedures following breakdowns. Site leads have met with the business continuity team to agree on the process of updating plans. Due to operational pressures this needs further time to fully complete. |
| | | Work with planning colleagues about sourcing capital funding through DCP and AWCP. | Evans, Amanda | ~~30/06/2019~~ ~~01/04/2020~~ 31/12/2020 | Funding for one scanner has been agreed with plans submitted to WG for the replacement of four CT scanners that are approaching end of life. |
| | | Develop plan in line WG Operating Framework for Q1 to deal with COVID and non-COVID patient flows and potential backlog. | Evans, Amanda | 31/05/2020 | Submit to Bronze Acute Group by 18/05/20. |
| | | Monthly project meeting to discuss commissioning of agreed equipment with estates, planning and manufacturers | Evans, Amanda | 31/12/2020 | Commissioning equipment is dependent on lockdown measures in and outside of UK and contractor availability to undertake work. |

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

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Reduction of waiting times to under 6 weeks by Mar22.<br><br>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 | 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 | | | | | | | | |

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|---|---|
| **Strategic Objective:** | *The Health Board objectives for 2020/21 to be confirmed.* |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Shakeshaft, Alison | **Date of Review:** | May-20 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | Jun-20 |

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

| | | |
|---|---|---|
| **Risk Rating:(Likelihood x Impact)** | | **No trend information available.** |
| **Domain:** | Statutory duty/inspections | |
| **Inherent Risk Score (L x I):** | 5×4=20 | |
| **Current Risk Score (L x I):** | 4×4=16 | |
| **Target Risk Score (L x I):** | 2×3=6 | |
| **Tolerable Risk:** | 8 | |
| **Trend:** | *N/A* | |

| **Rationale for CURRENT Risk Score:** |
|---|
| The ALNET Act (Wales) 2018 places new statutory duties on the Health Board. The full impact of these new statutory duties on individual services/departments/directorates is not fully understood as yet.<br>Due to the COVID-19 pandemic the focus of the organisation is to formulate and enact a response to the pandemic, which means that the focus as well as resources are moved away from preparing for the implementation of the ALNET Act, despite the backdrop that the implementation of the ALNET Act on 1st September 2021 remains a priority for the Welsh Government. |

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

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

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

| | | | | | |
|---|---|---|---|---|---|
| # DECLO (Designated Education Clinical Lead Officer) appointed (one of the 4 new statutory duties)<br># DECLO member of the All Wales DECLO Group<br># DECLO member of Regional ALN Transformation Leadership Group.<br># Hywel Dda ALN Implementation Group established.<br># Hywel Dda Readiness Survey completed.<br># Hywel Dda ALN Implementation Plan in situ.<br># Hywel Dda represented at the relevant regional ALN work streams.<br># Local systems in place to capture SEN, which may be transferable to ALN.<br># Strong local, operational working relationships with Local Authority Education Services, Social Services, Schools and Further Education Institutions.<br># Successful grant application to fund fixed term Business Support to assist with the implementation of the ALN Implementation Plan.<br># Project Support Manager - ALN appointed for 12 months.<br># Information raising session at OD Session of the Board and at Executive Team. | *A deficit in information management requirements to inform performance reporting.<br>*A lack of service/ department/directorate systems and processes to ensure adherence with the statutory requirements of the ALNET Act .<br>*A lack of staff awareness and understanding of the relevance of ALNET Act upon their practice.<br>*Inability to fully meet requirements in relation to Welsh Medium provision and dispute resolution.<br>*Project Support Officer (started 09/12/2020) been deployed on 24/03/2020 in support of COVID-19.<br>*ALN Implementation Group stood down in support of Covid-19<br>*Reduced capacity within Services/Departments/Directorates to focus on readiness for implementation due to current focus on Covid-19. | Implement ALN Implementation Plan, which includes actions to address the assurance gaps | Vanderlinden, Natalie | 31/08/2020 | Relevant actions being progressed and are on track. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| | Hywel Dda ALN Implementation Group monitor the progress against the actions within the implementation plan | 1st | | | Executive Team, ALN Act Implementation - Sep19 | Performance and governance arrangements currently not in place to provide the necessary assurance that | Confirm key performance indicators | Vanderlinden, Natalie | 31/08/2020 | Underway. |

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| | Regional ALN Transformation Group monitor progress made against the actions within the ALN Health work stream plan | 1st | | | the organisation fulfils its duties under the Act. | Confirm key performance reporting arrangements | Vanderlinden, Natalie | 31/08/2020 | Underway |
| | | | | | | Confirm key quality, safety and experience indicators | Vanderlinden, Natalie | 31/08/2020 | Underway. |
| | | | | | | Confirm key quality, safety and experience assurance arrangements | Vanderlinden, Natalie | 31/08/2020 | Underway |

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| **Strategic Objective:** | *The Health Board objectives for 2020/21 to be confirmed.* |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Carruthers, Andrew | **Date of Review:** | Feb-20 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | Mar-19 |

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

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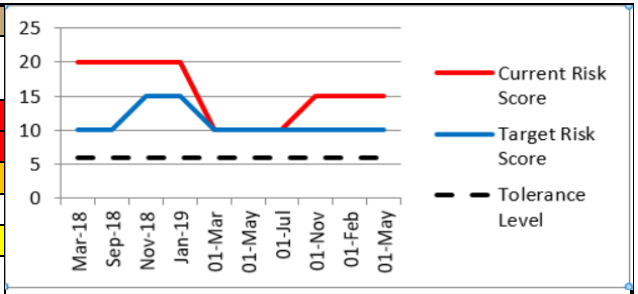
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Safety - Patient, Staff or Public |
| **Inherent Risk Score (L x I):** | 5×5=25 |
| **Current Risk Score (L x I):** | 3×5=15 |
| **Target Risk Score (L x I):** | 2×5=10 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟷ |




| **Rationale for CURRENT Risk Score:** |
|---|
| The UHB is still experiencing delays in transferring patients to Swansea Bay UHB (SBUHB) tertiary service for a range of cardiac investigations, treatments and surgery. The historic risk specifically associated with transfer delays for N-STEMI patients (NICE: 'within 72 hours') has reduced since development of the NSTEMI Treat & Repatriate service. However, patients waiting for other reasons, such as cardio-thoracic surgery, permanent pacemaker implantations and electrophysiology studies continue to wait prolonged periods for transfer to the tertiary service. |

| **Rationale for TARGET Risk Score:** |
|---|
| The target score was reduced to 10 in March 2019 on account of the Anticipated benefits of the Regional N-STEMI 'Treat & Repat' arrangement. The service initiated in January 2019 saw a reduction in transfer wait from an average of 10.7 to 3 days by April 2019. Between April and July 2019 waiting times increased to an average of approximately 5.8 days and is reflected in the increased current risk score of 15. Update on February 2020 waiting time position currently awaited from SBUHB. |

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

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

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|---|---|---|---|---|---|
| # All patients are risk scored by cardiac team at SBUHB on receipt of patient referral from HDUHB.<br># 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.<br># Bi-monthly operational meeting with Swansea Bay UHB (SBUHB) to monitor activity/patient flow and address associated risks/issues.<br># 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.<br># NSTEMI Treat & Repatriate service in place since January 2019 providing 6 ring-fenced beds at PPH supporting timelier transfer for BGH and WGH patients to SBUHB for angiography/coronary revascularisation.<br><br># Cardiology SDM engaged with Regional planning in support of improvements in coronary angiography capacity across South West Wales.<br># Cardiology SDM engaged with ARCH/Regional planning in support of improvements in pacing capacity across South West Wales. | Lack of capacity in tertiary centre to manage a range of specialised cardiac investigations, treatments and surgery.<br><br>Lack of available data and business intelligence to support daily monitoring/escalation of waiting times across all sites for the full range of cardiac investigations, treatments and surgery.<br><br>Lack of cardiac catheter capacity in HDUHB to reduce reliance on tertiary centre angiography.<br><br>Lack of theatre / pacing capacity in HDUHB to reduce reliance on tertiary centre pacing.<br><br>Lack of CT Coronary Angiography capacity in HDUHB to reduce reliance on in-house and SBUHB angiography. | Develop business case to outline and evidence the benefits of increasing in-house coronary angiography capacity in 2020/21 as part of a broader plan to reduce reliance on tertiary service angiography. | Smith, Paul | ~~31/01/2019~~ 30/04/2020 | Cardiology SDM is engaged with JRPDF concerning this development. SDM/Clinical Lead currently prioritising development of CT Coronary Angiography in support of reducing reliance on conventional in-house and tertiary care coronary angiography. SDM currently working with Commissioning Manager to review scope and potential to repatriate an element of elective angiography activity (LTA) from SBUHB. |
| | | Develop long term regional plan. | Carruthers, Andrew | ~~30/09/2019~~ 31/12/2020 | Decision taken not to establish a regional Cardiac Network/ Collaborative. Development of long term regional plan now being overseen by Joint Regional Planning and Delivery Forum and Committee and ARCH workstreams. SDM/Clinical Lead are engaged with these workstreams. |
| | | Develop business case to support the long-term sustainability of the N-STEMI 'Treat & Repat' service, in particular for the following cost elements:<br>• the transportation costs to ensure early transfer of patients to Morriston for same day cardiac catheter treatment and same day repatriation to HDdUHB; and<br>• 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. |

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| Address issues identified regarding needed improvements to referral processes as reported in August JRPDC paper:<br>• the internal communication and transfer processes within HDdUHB are a critical part of the success of the treat and repatriate pathway; and<br>• 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. |

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| | | Develop business case to outline and evidence benefits of increasing in-house pacing capacity in 2019/20 as part of a broader plan to repatriate the pacing LTA from SBUHB. | Smith, Paul | ~~31/10/2019~~ 30/04/2020 | Pacing SBAR (Aug '19) approved by Execs in Sept '19 supporting repatriating Simple Bradycardia Pacing (LTA) from SBUHB. Initial plan to phased repatriation from October/November 2019 impeded by HDUHBs pacing operational/capacity pressures (loss of 50% capacity at GGH site; loss of 33% Health-board-wide). SDM/Clinical Lead currently working to return service capacity to baseline and accelerate plans around activity repatriation. HDUHB Pacing Group meets bi-weekly to review local development plan progress. SDM/Clinical Lead engaging with ARCH Brady Pacing Sub Group. |

| 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 |

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|---|---|---|---|---|---|---|---|---|---|---|
| Performance indicators for Tier 1 targets. | Daily/weekly/monthly/ monitoring arrangements by management | 1st | | | | Lack of oversight at the Board and Committees. | Review reporting arrangements of emergency and elective waits. | Carruthers, Andrew | ~~01/10/2018~~ 30/04/2020 | Discussions continue with SBUHB for information on cardiac patients(on all pathways)to be provided to Hywel Dda for inclusion in the IPAR. Whilst access has been agreed to SBUHB's cardiac activity, there are still issues with accessing the system which have raised with SBUHB. once this is resolved, a routine report can be developed to allow the reporting of time taken from referral in HDUHB to treatment in SBUHB. |
| | Audit of N-STEMI referral undertaken by Clinical Lead show average wait of 5.8 days - currently being reviewed for February 2020 position | 1st | | | | | | | | |
| | Executive Performance Reviews | 2nd | | | | | | | | |
| | IPAR Performance Report to BPPAC & Board | 2nd | | | | | | | | |
| | Monthly oversight by WG | 3rd | | | | | | | | |

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| **Strategic Objective:** | *The Health Board objectives for 2020/21 to be confirmed.* |

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| **Executive Director Owner:** | Carruthers, Andrew | **Date of Review:** | May-20 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | Jul-20 |

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

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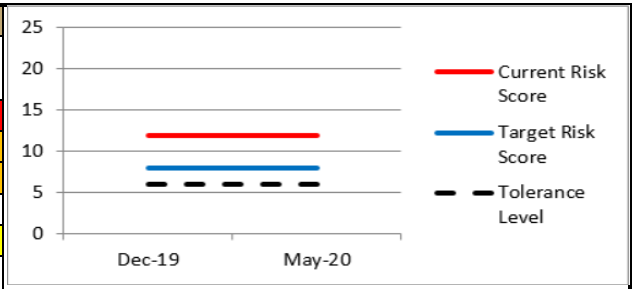
|---|---|
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Safety - Patient, Staff or Public |
| **Inherent Risk Score (L x I):** | 4×4=16 |
| **Current Risk Score (L x I):** | 3×4=12 |
| **Target Risk Score (L x I):** | 2×4=8 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟷ |




| **Rationale for CURRENT Risk Score:** |
|---|
| There is a national recruitment issue in relation to consultant cellular pathologists. There is a current gap of 3.0WTE Consultant cellular pathologist posts (out of 9.0WTE established posts) in Hywel Dda which significantly impacts the UHB's ability to meet timescales set out in the new single cancer pathway. The vacancy budget is being used to fund additional sessions and ILOL claims by the current substantive staff, however this is not sufficient to meet required timescales or enable the service to attend MDTs to review cancer cases. The service is also unable to source agency consultant cellular pathologist locums within the All Wales Framework due to the current price cap. |

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

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

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

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| Consultant Cellular Pathologists centralised to Glangwili General Hospital (GGH) site.<br><br>Tissue processing centralised to GGH site.<br><br>Consultant Cellular Pathologists are undertaking additional sessions to maintain workload in house to ensure turn around times are maintained.<br><br>Additional 6 sessions provided by current 3.0WTE substantive consultants.<br><br>Prioritisation of suspected cancer cases over routine tissue samples.<br><br>Actively working with medical staffing to recruit to vacant posts. | National shortage of available consultant cellular pathologists.<br><br>Inability to secure locum consultant cellular pathologists within All Wales Framework.<br><br>Inability to develop new staffing model whilst significantly understaffed(and 2 consultants working from home due to COVID-19). | Full implementation of digital pathology solutions to enable scanning of tissue samples to help reduce delays in analysis. | Stiens, Andrea | ~~31/03/2021~~ (TBC) | Phase 2 of project has developed and tested the Hub and spoke concept - this phase closed in Nov 2019. Phase 3 has just started with a business case that will support national scale up, infrastructure and data storage solution currently being developed. Date of completion for Phase 3 will depend on approval and funding from WG. |
| | | Implementation of regional service through the ARCH project. | Stiens, Andrea | ~~31/03/2024~~ 30/09/2020 | Strategic Outline Case (SOC) approved by Hywel Dda UHB, Swansea Bay UHB and Public Health Wales, has been submitted to Welsh Government (WG) for scrutiny and the UHB is awaiting WG approval. This will be delayed due to COVID-19. |
| | | Commence the modernisation of the technical workforce through recruitment of staff trained in dissection. | Stiens, Andrea | ~~31/12/2019~~ ~~31/03/2020~~ 31/03/2021 | Progress may be limited until regional model is adopted. This will be delayed due to COVID-19. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) | 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. | Review of KPIs at Monthly Pathology Strategy Group meeting | 1st | | | QSEAC -Feb19 & Apr19 & Feb20 (planned)<br><br>Op QSE SC - May19 | Lack of independent assurance of service | Submit application for pre-assessment visit accreditation (UK Accreditation Scheme) re compliance with ISO 15189 Laboratory Standards) | Stiens, Andrea | ~~31/03/2020~~ 30/09/2020 | Rigorous accreditation process requires a pre-assessment visit which is unlikely to be before Sep20. |

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| External Quality Assessments by Consultant Staff - issues picked up through supervision | 1st | | | | | | | |

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| **Strategic Objective:** | *The Health Board objectives for 2020/21 to be confirmed.* |

| | | | |
|---|---|---|---|
| **Executive Director Owner:** | Carruthers, Andrew | **Date of Review:** | May-20 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | Jul-20 |

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| **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 rate. |
| **Does this risk link to any Directorate (operational) risks?** | 229 | | |

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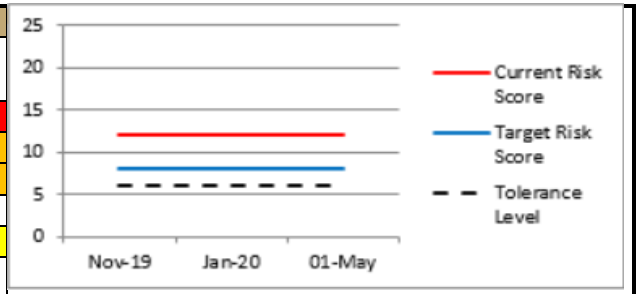
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Safety - Patient, Staff or Public |
| **Inherent Risk Score (L x I):** | 5×4=20 |
| **Current Risk Score (L x I):** | 3×4=12 |
| **Target Risk Score (L x I):** | 2×4=8 |
| **Tolerable Risk:** | 6 |
| **Trend:** | ⟷ |




**Rationale for CURRENT Risk Score:**

WGH should have 7 middle grade doctors to fill rota. Despite improvement through locum staff being secured, middle grade rota remains under constant review and management as the department are fully reliant on temporary staff. The risk has however been reduced to 12 based on 5 long term agency/NHS locum/zero hours doctors being secured. Unfortunately, only 2 of these doctors work a full rota, including nights.

**Rationale for TARGET Risk Score:**

It is anticipated that the completion of the recruitment process of 4 middle grade posts will provide some stability to the department. The contingency plan, which is currently under development, will ensure that robust procedures are in place in the event that the middle grade rota cannot be filled.

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Daily review of team strengths by rota co-ordinators and service manager unscheduled care. Issues identified escalated to GM and SDM.<br><br>Recruitment program on-going to fill gaps and recruit into vacant posts.<br><br>Medacs agency filling whenever possible with long term locums.<br><br>Continuous monitoring of the team strengths to ensure consultant and senior support and supervision.<br><br>Links with other Health Board sites (HDUHB & SBUHB) to outline current | Contingency plan for when middle grade shift is uncovered.<br><br>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. |

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| pressures and any opportunities to cross cover and to assess overall medical staffing position across HDUHB<br><br>Weekly Urgent Response Group review rotas for the next six months.<br><br>3 x long term locums in place (6 months).<br><br>Escalation procedures in place.<br><br>March 2020 Middle grade rota merged with medical rota to strengthen workforce across 2 EDs | | Complete the recruitment of 4 middle grade doctors. | Cole-Williams, Janice | ~~31/12/2019~~ 07/11/2020 | Posts out to advert |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) |
|---|---|---|---|---|---|
| **Performance Indicators** | **Sources of ASSURANCE** | **Type of Assurance (1st, 2nd, 3rd)** | **Required Assurance / Current Level** | | |
| A&E 4hr waiting times (<95%)<br><br>A&E 12hr waiting times (0 target)<br><br>Number of ambulance handovers over one hour (0 target)<br><br>Incidents level 4 or 5 | Daily review of rotas | 1st | | | * Executive Committee - Jul19<br><br>* In-committee Board - Jul19 |
| | Daily review of incident reports | 1st | | | |
| | Local governance meeting monthly | 1st | | | |
| | Tier 1 target performance reviewed at Business Planning and Performance Committee | 2nd | | | |

| Gaps in ASSURANCES | | | | |
|---|---|---|---|---|
| **Identified Gaps in Assurance:** | **How are the Gaps in ASSURANCE will be addressed<br>Further action necessary to address the gaps** | **By Who** | **By When** | **Progress** |
| None identified. | | | | |
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| **Strategic Objective:** | *The Health Board objectives for 2020/21 to be confirmed.* |

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| **Executive Director Owner:** | Moore, Steve | **Date of Review:** | May-20 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | Jun-20 |

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| **Risk ID:** | **855** | **Principal Risk Description:** | There is a risk that the UHB's normal business will not be given sufficient focus. This is caused by corporate and operational focus diverted to COVID-19 planning. This could lead to an impact/affect on poor patient outcomes and experience, increase in complaints, increased follow-ups, delays to treatment, increase in financial deficit, increase scrutiny by regulators/inspectors. |
| **Does this risk link to any Directorate (operational) risks?** | | | |

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|---|---|
| **Risk Rating:(Likelihood x Impact)** | **No trend information available.** |
| **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:** | *N/A* |

| **Rationale for CURRENT Risk Score:** |
|---|
| At this early stage of the pandemic, to prevent deterioration urgent patients and those needing cancer, rheumatological and other services continue to receive care and processes are in place to maintain this. Impact is based on the fact that harm will be done if the risk materialises. |

| **Rationale for TARGET Risk Score:** |
|---|
| Revised Planning Guidance Requirement issued by Tactical to Bronze will lead to a prioritised risk based plan to restart services that have been scaled back or suspended. |

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
|---|---|---|---|---|
| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Ethics Panel established and asked to consider issues related to the care of non-COVID-19 patients.<br><br>Clinicians are making case by case risk based decisions for high risk/vulnerable patients.<br><br>All urgent and emergency work continuing at present.<br><br>Werndale capacity being used for cancer services.<br><br>Revised Strategic Plan Requirement issued by Gold to Tactical on 27/04/20 to include non-COVID planning.<br><br>Establish Transformation Steering Group. | 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 | 31/08/2020 | To be established through the Command and Control Structure |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| None identified. | Command and Control Structure developing and approving plans to re-establish and maintain essential services | 2nd | | | Responding to the COVID-19 pandemic - Board (Apr20&May20) | No performance measures.<br><br>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 | Work underway. |
| | Board oversight of revised quarterly plans | 2nd | | | | | | | | |

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| **Strategic Objective:** | *The Health Board objectives for 2020/21 to be confirmed.* |

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| **Executive Director Owner:** | Carruthers, Andrew | **Date of Review:** | May-20 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | Jul-20 |

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

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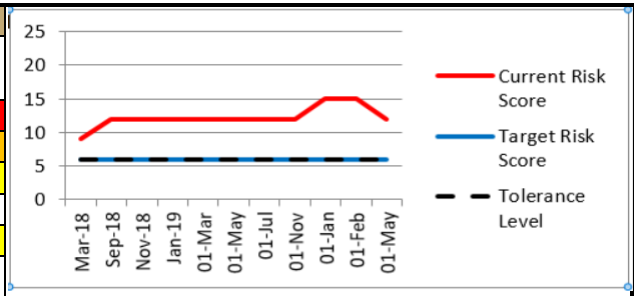
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Service/Business interruption/disruption |
| **Inherent Risk Score (L x I):** | 5×3=15 |
| **Current Risk Score (L x I):** | 4×3=12 |
| **Target Risk Score (L x I):** | 2×3=6 |
| **Tolerable Risk:** | 6 |
| **Trend:** | |




| **Rationale for CURRENT Risk Score:** |
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| Whilst the COVID pandemic combined with the temporary overnight service changes (reduction of 5 to 3 bases with a new OOH/MIU GP pathway in PPH) has brought some respite to the recent fragility, any lifting of lock down as well as possible impacts on in-hours provision is likely to result in a fragile workforce position once again. The rationale that was placed around the need for service improvement and modernisation should not be forgotten. Significant sickness levels amongst salaried GP workforce have been resolved however, in the event of a significant COVID outbreak, there are a number of staff who may become unavailable to work due to health-related vulnerabilities. The APP model continues to provide significant resilience (when available) in terms of supplementary resource. Discussions to assess potential for expansion of this model have now commenced but no decision has yet been reached. The risk score has reduced however the situation may deteriorate in the Autumn period. |

| **Rationale for TARGET Risk Score:** |
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| Despite the improvement in current rota provision, the service remains at risk. Therefore, medium term actions are still required, especially in terms of Winter planning. As soon as the present situation allows, work to develop a long term plan for OOH Services must recommence in order to reduce this risk on a permanent basis so to ensure the out of hours service provision is not interrupted. The project management office has been supporting service leads in this area. |

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

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

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| # GP's rotas across the 3 counties are now managed centrally via the administration team based in Haverfordwest<br># Dedicated GP Advice sessions in place at times of high demand (mostly weekends).<br># Remote working telephone advice clinicians secured where required.<br># Additional remote working capacity has been secured to assist with clinicians who may be shielding/ isolating.<br># Ongoing workforce support from 111 programme team in addressing OOH fragilities in place.<br># Health Professional feedback form in use between clinicians, service management and 111 (WAST) leads.<br># WAST Advance Paramedic Practitioner (APP) resource continued.<br># Ongoing recruitment of clinicians has resulted in 14 appointments (sessional or bank basis) in the last 3 months.<br># Rationalisation of overnight bases in place since March 2020 appear successful in supporting wider service delivery in current model.<br># A new approach to engage with the GP network was held in terms of a workshop in Oct19 - further workshops to be held in 2020, but re-arrangement is affected by COVID-19 restrictions.<br># Programme Management Office (PMO) project to assess service and workforce redesign is presently on hold due to the COVID-19 situation. | The ability to influence workforce participation remains limited due to the lack of contractual agreements (reliance on sessional staff). At present the staffing availability has improved and by default the working environment is now more conducive to achieving good shift fill. However, as this current situation is likely due to the current COVID-19 situation, a need for formalised workforce plan and redesign is still required - support from PMO to achieve this has been obtained and a working group will reconvene as soon as conditions allow.<br><br>The potential for the service to destabilise in relation to COVID-19 outbreak or easing of lock down (enabling staff to holiday or work abroad) is significant and is reflected in the revised risk score. | Ensure Transforming Clinical Services Programme incorporates a long term, viable plan for OOH. | Rees, Gareth | 31/03/2020 | Project Management Office (PMO) has convened a working group to develop short to medium term service development plan for inclusion in the IMTP 2019/22 to manage the current fragilities within the Out of Hours Service. 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. |
| | | 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 | ~~28/06/2019~~ 31/03/2020 | 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.<br>On target for rationalisation of night base cover from 09 March 2020 |
| | | Investigate potential external alternatives to current workforce position. | Davies, Nick | 30/04/2020 | Specifically to assess the potential for outsourcing of clinical sessions to external agencies/ creation of a "chamber" approach. to support the provision of immediate resilience. This will include a need to review the introduction of similar schemes in the UK including one in Merthyr. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls) | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Indicators | Sources of ASSURANCE | Type of Assurance (1st, 2nd, 3rd) | Required Assurance / Current Level | | | Identified Gaps in Assurance: | How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps | By Who | By When | Progress |
| | Weekly sitreps/Weekend briefings for OOH | 1st | | | ET- Risk to OOH business continuity - Sep19<br>QSEAC OOH Update Sep19<br>ET- OOH resilience - Nov19<br>BPPAC - update on the OOH Services peer review paper Dec19<br>BPPAC Quarterly monitoring Nov19<br>QSEAC OOH Update Feb20<br>ET - OOH resilience Q3 monitoring Jan20<br>QSEAC - Peer review - Feb20<br>BPPAC - OOH service design Feb20 | Lack of meaningful performance indicators. | Assess NHS 111 performance metrics to understand how they may influence Hywel Dda OOHs performance, and if a viable alternative - which may support improvement in shift fill. | Davies, Nick | 31/07/2020 | 15/5 Discussed with 111 programme manager and agreed in principle to assess. Matters have since been delayed by COVID-19 planning but will be revisited as soon as possible. |
| | Monitoring of performance against 111 standards | 1st | | | | | | | | |
| | Executive Performance Reviews | 2nd | | | | | | | | |
| | BPPAC monitoring | 2nd | | | | | | | | |
| | QSEAC monitoring | 2nd | | | | | | | | |
| | WG Peer Review Oct 19 | 3rd | | | | | | | | |

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| **Strategic Objective:** | *The Health Board objectives for 2020/21 to be confirmed.* |

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| **Executive Director Owner:** | Carruthers, Andrew | **Date of Review:** | Mar-20 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | Apr-20 |

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

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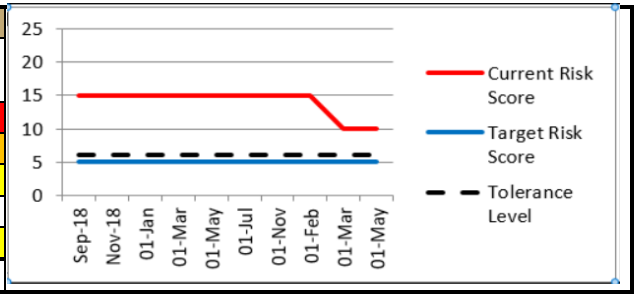
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Safety - Patient, Staff or Public |
| **Inherent Risk Score (L x I):** | 3×5=15 |
| **Current Risk Score (L x I):** | 2×5=10 |
| **Target Risk Score (L x I):** | 1×5=5 |
| **Tolerable Risk:** | 6 |
| **Trend:** | |




**Rationale for CURRENT Risk Score:**

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

**Rationale for TARGET Risk Score:**

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

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
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| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| Resident Operating Department Practitioners (OPD) Team<br><br>24/7 anaesthetic cover on site (obstetrician and consultant anaesthetist).<br><br>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. | 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. |

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| Principle of removal of on-call compensatory rest approved by Executive Team. | | Agreement with theatre teams (employee relations) for removal of compensatory rest.<br><br>Formal 90 day OCP for Scrub and Band 3 circulatory staff to commence 16/01/19. | ~~Barker, Karen~~ Carruthers, Andrew | ~~30/11/2018~~ ~~30/04/2019~~ ~~14/06/2019~~ ~~15/07/2019~~ 31/03/2020 | OCP completed for SCRUB and Band 3 team. Resolution of the process to remove compensatory rest days was paused during the COVID-19 and will form part of the Quarter 2 plan. Staff and union representatives have been informed. |
| | | 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) |
|---|---|---|---|---|---|
| **Performance Indicators** | **Sources of ASSURANCE** | **Type of Assurance (1st, 2nd, 3rd)** | **Required Assurance / Current Level** | | |
| No of incidents reported where 30 minute response target is missed. | Maternity Services governance systems review of incident reports | 1st | | | Executive Team - Jul18<br><br>Executive Team - Dec18<br><br>ARAC - Jun19 |
| | Management audit of cases presented to QSEAC | 2nd | | | |
| | Discussions with WG Chief Nursing Officer & UHB Medical & Nursing Director | 3rd | | | |

| Gaps in ASSURANCES | | | | |
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| **Identified Gaps in Assurance:** | **How are the Gaps in ASSURANCE will be addressed**<br>**Further action necessary to address the gaps** | **By Who** | **By When** | **Progress** |
| None identified. | | | | |
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| **Strategic Objective:** | *The Health Board objectives for 2020/21 to be confirmed.* |

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| **Executive Director Owner:** | Jervis, Ros | **Date of Review:** | May-20 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | Jul-20 |

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

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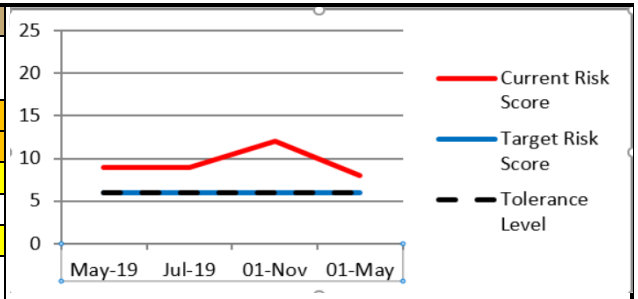
| **Risk Rating:(Likelihood x Impact)** | |
| **Domain:** | Service/Business interruption/disruption |
| **Inherent Risk Score (L x I):** | 3×4=12 |
| **Current Risk Score (L x I):** | 4×2=8 |
| **Target Risk Score (L x I):** | 2×3=6 |
| **Tolerable Risk:** | 6 |
| **Trend:** | |




| **Rationale for CURRENT Risk Score:** |
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| By reflecting of on-going work, and plans at local, regional and national levels, and recent resilience measures adopted by the organisation in response to COVID19 we have reduced the current score. The compounding effect of a Brexit no-deal scenario with winter plans, maintaining the Covid-19 response and the increasing concern regarding the fragility of the independent social care sector requires the likelihood to remain at 4 however the impact score has been reduced to 2 to reflect the additional resilience at a national, regional and local level due to COVID19 |

| **Rationale for TARGET Risk Score:** |
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| This will be affected by confirmation of Brexit outcome by UK Government. The UK government will commence the fourth round of trade talks with the EU from 01 June. However, the UK Government has repeatedly ruled out extending the transition period and will move to trading with the EU on World Trade Organisation rules from 2021 if no agreement is reached. |

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
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| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| * Brexit Steering Group established to manage the consequences of Brexit and its interface with partners.<br>* Wider governance infrastructure in place - of note the Dyfed Powys LRF Brexit Group and Welsh Government led groups (currently stood down).<br>* Risk assessments and business continuity plans feed into a dynamic risk summary document which continues to track on-going risks and controls assurance with business continuity.<br>* Scoping exercise undertaken within Workforce to identify EU nationals and resolve data gaps in ESR. Workforce Brexit Plan developed. | Full understanding of potential impacts and implications for the UHB due to the unknown final outcome of Brexit. | Scoping Exercise and liaison with other HBs and WG. | Hussell, Sam | Completed | Completed. |
| | | Completion of suite of risk assessment and business continuity plans (BCPs) by service leads to mitigate highest risks. | Hussell, Sam | Completed | Completed. |

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| * Staff Brexit Intranet page developed as single point of information plus a closed Facebook Group for EU staff.<br>* Sitrep process at local, regional and national level for reporting and escalating impacts of consequences of Brexit (currently stood down).<br>* Staff bulletins issued to inform and raise awareness. | | Completion of workforce scoping exercise and resolution of ESR data gap. | Gostling, Lisa | ~~31/01/2019~~ ~~30/06/2019~~ 31/10/2019 | ESR Data Gap significantly reduced with on-going campaign to complete. Line managers being directly approached to resolve data gaps within their teams. |
| | | NHS Wales exercise planned for Jan19 to rehearse Brexit no-deal contingencies. | Hussell, Sam | Completed | Completed. |

| ASSURANCE MAP | | | | Control RAG Rating (what the assurance is telling you about your controls | Latest Papers (Committee & date) | Gaps in ASSURANCES | | | | |
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| **Performance Indicators** | **Sources of ASSURANCE** | **Type of Assurance (1st, 2nd, 3rd)** | **Required Assurance** / **Current Level** | | | **Identified Gaps in Assurance:** | **How are the Gaps in ASSURANCE will be addressed** / **Further action necessary to address the gaps** | **By Who** | **By When** | **Progress** |
| None identified. | Response submitted on 19Nov18 to Andrew Goodall letter of 05 October stating approach to be taken by Health Boards confirming progress | 1st | | | No recent papers. | Further sources to be identified when risk is fully understood. | Respond to WG letter of 05/10/18 requesting further information on the approach taken by UHB and progress to date. | Hussell, Sam | Completed | Response sent by 19/11/18. |
| | Response submitted to Wales Audit Office letter notifying of intention to undertake an initial baseline of arrangements by 30Nov19 | 1st | | | | | Respond to WAO request for information to inform their baseline assessment of arrangements for Brexit. | Hussell, Sam | Completed | Response provided by 30/11/18. |
| | Emergency Planning Team to review UHB no deal Brexit arrangements and associated BCPs | 1st | | | | | Respond to request for written evidence of Brexit preparations to Health, Social Care and Sport Committee, Welsh Government | Hussell, Sam | Completed | Response submitted to CEO Office 20/06/2019. |

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| Executive oversight of Brexit arrangements and BCPs | 2nd | | | | | | Respond to request from Welsh NHS Confederation in relation to providing support to vulnerable patients. | Hussell, Sam | Completed | Response sent 30/07/19. |
| Review of Exercise planned for Jan19 | 3rd | | | | | | | | | |
| WAO Review of Brexit Preparedness | 3rd | | | | | | | | | |

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| **Strategic Objective:** | *The Health Board objectives for 2020/21 to be confirmed.* |

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| **Executive Director Owner:** | Moore, Steve | **Date of Review:** | May-20 |
| **Lead Committee:** | Quality, Safety and Experience Assurance Committee | **Date of Next Review:** | Jun-20 |

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| **Risk ID:** | **853** | **Principal Risk Description:** | There is a risk that the UHB's response to COVID-19 will be insufficient to address peak in demand terms of bed space, workforce and equipment/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?** | | | |

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| **Risk Rating:(Likelihood x Impact)** | | **No trend information available.** |
| **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:** | *N/A* | |

| **Rationale for CURRENT Risk Score:** |
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| Likelihood is based on a balanced view of all the limiting factors related to an unprecedented expansion of the UHB's bed base versus some improvement in modelling forecasts which reduce the initial peak. Impact recognises the significant clinical risk of the risk becomes reality. At present, based on estimated COVID demand and the planning undertaken to respond to COVID-19, the likelihood of this risk has been reduced from 3 to 1. |

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

| **Key CONTROLS Currently in Place:** (The existing controls and processes in place to manage the risk) | **Gaps in CONTROLS** | | | |
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| | **Identified Gaps in Controls :** (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working) | **How and when the Gap in control be addressed** Further action necessary to address the controls gaps | **By Who** | **By When** | **Progress** |
| A strong Command & Control structure has been implemented and judged fit for purpose by our assigned Military Liaison Officer.<br><br>Planning numbers have been clearly communicated from Gold to Tactical and Bronze groups at the earliest opportunity.<br><br>Tactical and Bronze groups responded quickly to the planning numbers set out in the RWC -66% model thus maximising the chances of securing the capacity needed.<br><br>Clinical debate continues to attempt to address the areas of most concern such as ventilator support.<br><br>An Ethics Panel has been established to consider the challenges ahead and provide guidance.<br><br>QSEAC will scrutinise PPE and areas of concern such as oxygen supply | Inability to control lift of lockdown measures. | No further actions as target score has been met. | | | |
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| QSEAC will scrutinise PPE and areas of concern such as oxygen supply and ventilators.<br><br>Public Health modelling cell established to provide regular forecasts of the progress of the pandemic at local level.<br><br>Functional capacity forecasting tool provides time to respond to changes in forecasting. | | | | | | |

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