Risk Ref	Risk (for more detail see individual risk entries)	Included on BAF	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Nov-20	Trend	Target Risk Score	Risk on page no...
624	Ability to maintain and address backlog maintenance and develop infrastructure to support long term strategic objectives	Strategic Objectives agreed by Board - BAF under development	Thomas, Huw	Business objectives/projects	6	5x4=20	5x4=20	↔	4x4=16 Accepted	3
646	Ability to achieve financial sustainability over medium term.		Thomas, Huw	Finance inc. claims	6	3x4=12	4x4=16	↑	2x4=8	8
750	Lack of substantive middle grade doctors affecting Emergency Department in WGH.		Carruthers, Andrew	Safety - Patient, Staff or Public	6	3x4=12	4x4=16	↑	2x4=8	12
684	Lack of agreed replacement programme for radiology equipment across UHB		Carruthers, Andrew	Service/Business interruption/disruption	6	4x4=16	4x4=16	↔	2x3=6	15
1018	Delivery of Q3/4 Operating Plan – Insufficient workforce to support delivery of essential services		Gostling, Lisa	Workforce & OD	8	N/A	4x4=16	New		18
813	Failure to fully comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO)		Carruthers, Andrew	Statutory duty/inspections	8	3x5=15	3x5=15	↔	3x5=15	20
1016	Delivery of Q3/4 Operating Plan - Increased COVID-19 infections from poor adherence to Social Distancing		Rayani, Mandy	Safety - Patient, Staff or Public	6	N/A	3x5=15	New	2x5=10	27
1017	Delivery of Q3/4 Operating Plan - Test, Trace and Protect Programme being able to quickly identify & contain local outbreaks		Shakeshaft, Alison	Safety - Patient, Staff or Public	6	N/A	3x5=15	New	2x5=10	29
956	Risk that the Health Board will be breach its Capital Resource Limit in 2020/21		Thomas, Huw	Statutory duty/inspections	8	N/A	3x5=15	New	2x4=8	31
628	Fragility of therapy provision across acute, community and primary care services		Shakeshaft, Alison	Safety - Patient, Staff or Public	8	4x4=16	3x4=12	↓	3x4=12	34
451	Cyber Security Breach		Thomas, Huw	Service/Business interruption/disruption	6	3x4=12	3x4=12	↔	3x4=12 Accepted	37
291	Lack of 24 hour access to Thrombectomy services		Carruthers, Andrew	Quality/Complaints/Audit	8	4x4=16	3x4=12	↓	2x4=8	42
894	Delivery of Q3/4 Operating Plan – Reduced clinical workforce due to underlying medical condition, pregnancy or ethnicity (BAME)		Gostling, Lisa	Safety - Patient, Staff or Public	6	3x4=12	3x4=12	↔	2x4=8	45
129	Ability to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda patients		Carruthers, Andrew	Service/Business interruption/disruption	6	4x3=12	4x3=12	↔	2x3=6	47
635	No deal Brexit affecting continuity of patient care		Thomas, Huw	Service/Business interruption/disruption	6	4x2=8	4x3=12	↑	2x3=6	51
117	Delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery		Carruthers, Andrew	Safety - Patient, Staff or Public	6	2x5=10	2x5=10	↔	2x5=10	56
634	Overnight theatre provision in Bronglais General Hospital		Carruthers, Andrew	Safety - Patient, Staff or Public	6	2x5=10	2x5=10	↔	1x5=5	60
371	Inability to meet WG target for clinical coding and decision-making will be based on inaccurate/incomplete information		Thomas, Huw	Business objectives/projects	6	4x4=16	3x3=9	↓	3x4=12	62
633	Ability to meet the 1% improvement target per month for waiting times for 2020/21 for the new Single Cancer Pathway		Carruthers, Andrew	Quality/Complaints/Audit	8	3x3=9	3x3=9	↔	3x2=6	65
855	Risk that UHB's non-covid related services and support will not be given sufficient focus		Moore, Steve	Quality/Complaints/Audit	8	3x4=12	2x4=8	↓	2x4=8	68
856	Risk to delivery of the Financial Plan for 2020/21		Thomas, Huw	Statutory duty/inspections	6	4x5=20	2x4=8	↓	2x4=8	70
854	Risk that Hywel Dda's Response to COVID-19 will be larger than required for actual demand		Moore, Steve	Adverse publicity/reputation	8	2x3=6	2x3=6	↔	2x3=6	74
853	Risk that Hywel Dda's response to COVID-19 will be insufficient to manage demand.		Moore, Steve	Safety - Patient, Staff or Public	6	1x5=5	1x5=5	↔	1x5=5	77

Assurance Key:

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

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

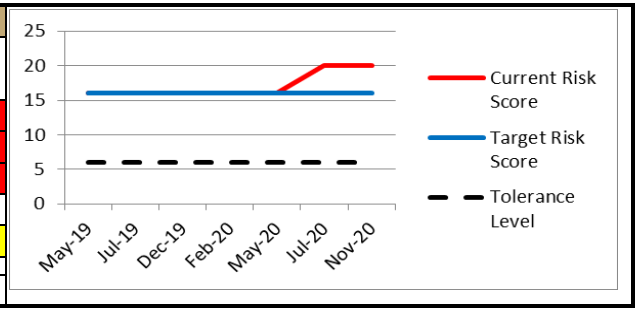
NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you

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

Date Risk Identified:	Sep-18	**Executive Director Owner:**	Thomas, Huw	**Date of Review:**	Nov-20
Strategic Objective:	6. Sustainable use of resources	**Lead Committee:**	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Dec-20

Risk ID:	**624**	**Principal Risk Description:**	There is a risk the UHB will not be able to maintain and address either the backlog maintenance or development of its estate, medical equipment and digital infrastructure, that it is safe and fit for purpose. This is caused by insufficient capital, both from the All Wales Capital Programme and Discretionary Capital allocation. This could lead to an impact/effect on delivery of strategic objectives, service improvement/development and delivery of day to day patient care.
Does this risk link to any Directorate (operational) risks?		Yes	

Risk Rating:(Likelihood x Impact)	
Domain:	Business objectives/projects
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	5×4=20
Target Risk Score (L x I):	4×4=16
30/05/2019 - Board 'Accept' Target Risk	
Tolerable Risk:	6
Trend:	⟺



Rationale for CURRENT Risk Score:

This risk has increased due to the use of All Wales Capital resources in the management of COVID-19 response. Although there are a number of controls in place, the risk cannot be managed within the current capital allocation and the risk to that allocation has the potential to increase should discretionary capital have to be used to support Covid-19 related expenditure. Any All Wales Capital schemes intended for funding in 2020/21 but not yet approved, are now unlikely to be funded in 2020/21.

Rationale for TARGET Risk Score:

The target risk score of 16 reflects the actions and processes planned and controls in place to help mitigate the risk.

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**
* There is an annual programme of replacement in place for equipment, IT and Estates which follows a prioritisation process. * The Business Planning & Performance Committee (BPPAC) and Capital Estates & IM&T Sub Committee (CEIM&T) (to date with IM membership and wide stakeholder engagement in prioritisation process), receive reports and recommendations on the prioritisation and allocation of available capital. * When possible, aligning replacement equipment to large All Wales Capital schemes to minimise the impact on discretionary capital within the UHB.	Capital funding is significantly short of the level required to deal with backlog maintenance programme for estates, digital & equipment. An Estates Strategy aligned to the Board approved Health and Care Strategy. Uncertainty over the full funding by	Undertake backlog maintenance through the All Wales Capital programme for new equipment, digital and estates infrastructure. The Strategy is to apply discretionary capital in a prioritised way within the UHB however to take advantage of all Wales capital schemes where possible and any additional in-year capital allocations.	Thomas, Huw	Completed	As previously reported, significant pressures remain on the All Wales Capital Programme which limits flexibility in relation to backlog capital. The equipment and digital allocations were supplemented by the allocation of year end monies from WG in 2019/20.

* Completion of the medical devices inventory by the operational management team which helps in the prioritisation of available funds. * Retention of a medical equipment capital contingency to manage urgent issues of repair or replacement. * Review of regulatory reports which have a capital component ie. HIW, WAO, CHC. * Investigating the potential for 'Charitable' funding rather than Discretionary Capital Programme as appropriate. * Communication with Welsh Government via Planning Framework and IMTP (Infrastructure & Investment Enabling Plans) and regular dialogue through Capital Review meetings to understand the impact of All Wales Capital being required to support COVID 19 management, and any knock on impact on the 2020/21 DCP.. * Preparation of priority lists for equipment, Estates and IM&T in the event of notification of additional capital funds from Welsh Government i.e. in year slippage and to enable where possible, the preparation of forward plans. This is also addressed through the identification of high priority issues through the annual planning cycle. * Reports to CE&IMT SC set out priorities for imaging equipment and established a much firmer baseline position in relation to medical devices backlog. * Committed and planned capital expenditure associated with the COVID-19 pandemic has been shared with WG.	WG of COVID-19 related capital expenditure which if not fully funded will impact on 2020/21 DCP. An updated Strategic Outline Programme for Digital Services to provide a forward look and also the backlog maintenance	Development of a medical devices inventory.	Rees, Gareth	Completed	The medical devices inventory has been updated and reflects the higher than anticipated capital spend on equipment backlog issues in 2019/20. This has been the subject of a CEIM&T report and will be used to prioritise the equipment backlog taking into account items also purchased in response to the management of Covid-19 pressures.
		The annual planning cycle identifies key capital enabling plans and priorities. The 2019/20 planning cycle will also include the start of the development of an Estates Strategy in support of the clinical strategy which will establish the timing and scope of key estate developments which will help address backlog issues across the UHB. This element will be taken forward as part of the Programme Business Case for AHMWW and finalised in the Outline Business Case planned for 2021/22.	Thomas, Huw	~~31/03/2020~~ 31/12/2020 31/03/2021 30/06/2021	Evidenced in work in support of implementation of 'A Healthier Mid & West Wales' and inclusion in the Infrastructure and Investment Enabling Plan produced as part of the 2019/20 and planned to be produced for the 2020/21 Planning Cycle; the Pre Programme Business Case shared with WG Qtr3 2019/20; the Programme Business Case is planned for completion Qtr 1 2021/22.
		Respond to Welsh Government request of 24Jul19 requesting a prioritised imaging equipment which could be provided 2019/20 (deadline for submission is 7th August 2019). Completion of these schemes has been delayed due to Covid 19 related issues.	Thomas, Huw	Completed	List was submitted to WG and funding has been allocated which has resulted in new digital general x-ray room equipment in both PPH and WGH plus new fluoroscopy equipment in GGH August 2020. In addition, an allocation has been agreed to allow the replacement of the WGH MRI in 2020/21. This is likely to be delivered early 2021/22. The opportunity has also been taken to procure short term capacity through a demountable 2nd CT scanner for Glangwili.

Following the submission of the Strategic Medical Device Replacement report to the CEIM&T Sub-Committee, discussions need to be had with Welsh Government colleagues at the Capital Review Meeting (CRM) on 30Jul19 about the progression of a business case for funding to help address priority backlog areas.	Thomas, Huw	Completed	Completed - As stated above, following the higher than anticipated levels of investment in 2019/20 and 2020/21 in imaging and general equipment backlog, the medical devices inventory is now to be re-assessed to establish priority requirements for 2021/22. It is likely that DCP funds will need to be supplemented through a bid for All Wales capital to support essential replacements in 2021/22.
Estate Major Infrastructure backlog has been the subject of a draft Programme Business Case (PBC) which is now being refreshed following the TCS outcome with the purpose to address essential infrastructure backlog on hospital sites pending new developments as part of the UHB Health & Care Strategy.	Thomas, Huw	~~31/03/2020~~ 31/03/2021	The Programme Business Case has been shared in draft with WG and with the Executive Team and IMs. This has now been endorsed at the October 2020 PPPAC before final approval and submission to WG. Given the AWC position, funding appears unlikely during 2020/21.
Digital Bids have been forwarded to Welsh Government to access the £25m in capital and revenue funding available in 2019/20. This is intended however for innovation and the digital backlog issues contained in the PBC submitted to Welsh Government along with other UHBs in 2017 remains unresolved.	Thomas, Huw	Completed	Further digital allocations are anticipated in 2020/21. The digital expenditure related to the COVID-19 response has been the subject of a WG allocation letter to the UHB.

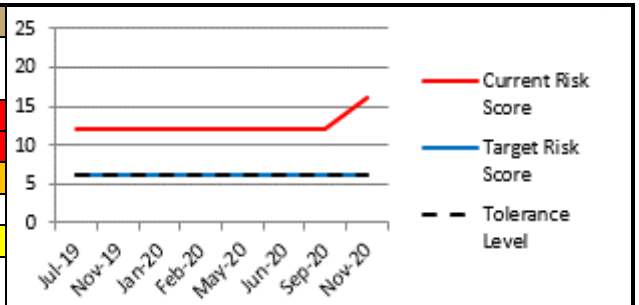
		Discussions with WG through the Capital Review Meetings and finance will continue to address the controls associated with COVID-19 related capital funding. The working assumption is that spending will be fully funded by WG however there are identified pressures which are not yet funded. These will be discussed further at the Sept CRM.	Thomas, Huw	30/09/2020	Capital schedules have been shared with WG as they have evolved and the open and transparent approach will continue as new COVID related capital pressures are identified. A decision is awaited on a request for further capital support in support of backlog and Covid-19 related pressures which is expected to be known in Nov20.

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 against plan & budget.	Reports of delivery against capital plan & budget	1st			* DCP and Capital Governance Report - PPPAC Oct20 and CEIM&T Sub-Committee Sep20 * Radiology Equipment Risk CEIM&T Sub-Committee Jan20&Sep20 * Strategic Medical Device Replacement CEIM&T Sub-Committee Jun19 * Estate Infrastructure PPPAC Oct20 and CEIM&T Sub-Committee Jul20 * IM&T Infrastructure CEIM&T Sub-Committee Jul20					
	Capital Audit Tracker in place to track implementation of audit recommendations	1st								
	Monitoring returns to WG include Capital Resource Limit	1st								
	Datix & risk reporting at an operational management level	1st								
	BPPAC & CEIM&T Sub-Committee reporting (supported by sub-groups)	2nd								
	Bi-monthly Capital Review Meetings with WG to discuss/monitor Capital Programme	2nd								
	NWSSP Capital & PFI Reports on capital audit	3rd								
	WAO Structured Assessment 2017	3rd								

Date Risk Identified:	Sep-18	**Executive Director Owner:**	Thomas, Huw	**Date of Review:**	Nov-20
Strategic Objective:	1. Putting people at the heart of everything we do and 2. Working together to be the best we can be and 3. Striving to deliver and develop excellent services and 4. The best health and wellbeing for our individuals and families and our communities and 5. Safe and sustainable and accessible and kind care and 6. Sustainable use of resources	**Lead Committee:**	Finance Committee	**Date of Next Review:**	Dec-20

Risk ID:	**646**	**Principal Risk Description:**	There is a risk the Health Board not achieving breakeven over the medium term. This is caused by the inability to either: 1. Develop a sufficiently robust financial plan which shows an achievable improvement trajectory, 2. Manage the impact of the COVID-19 pandemic within available funding, 3. Manage the impact on the underlying deficit of resulting non-delivery of the recurrent savings requirement, 4. Recover the unmet demand arising as a result of actions taken and the financial implications, especially regarding RTT and Mental Health, or 5. Identify and implement opportunities in such a way that the financial gains are realised and an improvement trajectory is achieved. This could lead to an impact/Effect on a significant long term detrimental impact on the Health Board's financial sustainability.
Does this risk link to any Directorate (operational) risks?		Corporate risk	

Risk Rating:(Likelihood x Impact)	
Domain:	Finance inc. claims
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	4×4=16
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6
Trend:	↑



Rationale for CURRENT Risk Score:
The Health Board has not developed a full long term financial base-case model, which can then be used to assess the impact of A Healthier Mid and West Wales and other medium term changes. The Health Board's underlying deficit also requires further work to fully explore and understand the opportunities for improvement which can be realised over the medium term. The forecast financial impact of COVID-19 on the underlying position is currently informed by modelling intelligence due to the fluid nature of the pandemic and the multitude of unknown variables inherent in such a situation. Furthermore, the funding from Welsh Government in response to the pandemic in FY21 has been confirmed on a non-recurrent basis; the recurrent funding position remains uncertain.

Rationale for TARGET Risk Score:
Achieving financial balance on a three-year rolling basis is a statutory requirement for the Board, and a clear requirement from the Board and Welsh Government. Given the challenge in delivering the financial position in FY21 and the implications of this in the medium term, it is unlikely that the Health Board will achieve a risk which is in line with the tolerable risk for the year. Consequently, the target risk score exceeds the tolerable risk at this point. This is not an acceptable position, and further work is ongoing to manage this risk.

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**
Understanding the underlying deficit. A pre-COVID-19 assessment has been completed, which will need to be reviewed in light of the impact of the pandemic. Very high level base-case long term financial model.	Actions in response to external review of underlying deficit calculation largely superseded by necessary shift in focus in response to COVID-19. Assessment of impact of COVID-19 on underlying deficit not yet undertaken. Assessment not subject to planning scrutiny. Development of the Opportunities Framework, Savings Framework and Value for Money Framework. Early development of three-year Financial Plan.	Action Plan to be reviewed and re-prioritised to pursue those supportive of the response to COVID-19.	Thomas, Huw	~~31/07/2020~~ 31/10/2020 31/01/2021	Reviews have been undertaken, however operational and clinical focus continues to be on service management and prioritisation of patient care. The Q3&4 Operational Plan submitted to WG in mid October focused on addressing patient care. This included looking at embedding new ways of working that have been necessary to meet the pandemic challenge.
		Assessment refreshed to quantify likely impact of COVID-19 on the underlying deficit, focusing on both the adverse impact such as non-delivery of recurrent savings, and the opportunities arising due to service changes in response to COVID-19.	Thomas, Huw	~~30/09/2020~~ 31/01/2021	Early assessments are being conducted as part of the forecasting process, however the fluidity of the situation as the pandemic evolves provides limited information as a basis at this time. The position is kept under review but remains too volatile to make a definitive assessment at this time.
		Refine the Frameworks and embed these into the monthly reporting and Committee cycles as appropriate.	Thomas, Huw	Completed	Existing Frameworks have been refined and are now embedded into the reporting and Committee cycles.

		Early iterations of the three-year Financial Plan for discussion at Finance Committee.	Thomas, Huw	~~30/09/2020~~ 31/01/2021	A Principles Paper and timetable have been completed and shared with the Finance Delivery Unit (FDU). The FDU feedback has been reflected. Alignment of the operational planning and financial planning cycles is underway with a Planning Steering Group established. The focus will be on 2021/2022, with the Health Board looking to sign post actions for years 2 and 3. A monthly reporting cycle is in place to the Finance Committee.

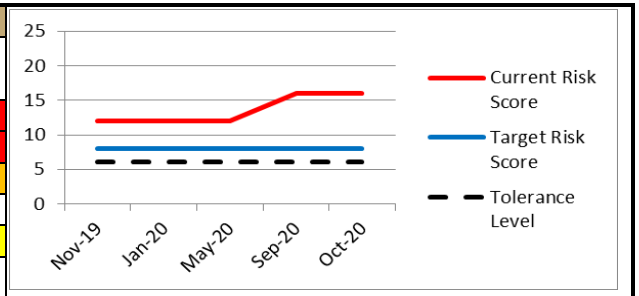
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the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

Operational agreement to underlying deficit assessment. Welsh Government accepting of impact of COVID-19 on underlying deficit. Plan in place to develop a long term financial plan. High level financial assessment of A Healthier Mid and West Wales in place.	Reporting to Finance Committee .	1st			N/A	None				

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

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

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



Rationale for CURRENT Risk Score:

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

Rationale for TARGET Risk Score:

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

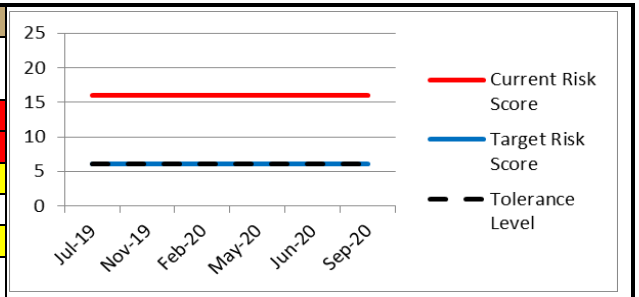
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Daily review of team strengths by rota co-ordinators and service manager unscheduled care. Issues identified escalated to GM and SDM. Recruitment program on-going to fill gaps and recruit into vacant posts. Medacs agency filling whenever possible with long term locums. Continuous monitoring of the team strengths to ensure consultant and senior support and supervision. Links with other Health Board sites (HDUHB & SBUHB) to outline current pressures and any opportunities to cross cover and to assess overall medical staffing position across HDUHB Weekly Urgent Response Group review rotas for the next six months. 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	1 Post out to advert. Others offered but candidates are overseas. delays in transporting to the UK due to the Coronavirus pandemic and related travel restrictions.

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

Date Risk Identified:	Jan-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Sep-20
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Oct-20

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

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



Rationale for CURRENT Risk Score:

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

Rationale for TARGET Risk Score:

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # CT Scanner including fluoroscopy room and WGH MRI included on all Wales Capital Programme (AWCP)(not yet agreed)and AWCP secured for replacing the BGH MRI. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports. Some funding has been secured from AWCP for some replacements but does not cover all outdated equipment nor the future requirements. # Escalation process in place for service disruptions/breakdowns.	Limitation of spare parts for some older equipment leading to extended outages. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Delayed commissioning of new MRI Scanner in WGH and agreed funding for replacement CT due COVID-19.	Review and strengthen site business continuity plans with individual site leads to ensure robust response to breakdown.	Evans, Amanda	Completed	Site leads in process of developing up-to-date and robust business continuity plans which will operationalise procedures following breakdowns. Site leads have met with the business continuity team to agree on the process of updating plans. Due to operational pressures this needs further time to fully complete.
		Work with planning colleagues about sourcing capital funding through DCP and AWCP.	Evans, Amanda	~~30/06/2019~~ 01/04/2020 31/12/2020	Funding for one scanner has been agreed with plans submitted to WG for the replacement of four CT scanners that are approaching end of life.
		Develop plan in line WG Operating Framework for Q1 to deal with COVID and non-COVID patient flows and potential backlog.	Evans, Amanda	Completed	Submit to Bronze Acute Group by 18/05/20.
		Monthly project meeting to discuss commissioning of agreed equipment with estates, planning and manufacturers	Evans, Amanda	31/12/2020	Commissioning equipment is dependent on lockdown measures in and outside of UK and contractor availability to undertake work.
		Additional CT resource due to delay in funding from WG	Evans, Amanda	30/10/2020	Additional CT resource obtained from NHS England in the form of a demountable unit . Resource to be shared with SBUHB. Due to be installed 18th September operational in October

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

Date Risk Identified:	Nov-20
Strategic Objective:	Delivery of the Quarter 3/4 Operating Plan

Executive Director Owner:	Gostling, Lisa	**Date of Review:**	Nov-20
Lead Committee:	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Dec-20

Risk ID:	**1018**	**Principal Risk Description:**	There is a risk there will be insufficient workforce available to deliver services required for the quarter 3 and 4 plans. This is caused by an increase in Covid infections and outbreaks within acute, community and social care facilities which could lead to increased sickness absence directly due to COVID, increased self isolation of staff, and the ability to recruit new staff quickly to provide additional support. This could lead to an impact/affect on the Health Board's ability to staff field hospitals, surge capacity within general hospitals, effectively managing the impact from COVID outbreaks, delivering a mass vaccination programme and the delivery of planned care.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Workforce/OD
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:	*New risk*

No trend information available.

Rationale for CURRENT Risk Score:
Given the workforce starting position in terms of gaps within our Registered Nursing workforce, increasing demands to open surge facilities, the current risk score is considered to be "likely" and has the potential to have a "major" impact. The result of an outbreak would see a significant number of key staff unavailable which would impact on service delivery and stretch service provision.

Rationale for TARGET Risk Score:
The Target Risk score indicates the likelihood of the risk occurring (and to note there have been minor outbreaks occurring weekly) which suggests this may continue, therefore the probability sits between 25-75% which we hope will be mitigated by the actions noted below.

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**
Bronze, Silver & Gold Command structure, PPPAC Workforce Planning Task & Finish Group	An organisational wide escalation plan	Flexible deployment plans for each service area/and organisationally	Walmsley, Tracy	31/12/2020	Work underway.
		Ongoing onboarding of a flexible contingent workforce in areas of need i.e. cleanliness/infection control activity,	Walmsley, Tracy	31/01/2021	Continuous cycle of review and adapt based on assessed need.
		Risk assessment of each service area based on workforce availability.	Walmsley, Tracy	31/12/2020	Work underway.

Assessment of corporate lead deployment options.	Walmsley, Tracy	31/12/2020	Initial review of workforce available. Requires alignment to operational needs and risk assessments to be completed and signed off.
Introduction of partnership agreement with key agencies to stabilise agency workforce to continue to fill establishment gaps	Walmsley, Tracy	31/12/2020	Work is underway to develop agreement for Pembrokeshire and Carmarthenshire.
Prioritisation of recruitment/onboarding of new employees to the highest areas of risk in terms of maintaining service delivery	Walmsley, Tracy	31/12/2020	Bi-weekly prioritisation taking place within Workforce & OD Team.

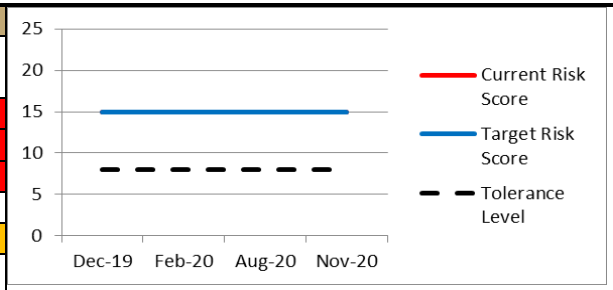
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**		
None identified.	Workforce Planning Task & Finish Group	1st			
	Workforce levels monitored at Bronze Workforce Group and reported to Silver and	2nd			
	Workforce and Q3/Q4 plan overseen by People, Planning & Performance Assurance Committee	2nd			

Gaps in ASSURANCES				
Identified Gaps in Assurance:	**How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
	Undertake workforce planning audit	Walmsley, Tracy	31/12/2020	Underway.

Date Risk Identified:	Oct-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Nov-20
Strategic Objective:	3. Striving to deliver and develop excellent services	**Lead Committee:**	Health and Safety Assurance Committee	**Date of Next Review:**	Dec-20

Risk ID:	**813**	**Principal Risk Description:**	There is a risk of failing to fully comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO). This is caused by 1. A lack of available resources within the current operational maintenance function, to undertake a fully HTM compliant pre planned maintenance programme (PPM's) for all fire safety components across the entire HB's estate. 2: The age, condition and scale of physical backlog, circa £20m relating to fire safety across our estate significantly affects our ability to comply with the requirements of the RRO in every respect. 3: A lack of fire safety ownership and understanding of fire safety responsibilities at local hospital management level. This could lead to an impact/effect on the safety of patients, staff and general public, HSE investigations and further fire brigade enforcement, fines and/or custodial sentences, adverse publicity/reduction in stakeholder confidence.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Statutory duty/inspections
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	3×5=15
Tolerable Risk:	8
Trend:	⇔



Rationale for CURRENT Risk Score:

Despite significant progress being made since the NWSSP IA Fire Precautions Report in May 2017 with regards to the key recommendations, such as, the establishment of a fully resourced fire safety team, the embedding of appropriate reporting arrangements for fire safety and addressing the backlog of out of date fire risk assessments across the UHB. There are still some significant challenges faced by the UHB to fully comply with the fire safety order. Whilst the fire safety team are in a position to provide support now to the UHB in the form of expertise and technical knowledge. The UHB still needs to manage and address the physical backlog of fire safety across its estate. Also successfully embed an improved fire safety management culture and management ownership for fire safety. This is evident from the recent fire safety improvement notice (FSIN) served on the UHB in Sep19 for Withybush General Hospital and Glangwili General Hospital on 17Apr20.

Rationale for TARGET Risk Score:

Whilst it is likely that the UHB will address its staff shortfall issues in respect of fire safety for HTM compliance there are further improvements in culture and ownership for fire safety. It is the scale of physical backlog for fire safety compliance (circa £8m at present predicted to increase following additional surveys) that will remain until appropriate measures are put in place to address the deficit.
Despite annual investment from statutory capital for fire safety components (circa £200k), the scale of current investment is clearly not adequate to address the true scale of backlog the UHB has.

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**
1.Pre Planned Maintenance (PPM) checks are carried out across the UHB on fire safety components. 2. A detailed physical estates backlog system is in place that identifies the scale (£) and risk of backlog for UHB. Data used to manage backlog maintenance & statutory decision making also regularly reported to WG. 3. Individual Fire Risk Assessments (FRA's) in place for all sites across the UHB identifying fire related risks. 4. Training Needs Analysis (TNA) for fire safety training in place, as defined in Fire Policy. 5. UHB has implemented a governance structure for fire safety reporting. 6. Estate plans with fire zones, fire doors, fire compartmentation, fire infrastructure items (alarm and detection system). 7. UHB assesses its performance in respect of operational maintenance work carried out on fire safety components and presents this information as a formal paper at all UHB wide fire safety meetings. 8. Annual prioritisation of investment against high risk backlog.	Significant staff shortfall to achieve agreed level of operational compliance (>85% target) for fire safety and other Health Technical Memorandum (HTM) engineering disciplines Significant additional investment is required to address physical and engineering backlog shortfall for the UHB (approx circa £20m). Inability to allocate fire risk actions to appropriate owners on current fire risk assessment system hosted by NHS Wales Specialist Estates Services (NWSSP-SES). Inability to manage and control recommendations within the HB's own Fire Risk Assessments. Shortfall in advanced fire safety training especially in bariatric evacuation.	Secure funding for the identified staffing gap identified in the operational staff gap analysis (based on size, geography and estate of the organisation)	Williams, Heather	Completed	A business case for additional staff support has been approved by the executive team subject to review by NWSSP-SES to substantiate its accuracy. Job descriptions have now been created for these roles, jobs are on Trac and interviews scheduled for April 2020.
		Reassess remaining backlog and develop a prioritised plan that will address the high risk areas and where possible, will align to TCS modernisation programme for the UHB. A Programme business case is being developed for the remaining acute hospital sites to identify key fire safety compliance issues in order to seek for additional capital funding.	Elliott, Rob	~~31/03/2020~~ 30/09/20 (All actions will be reviewed and dated individually by this date)	The HB has now developed a detailed programme for both WBH and GGH to deal with all fire enforcement notices and letters of Fire Safety issued by the fire brigade (NWWFRS). In the case of WBH, Tripartite meetings with WG,HB and MWWFRS have taken place to agree a programme of investment and business case development. In the case of GGH the HB has submitted a detailed programme to MWWFRS which has been agreed. (Whilst verbal agreement been given by MWWFRS we await formal written confirmation) A meeting is planned for mid to late September on Tripartite bases to agree the same process as WBH. Current challenges around capital availability has the potential to impact on timeline - these implications are being worked through with WG. The HB is therefore looking to introduce increased mitigation options prior to capital availability, this will be in the form of. 1:Weekly site walkabouts with

				estates/management staff. 2:Increased fire drills in specific locations. 3:Increased staff numbers for night shifts in ward areas. 4:Monthly Global e-mail alerts for all staff to encourage good practice of fire safety. 5:Improved Site Management engagement. 6:Review of capital prioritisation. There are several completion dates associated with this action, which are all being regularly tracked on the HB's fire governance tracker system.
		Introduce a system to manage fire risk assessment recommendations more effectively. System to have the ability to assign risks to risk owners, to track/manage risk and to demonstrate progress on the actions.	Lloyd, Gareth	~~31/03/2020~~ 30/06/2020 28/01/2021	The fire team are utilising the current system as best as possible. An Excel system is being introduced (completion Jun20) however a more robust automated system is needed by the HB to track the significant number of actions. Progressing this has been delayed due to COVID-19, however quotes have now been obtained and are under discussion with the Director of Facilities. Approval has now been provided to purchase a system. Completion date for system implementation with live data by Jan 2021.

Undertake a review of fire training to address identified shortfall in training provision, specifically the evacuation of bariatric patients and site fire management responsibilities.	Lloyd, Gareth	~~31/03/2020~~ 31/12/2020	A review has been undertaken and an action plan produced with the learning development teams. The HB has reintroduced the e-learning module for all levels of training instead of the face to face method which was suspended due to COVID-19, to improve fire training compliance which has dipped over recent months. A target of 85% for advanced training has been agreed, which will be achieved by Dec20. General fire safety training currently stands at 68%, which is not considered a concern at this stage and will now improve following the e-learning implementation. This will be reviewed monthly.
Clarify responsibilities and identify management ownership for fire safety to facilitate an improved fire safety management culture across all sites	Lloyd, Gareth	~~30/09/2020~~ 31/01/2021	General Managers (GMs)and Responsible Persons have been identified across the UHB who have responsibility for fire safety on sites. This will be supplemented with site management training (level 5 training for all responsible managers which was to be introduced by Mar20). This work has been delayed due to COVID-19 however regular discussions with GMs is taking place to remind them of their ongoing responsibilities.

		Undertake a review of scale of work required to improve fire drawings in the UHB.	Evans, Paul	~~31/03/2020~~ 31/08/2020 30/09/2020	A review of this has already commenced as to the scale of the work required through the appointment of external contractors/specialists to undertake this work for the UHB and the availability of capital money. The department has further reviewed this issue and will be looking to address this by appointing new staff in the operational team as CAD operators (x2) to undertake drawing updates. Job description been produced and has been issued for job matching. Update - Still awaiting Job Matching to be concluded, as soon as this is returned the positions will be on Trac and advertised.

		Review the compliance report to include the gaps associated with any risks on the fire safety components and not just levels of PPM performance.	Evans, Paul	~~29/02/2020~~ 31/08/2020	An update template has already been produced and discussed amongst the fire and operational maintenance teams. The draft ops compliance paper was presented at the Dec20 Fire Safety Group meeting and it was agreed that the new version was significantly improved and offered more assurance. This is now being taken forward as the model for the department and is being finalised by the operational teams to include all aspects of maintenance. This work was delayed due to COVID-19 and will now be taken forward. Update - The maintenance fire paper was presented at the July fire safety group meeting for action. This report is significantly more detailed and covers enhanced reporting over and above PPM data. Over time, this document will change as more information becomes available.

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**
Achievement of 50% attendance Level 5 Manager Fire Training for Band 8Bs and above by Mar21. Maintain 95% high risk PPM compliance.	Bimonthly review of outstanding actions from fire risk assessments	1st			IA Fire Precautions Report - ARAC Jun18 Fire Action Update - H&SC - May20	General site management checks/walkarounds on all sites	Responsibilities of site management to undertake routine workarounds to be implemented level 5 training	Lloyd, Gareth	~~30/09/2020~~ 31/12/2020	Site management training (level 5) training for all responsible managers which will be introduced by Dec20.
	Site Fire wardens reporting fire safety issues	1st								

Zero compliance on outstanding fire risk assessments by Jan20.	Review of compliance through fire safety groups	2nd							
	Compliance reports regularly issued to HSEPSC	2nd							
	Fire inspections by Fire Service & Fire Improvement Notices	3rd							
	NWSSP fire advisor inspections	3rd							
	NWSSP IA Fire Precautions Follow Up May-18 - Reasonable Assurance	3rd							

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

Risk ID:	**1016**	**Principal Risk Description:**	There is a risk of increasing COVID infections across the Health Board. This is caused by staff and others not adhering to the Health Board guidance and National Social Distance legislation. This could lead to an impact/effect on increased levels of staff absence due COVID infection and self isolation, some essential services being closed leading to longer waiting times and delays for treatment for patients, enforcement action/fines from HSE for non-compliance with Social Distancing legislation.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	4×5=20
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	*New risk*

No trend information available.

Rationale for CURRENT Risk Score:

Q3 has seen an increase in clinical activity compared to Q1 when many services were stopped. Social Distance risk assessments have been undertaken that highlight ways to allow services to be re-introduced while maintaining the social distance measures, however successful management of the risk depends on staff, visitors or patients adhering to the social distance guidance or using the 'Key Controls' measures in place.

Rationale for TARGET Risk Score:

The TARGET score focuses on reducing the likelihood of an incident as the impact score would remain at 5 (as outlined under CURRENT score). By introducing effective social distancing measures such as screening in high priority areas and alternative solutions in other areas, such as PPE, staff would be able to man more areas thus allowing services to resume as far as reasonably practicable. In terms of inpatient bed space, by reviewing all ward spaces and field hospitals against current guidelines and introducing either physical barriers or increasing spaces, as many services as possible will be able to return, however, strict adherence to the controls in place will be required to meet the target score.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
- Social distancing guidance in place for staff and is available on the intranet - Safety screen installations in hospital and ward/clinic reception areas - Instructional social distance posters and floor signs - Hand sanitisers stations	If staff, visitors or patients do not adhere to the social distance guidance or use the 'Key Control' measures provided.	To issue managers with reminders to ensure staff take responsibility for their own safety and others by following the social distance guidance.	Rayani, Mandy	30/11/2020	Reminders are routinely issued to staff and managers.
	Patient screens to be installed in PPH and WGH. Lack of formal auditing of compliance.	Safety monitoring forms to be introduced to aid compliance and to highlight breaches of social distancing rules.	Harrison, Tim	30/11/2020	Sent to Operational General Managers 11/11/20 for comment.

		Installation of screens to be competed in PPH and WGH	Harrison, Tim	30/11/2020	Plan of work in place and work in progress.
		Explore ways that compliance monitoring can be incorporated into existing auditing processes across the organisation and that a feedback mechanism is in place.	Harrison, Tim	30/11/2020	Discussions already underway with Estates Department.

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
	Oversight is provided by the Social Distancing Cell, Chaired by Director of NQPE	1st				None identified.				
	Reviewing grade 4&5 incidents (RIDDOR reportable) involving staff contracting hospital acquired COVID	1st								
	Social Distancing Cell reports into Silver and Gold Groups	2nd								

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

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

Risk Rating:(Likelihood x Impact)		**No trend information available.**
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:	*New risk*	

Rationale for CURRENT Risk Score:
Several months ago, the DHSC laboratory capacity was outmatched by a significant rise in demand for testing, resulting in the previously agreed Wales capacity being capped. This resulted in the public being unable to book testing locally, if at all, and delays of up to 10 days in the availability of test results, when tests were undertaken. This had serious implications for the Test, Trace and Protect Programme. There was a significant increase in the number of calls and emails to the Health Board to resolve issues that were mainly out of our control. Access to testing has now resolved with no delays in accessing tests, however TATs have recently been poor, but has improved over the past 2 weeks.

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

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

Operational Testing Delivery Plan for the coming 6 months based on demand modelling and assumed testing capacity across both the Welsh and UK Department of Health and Social Care (DHSC) systems. Plenty of testing capacity in the system. Plan updated on 10 November 2020. Issued clear communications to staff, partners, schools and the public to reinforce messaging to reduce the amount of inappropriate testing requests being made. Testing for symptomatic members of public is available in Aberystwyth, Carmarthen, Llanelli and Haverfordwest via the UK portal. Additional testing sites, not open to general public access, for pre-operative and pre-treatment testing e.g. prior to chemotherapy and for critical health and social care staff delivered by Health Board staff using the welsh laboratory network. Work underway to further expand Health Board delivered testing to reduce reliance on the UK system, which is out of our control. Testing Team in place with daily meetings to discuss and resolve any issues in the system.	Over recent months, the DHSC laboratory capacity has been outmatched by a significant rise in demand for testing, resulting in the previously agreed Wales capacity being capped. Turnaround Times (TATs) performance through the DHSC model has been extremely poor recently but improved over the past 2 weeks. All such requests for testing via the UK model is booked via the UK portal and capping testing slots is not within UHB control. PHW laboratory capacity has previously been limited but has recently increased with further plans in place to increase this significantly over next month. To date the majority of community testing has been by the DHSC testing system.	Continuous review of the Operational Testing Delivery Plan in place to ascertain the sustainability of an in-house testing provision for Hywel Dda population	Shakeshaft, Alison	31/12/2020	This is going to Public Health Gold Cell and Hywel Dda Public Board Nov20.
		Currently recruiting additional staff to increase community testing through the PHW system to circa30%	Shakeshaft, Alison	31/12/2020	On track for delivery.
		Further increase community testing through PHW system to reduce reliance DHSC system (50/50)	Shakeshaft, Alison	31/12/2020	Work underway.
		Consider appropriate use of POCT when it becomes available	Shakeshaft, Alison	31/12/2020	Awaiting clarification from WG.

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 turnaround time results (100% within 24 hours) 100% Access to test within 24hours	Testing Team monitors booking, delivery and analysis of local testing on a daily basis	1st			Included in Covid Board paper - Nov20	Audit Wales Review on TTP due Dec20				
	Regular reports to Public Health Gold Cell and Gold Command on TTP	2nd								
	COVID Updates to Board include updates on testing	2nd								

Date Risk Identified:	Aug-20	**Executive Director Owner:**	Thomas, Huw	**Date of Review:**	Nov-20
Strategic Objective:	6. Sustainable use of resources	**Lead Committee:**	Finance Committee	**Date of Next Review:**	Dec-20

Risk ID:	**956**	**Principal Risk Description:**	There is a risk that based on the current capital funding issued to date from Welsh Government for COVID-19 that the Health Board may spend in excess of the capital resource it has available and will be unable to deliver all capital schemes required to mitigate the impact of COVID 19. This is caused by funding to date a)has been based on items delivered to sites and not for expenditure committed b)does not cover the potential cost of our response to the social distancing legislation c)does not cover the potential cost of the mitigating action required to ensure appropriate segregation of COVID and non-COVID patients in our services d)not cover additional costs of other estates adaptations or additional equipment that may be required as part of the Health Board's response to COVID-19. This could lead to an impact/effect on the Health Board breaching its statutory financial duty to breakeven against its Capital Resource Limit for 2020/21 by £2.781m on expenditure already committed, and on COVID-19 schemes not yet committed of £11.971m which would have a direct effect on the Health Board's ability to effectively deal with COVID-19 and respond to the pandemic.
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):	4×5=20
Current Risk Score (L x I):	3×5=15
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	8
Trend:	*New*

Rationale for CURRENT Risk Score:
The scale of the pandemic and the likely impact on the Health Board is evolving. The financial impact on capital in the first quarter of 2020/21 was significant and the current feasibility work being on schemes to deal with COVID -19 issues on ongoing basis would suggest that the Health Board's capital funding streams is insufficient.

Rationale for TARGET Risk Score:
The Health Board needs to demonstrate that it is able to manage its capital position effectively, cognisant of the risks which are inherent in the delivery of safe and timely care. Given the challenge in delivering the capital position this year, the Health Board will achieve a risk which is in line with the tolerable risk for the year. Effective prioritisation will aim to reduce the impact of this risk on statutory and clinical schemes.

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**

1. Modelling the anticipated impact of feasibility schemes being developed and the impact on equipment and operational requirements through Bronze Acute and Estates Groups to ensure full knowledge of prioritised schemes. 2. Prioritisation and expenditure commitment are managed and approved through Gold command.	The costs of addressing the Health Board's local needs may exceed available funding. Co-ordination of approval process to progress projects.	Working with Welsh Government to review and identify and mitigate the Financial Risk	Thomas, Huw	~~30/09/2020~~ 30/11/2020	Further clarification is expected in Nov20 around the potential availability of additional capital.

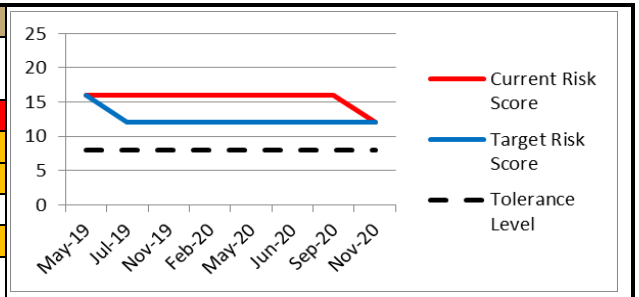
3. Timely financial reporting to Finance Committee, Board and Welsh Government on local costs incurred as a result of Covid-19 to inform central and local scrutiny, feedback and decision-making. 4. Monthly reporting to the Finance Committee regarding the Capital Risk.		Gold Command to approve prioritised list. Gold Command to approve any further changes to the prioritised list. No commitment to schemes without an agreed funding source.	Thomas, Huw	~~30/09/2020~~ 30/11/2020	Report to be prepared for consideration at Gold Command in Nov20. A schedule of the highest priority schemes has been shared with Finance Committee in Oct20.

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 against the Capital Resource Limit	Performance against plan monitored through Capital Monitoring Group with key internal stakeholders	1st			Monthly Reports to Finance Committee on capital reporting the COVID risk	None				
	Operational prioritisation through Bronze Group using the operational risk and benefit matrix	1st								
	Performance Reports through to Capital, Estates and IM&T Sub-Committee	2nd								
	Finance Committee oversight of current performance	2nd								
	Capital Report to People, Planning and Performance Assurance Committee	2nd								
	WG scrutiny through monthly monitoring and COVID capital returns	3rd								

Date Risk Identified:	Sep-18	**Executive Director Owner:**	Shakeshaft, Alison	**Date of Review:**	Nov-20
Strategic Objective:	2. Working together to be the best we can be	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Dec-20

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

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



Rationale for CURRENT Risk Score:

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

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 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** 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. # Locum staff utilised where appropriate, funded from within core budget (2 vacancies required to fund 1 Locum) # Short-term contracts/additional hours within budget used to cover maternity leave. # Training of support staff to safely deliver delegated tasks. # Over-recruitment of Newly Qualified Staff where appropriate and approved by the Clinical Director to mange foreseeable and predictable staffing level capacity gaps. # Local solutions include review of each vacant post to make them attractive, including skill mix review, early advertisements for new graduates. # Prioritisation of patients is undertaken through triage and risk assessment by therapy services. # Use of Digital Platforms to support agile working and remote access # Continued training of the Malcomess Care Aims Framework for MDT/Therapy Service.	Inability to secure funding for all developments identified in 20/21 annual plan. Shortage of qualified and specialist staff nationally Rurality of HDdUHB historically limits applications to some posts. Unplanned service development opportunities. Lack of cohesive approach to workforce planning across all therapy services. Deployment of Therapy workforce to support surge or Covid Pandemic response.	Developing robust plans to evidence improved patient outcomes and experience through reprovision of resource from elsewhere in the health and care system aligned with strategic direction of the HB. This is a significant, long term piece of work, which will need to run alongside strategic development through the Health and Care Strategy. This will include skill mix review such as new HCSW and Advanced Practitioners.	Reed, Lance	~~31/03/2020~~ 31/03/2021	Plans under development. Funding already secured for developments in pulmonary rehab, dementia, lymphoedema and to support some increase in front door/acute therapy input including plans to address malnutrition. Continued operational and strategic engagement with DoTHS, DOO, HoS, CDs and GMs to address COVID-19 response and to service developments that would release resource and savings from the wider health and care system through increased therapy provision, including areas of pathway re-design. WG funding for Therapy Assistant Practitioner HCSW role to support workforce model changes.
		Ensure process for robust workforce planning is in place to inform HEIW in respect to future graduate numbers required by the UHB/Region, which are aligned to the Health and Care Strategy workforce plan.	Shakeshaft, Alison	Completed	Long-term piece of work informed by action above on an annual basis. Lead in time of 3 years to benefit from graduate programme.
		Pursue opportunities to attract local people into therapy careers in the HB, eg 'grow your own' schemes, apprenticeship programmes, development of career pathways from HCSW to graduate, development of local graduate training programme.	Reed, Lance	~~31/03/2020~~ 31/03/2021	Commitment given to extend apprenticeship scheme to AHPs, agreed from 2020. Variety of HCSW training modules for level 3 and 4 developed and being implemented. HEIW review to commission local training provision for Physio & Occupational Therapy Undergraduate Training locally.

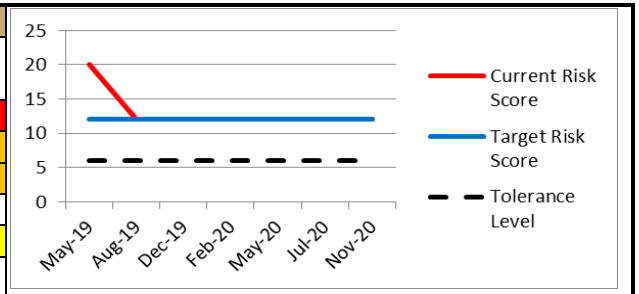
		Develop robust workforce plans that align to stroke, major trauma and neurology and COVID-19 rehabilitation service needs to maximise workforce opportunities.	Shakeshaft, Alison	~~31/03/2020~~ 31/03/2021	Plan being developed as part of Therapy 3 Year Plan 2021/23 to include extended and 7 day working.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Maintenance of 14 week waiting times for therapy services. Clearance of backlog for pulmonary rehabilitation, with 100% achievement of 14 week maximum wait by Dec21. Improved compliance with minimum standards for stroke therapy care by Q2 2021/22 (Dec21). Improved staffing ratios for priority areas by Dec21.	Management monitoring of breaches of 14 week waiting times	1st			Briefing on current position - QSEAC: Risk 628 - 06.10.2020					
	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:	May-17	**Executive Director Owner:**	Thomas, Huw	**Date of Review:**	Nov-20
Strategic Objective:	N/A - Operational risk	**Lead Committee:**	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Dec-20

Risk ID:	**451**	**Principal Risk Description:**	There is a risk the Health Board experiencing a cyber security breach. This is caused by a lack of defined patch management policy, lack of management on non-ICT managed equipment on network, end of life equipment no longer receiving security patching from the software vendor, lack of software tools to identify software vulnerabilities and staff awareness of cyber threats/entry points. This could lead to an impact/effect on a disruption in service to our users cause by the flooding of our networks of virus traffic, loss of access to data caused by virus activity and damage to server operating systems.
Does this risk link to any Directorate (operational) risks?		451, 356	

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):	3×4=12
Target Risk Score (L x I):	3×4=12
30/05/2019 - Board 'Accept' Target Risk	
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:

There are daily threats to systems which are managed by NWIS and UHB. Current patching levels within the UHB of is on average 91% for desktop/laptops and 89% for the server infrastructure (November 20). The patching levels fluctuate during the month depending on the number of updates released by the 3rd party vendor. Alongside the fluctuations there is lack of capacity to undertake this continuous work at the pace required. Impact score is 4 as a cyber-attack has the potential to severely disrupt service provision across all sites for a significant amount of time, however the processes and controls in place have reduced the likelihood due to the improvements in patching.

Rationale for TARGET Risk Score:

Increased patching levels will help to reduce to impact of disruption from a cyber threat. However this work is continuous and is dependent on obtaining the appropriate level of resources to undertake the patching anti-virus work at pace. The target risk score of 12 reflects the wider risk to other applications not Microsoft. The Board have accepted that there is an inherent cyber risk to the organisation, and have therefore accepted that the risk cannot be reduced lower than 12.

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**

Controls have been identified as part of the national Cyber Security Task & Finish Group. Continued rollout of the patches supplied by third party companies, such as Microsoft, Citrix, etc. £1.4m national investment in national software to improve robustness of NWIS. Further Task and Finish Group established to review the future patching arrangements within NHS Wales - this will lead future work locally to implement recommendations.	Lack of comprehensive patching across all systems used in UHB. Lack of staffing capacity to undertake continuous patching at pace. Lack of dedicated maintenance windows for updating critical clinical systems.	Work with system owners to arrange suitable system down-time or disruption.	Solloway, Paul	Ongoing	Patching policies have been created however little progress has been made due to lack of resources. Service catalogue creation is progressing well and this will be amalgamated with Information Asset Owners group to agree down-time for the key local systems. However patching KPI's will not be met until sufficient technical resources are in place.

Capital funding has been made available by WG in 2018/19 to improve cyber security - this will be used to purchase required software/equipment for penetration testing. Additional UHB funding.		Continue to implement the recommendations of the Stratia report	Solloway, Paul	Ongoing	The additional resources will be targeted towards the recommendations
		Implement the national products previously purchased (i.e. Security Information Event Management (SIEM)	Solloway, Paul	Ongoing	The additional resources will be targeted towards the recommendations
		Hire agency staff until such time that a permanent resource can be appointed.	Tracey, Anthony	30/11/2020	The first round of appointments did not provide suitable candidates so agency staff will be used to provide progression of the recommendations.

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 cyber incidents. Current patching levels in UHB. No of maintenance windows agreed with system owners. Removal of legacy equipment.	Department monitoring of KPIs	1st			External Security Assessment - IGSC - Jul 18 Update on WAO IT follow-up - ARAC - Oct19	National accreditation.	Progress the attainment of certificates and assurances as outlined by the National Cyber Security Centre (NCSC)	Tracey, Anthony	Ongoing	Regular reports on progress on External assessment to IGSC
	IGSC monitoring of cyber security workplan addressing recent internal and external audits/assessments	2nd								
	IGSC monitoring of National External Security Assessment	2nd								
	Follow-up Information Backup, Disaster Recovery & Business Continuity and Data Quality: Update on Progress	3rd								

NHS Wales External Security Assessment - Assessment Report and Security Improvement Plan for Hywel Dda University Health Board (HDUHB) Oct17	3rd								

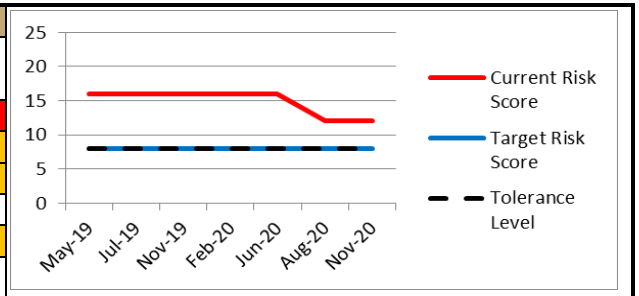
WAO IT risk assessment (part of Structured Assessment 2018	3rd								
Internal Audit IM&T Security Policy & Procedures Follow-Up - Reasonable Assurance	3rd								
IM&T Assurance - Follow Up - Reasonable Assurance - May20	3rd								
Cyber Security (Stratia Report) - Reasonable Assurance - Feb20	3rd								

Date Risk Identified:	Oct-17
Strategic Objective:	N/A - Operational risk

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

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

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



Rationale for CURRENT Risk Score:

Mechanical intervention for Stroke is available at North Bristol NHS Trust (NBT) (and Walton Centre NHS Foundation Trust for Bronglais Hospital). However this service is only available Mon to Fri 9-5pm therefore there is still a risk during out of hours. During the COVID -19 situation there has been no significant changes to the pathway. All 4 sites have been able to transfer patients when required.
Some HDUHB sites still have delays in 24/7 CT Angiography however all 4 sites have Mon-Sun 9-5 CT angiography. There is a plan for Bristol to be available from Sep20 to be 9-5, 7 day a week service, however this has not yet in place. There are no reports of any harm to date.

Rationale for TARGET Risk Score:

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

Mechanical intervention for Stroke is now available at Bristol (and Walton for Bronglais. However this service is only available 9am to 5pm (at Bristol) Mon to Fri. The risk for out of hours would stay the same.

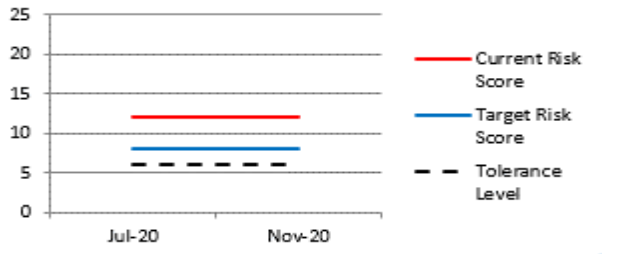
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)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

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

Date Risk Identified:	Jun-20	**Executive Director Owner:**	Gostling, Lisa	**Date of Review:**	Oct-20
Strategic Objective:	Delivery of the Quarter 3/4 Operating Plan	**Lead Committee:**	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Dec-20

Risk ID:	**894**	**Principal Risk Description:**	There is a risk the workforce will be depleted due to large numbers of staff having to work in alternative roles, or shielding, work from home or in non-clinical roles. This is caused by the government guidance in relation to assessing those who are unable to work in patient facing roles or Covid 19 areas due to their underlying medical condition, pregnancy or ethnicity. This could lead to an impact/effect on the HB's ability to provide enough staff to fill our current rota's and inpatient beds along with our ability to surge our capacity into field hospitals if required.
Does this risk link to any Directorate (operational) risks?	875		

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:
Due to the Covid-19 pandemic there is a risk that staff within the BAME categories in particular will be at greater risk. This will result in the possibility of not enough staff available to cover staff rotas.

Rationale for TARGET Risk Score:
Due to the Covid-19 pandemic there is a risk that staff within the BAME categories in particular will be at greater risk. This will result in the possibility of not enough staff available to cover staff rotas.

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**
Risk assessments for those in vulnerable category being undertaken and managers required to review these at regular intervals. Home-working options, telemedicine and staff deployment options are available. FAQs developed and updated so staff and managers are made aware of what is required. 15/07/2020 Further information and guidance disseminated by global link and available on the HB Intranet page.	Process for offer of PPE to be developed and implemented by Nursing Directorate.	Ensure the risk assessment process is disseminated to all managers.	Morgan, Steve	Completed	All managers to undertake this action. Line Managers have been requested to review risk assessments previously undertaken in light of the revised guidance.
		Ensure reviewed governance guidance is communicated and FAQs updated.	Morgan, Steve	Completed	The FAQ's have been updated to reflect the revised approach to risk assessment.

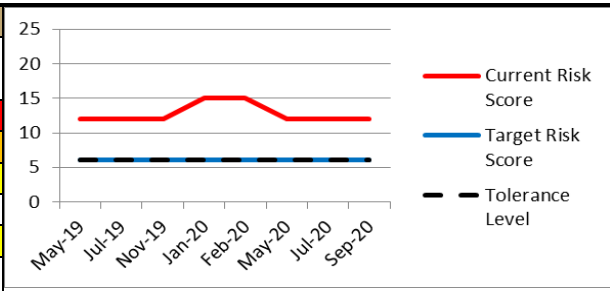
		Workforce contacting managers with staff in the BAME group to ensure that appropriate risk assessments are being undertaken for this staff group.	Morgan, Steve	Completed	The Workforce action has been completed - All Line Managers of BAME staff have been asked to encourage individuals to complete the risk assessment documentation. It is the respective Line Managers that will need to progress this action.
		Process for offer of PPE to be developed and implemented by Nursing Directorate.	Gostling, Lisa	~~30/06/2020~~ 30/09/2020	Director of Service to advise Nursing Directorate.

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**
Monitoring no's/% of risk assessments completed and BAME staff in work.	Workforce Senior Team meetings review and discuss the monitoring process	1st				None identified.				
	Bronze Workforce Group reviews effectiveness of WPF	2nd								

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

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

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



Rationale for CURRENT Risk Score:

The COVID pandemic combined with the temporary overnight service changes has brought some respite to the service fragility, and this is reflected in the current risk score. Demand is variable as are remaining workforce shortfalls - also reflected in the current assessment. Stability in the Carmarthen rota is now being seen but it coincides with destabilisation within Pembrokeshire. This, combined with any lifting of lock down/infection control related absence or impact on in-hours provision is highly likely to rapidly result in further deterioration of the current position. In the event of a significant COVID outbreak, there are more staff who will be unavailable to work, further exacerbating the situation, in addition to those already absent having been identified through risk assessment. Given the ongoing issues as described, the need for service modernisation continues and is likely to be instrumental in long-term service security.

Rationale for TARGET Risk Score:

Service rota positions remain variable with continued shortfalls in clinical cover variably affecting service provision. Despite the Carmarthen base rota now being stable, shortfalls in Pembrokeshire and Ceredigion have become evident- and this is further compounded by the need for staff to take leave. Medium term actions are still required, especially in terms of Winter planning and service modernisation. As soon as the present situation allows, work to develop a long term plan for OOH Services must recommence in order to reduce this risk on a permanent basis so to ensure the out of hours service provision is not interrupted. The project management office has been supporting service leads in this area prior to the Pandemic. A date has yet to be secured in relation to reconvening the working group.

Key CONTROLS Currently in Place:

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

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

# GP's rotas across the 3 counties are now managed centrally via the administration team based in Haverfordwest # Dedicated GP Advice sessions in place at times of high demand (mostly weekends). # Remote working telephone advice clinicians secured where required. # Additional remote working capacity has been secured to assist clinicians who may be shielding/ isolating to continue to support operational demand. # Ongoing workforce support from 111 programme team in addressing OOH fragilities in place. # Health Professional feedback form in use between clinicians, service management and 111 (WAST) leads. # WAST Advance Paramedic Practitioner (APP) resource continued. # Ongoing recruitment of clinicians has resulted in 14 appointments (sessional or bank basis) in the last 4 months. # Rationalisation of overnight bases in place since March 2020 appear successful in supporting wider service delivery in current model. # A new approach to engage with the GP network was held in terms of a workshop in Oct19 - further workshops to be held in 2020, but re-arrangement is affected by COVID-19 restrictions. # Programme Management Office (PMO) project to assess service and workforce redesign is presently on hold due to the COVID-19 situation.	The ability to influence workforce participation remains limited due to the lack of contractual agreements (reliance on sessional staff). At present the staffing remains challenging despite a stable rota now being agreed at the Carmarthen base- there are shortfalls in Pembrokeshire and Ceredigon that are affecting service provision throughout the 7 day operating period. The current situation is likely due destabilise further due to the current COVID-19 situation, and so need for formalised workforce plan and redesign is still required - support from PMO to achieve this has been obtained and a working group will reconvene as soon as conditions allow- timescale yet to be confirmed. In relation to service demand, activity is increasing (3860 contacts in August 2020- on a par with January expectation)and this further influences the risk-position. The focus on delivery of care via the telephone advice method is the significant factor in not increasing risk at this time- but any further reduction in capacity is likely going to require an increase in the risk level as the service enters the winter period.	Ensure Transforming Clinical Services Programme incorporates a long term, viable plan for OOH.	Rees, Gareth	30/09/2020	Project Management Office (PMO) has convened a working group to develop short to medium term 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. March 2020- Working group stood down due to Covid-19 commitments June2020- Requests to restart working group are subject to re-prioritisation - further information requested but outstanding.
		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

			Investigate potential external alternatives to current workforce position.	Davies, Nick	Completed	The Service is working with shared services and the 111 programme to develop a GP Hub where locum sessions can be accessed centrally to support service provision. This is similar to the Covid GP Hub and is supported by GP Wales. Access to this workforce stream (coordinated by GP Wales/111 project team) is anticipated to be available by end of December 2020

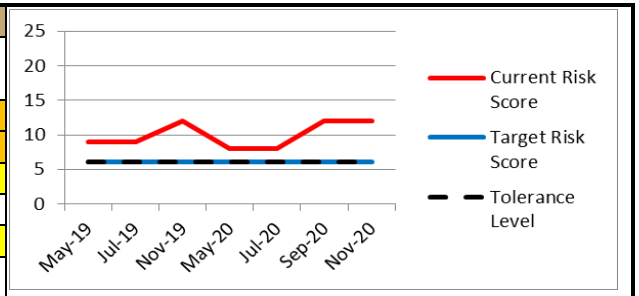
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
	Weekly sitreps/Weekend briefings for OOH	1st			QSEAC- Review of risk 129- (prepared September 2020) ET- Risk to OOH business continuity - Sep19 QSEAC OOH Update Sep19 ET- OOH resilience - Nov19 BPPAC - update on the OOH Services peer review paper Dec19 BPPAC Quarterly monitoring Nov19	Lack of meaningful performance indicators.	Assess NHS 111 performance metrics to understand how they may influence Hywel Dda OOHs performance, and if a viable alternative - which may support improvement in shift fill.	Davies, Nick	Completed	New 111 Wales performance metrics are being prepared and will soon be circulated for review.
	Monitoring of performance against 111 standards	1st								
	Executive Performance Reviews	2nd								

BPPAC monitoring	2nd			QSEAC OOH Update Feb20 ET - OOH resilience Q3 monitoring Jan20 QSEAC - Peer review - Feb20 BPPAC - OOH service design Feb20				
QSEAC monitoring	2nd							
WG Peer Review Oct 19	3rd							

Date Risk Identified:	Sep-18	**Executive Director Owner:**	Thomas, Huw	**Date of Review:**	Nov-20
Strategic Objective:	6.Sustainable use of resources	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Jan-21

Risk ID:	**635**	**Principal Risk Description:**	There is a risk of disruption to patient care across acute, community, primary and mental health services in Hywel Dda. This is caused by the possibility of a no-deal Brexit at the end of the transition period following the UK leaving the European Union (EU) on 31 January 2020 because the ongoing trade negotiations have not been finalised. This could lead to an impact/effect on patients being unable to access appropriate and timely treatment, the UHB being unable to maintain safe and effective levels of staffing, financial loss and adverse publicity/reduction in stakeholder confidence and increased mortality and ill-health across our population.
Does this risk link to any Directorate (operational) risks?			

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



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

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
* Brexit Steering Group established to manage the consequences of Brexit and its interface with partners. * Wider governance infrastructure in place - of note the Dyfed Powys LRF Brexit Group (due to reconvene) and Welsh Government led groups. * Risk assessments and business continuity plans feed into a dynamic risk	Full understanding of potential impacts and implications for the UHB due to the unknown final outcome of Brexit.	Ongoing dynamic review of the UHB's operational Brexit risk assessment and mitigating action to provide assurance that these remain current and that no new risks have been identified.	Thomas, Huw	Ongoing	Work is underway.

summary document which continues to track on-going risks and controls assurance with business continuity. * Work within Workforce and OD to identify EU nationals and resolve data gaps in ESR has been largely completed (98%). Workforce Brexit Plan developed. * Staff Brexit Intranet page developed as single point of information plus a closed Facebook Group for EU staff. * Sitrep process at local, regional and national level for reporting and escalating impacts of consequences of Brexit (currently stood down). * Staff bulletins issued to inform and raise awareness.			
Ensure Transforming Clinical Services Programme incorporates a long term, viable plan for OOH.	Rees, Gareth	30/09/2020	Project Management Office (PMO) has convened a working group to develop short to medium term 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. March 2020- Working group stood down due to Covid-19 commitments June2020- Requests to restart working group are subject to re-prioritisation - further information requested but outstanding.
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 09Marc20

	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 Dec20

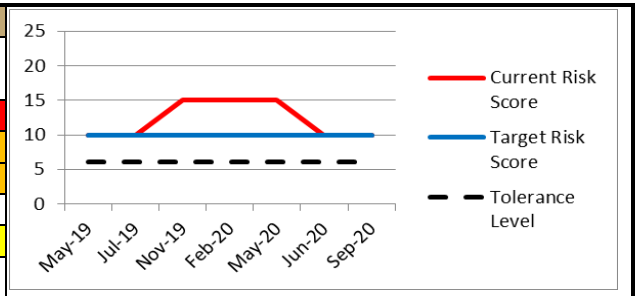
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the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

	WAO Review of Brexit Preparedness	3rd								

Date Risk Identified:	Feb-11	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Sep-20
Strategic Objective:	N/A - Operational risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Nov-20

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

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



Rationale for CURRENT Risk Score:

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

Rationale for TARGET Risk Score:

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

Key CONTROLS Currently in Place:

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

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

# All patients are risk scored by cardiac team at SBUHB on receipt of patient referral from HDUHB. # Medical and nursing staff review patients daily and update the Sharepoint referral database as appropriate to communicate and escalate changes in level of risk/priority for patients awaiting transfer. # Bi-monthly operational meeting with Swansea Bay UHB (SBUHB) to monitor activity/patient flow and address associated risks/issues. # Weekday telephone call between SBUHB Cardiology Coordinator and all 4 hospital Coronary Care Units (CCUs) to review patients awaiting transfer, in particular the progress on identified work-up actions. # NSTEMI Treat & Repatriate service in place since January 2019 providing 6 ring-fenced beds at PPH supporting timelier transfer for BGH and WGH patients to SBUHB for angiography/coronary revascularisation. # Cardiology SDM engaged with Regional planning in support of improvements in coronary angiography capacity across South West Wales. # Cardiology SDM engaged with ARCH/Regional planning in support of improvements in pacing capacity across South West Wales.	Lack of capacity in tertiary centre to manage a range of specialised cardiac investigations, treatments and surgery. 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. Lack of cardiac catheter capacity in HDUHB to reduce reliance on tertiary centre angiography. Lack of theatre / pacing capacity in HDUHB to reduce reliance on tertiary centre pacing. Lack of CT Coronary Angiography capacity in HDUHB to reduce reliance on in-house and SBUHB angiography.	Develop business case to 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~~ 30/11/2020	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 to work with Commissioning Manager to review the scope and potential to repatriate an element of elective angiography activity (LTA) from SBUHB. This has not been progressed in 2020 due to Covid pressures, however this is a point of focus at October '20 Cardiologist Meeting.
		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: • the transportation costs to ensure early transfer of patients to Morriston for same day cardiac catheter treatment and same day repatriation to HDdUHB; and • Consultant co-ordination/advice on the HDdUHB patients referred to the regional centre, t	Smith, Paul	Completed	Long-term funding now in place for PPH N-STEMI 'Treat & Repat' service - this service is now established and this action is now complete.

Address issues identified regarding needed improvements to referral processes as reported in August JRPDC paper: • the internal communication and transfer processes within HDdUHB are a critical part of the success of the treat and repatriate pathway; and • Secondary care Cardiology referrals now have Consultant to Consultant discussion ahead of the electronic referral being made.	Smith, Paul	Completed	Current controls working well. SharePoint system and daily weekday coordination calls between Morriston Hospital and 4 HDUHB hospital sites working well.
Develop more robust reporting of data and business intelligence to support daily monitoring/escalation of waiting times across all sites for the full range of cardiac investigations, treatments and surgery.	Smith, Paul	Completed	Currently piloting system at GGH for roll-out across all 4 hospital sites. In-house system monitored by Cardiology SDM works well in supporting escalation of prolonged waits to Morriston Cardiac Centre.
Develop business case to outline and evidence benefits of increasing in-house pacing capacity in 2019/20 as part of a broader plan to repatriate the pacing LTA from SBUHB.	Smith, Paul	~~31/10/2019~~ 30/11/2020	Pacing SBAR (Aug '19) approved by Execs in Sept '19 supporting repatriating Simple Bradycardia Pacing (LTA) from SBUHB. Initial plan to phased repatriation from October/November 2019 impeded by HDUHBs pacing operational/capacity pressures (loss of 50% capacity at GGH site; loss of 33% Health-board-wide). SDM/Clinical Lead currently working to return service capacity to baseline following significant pacing reduction due to COVID. T&F Group currently meeting weekly to focus on needed actions.

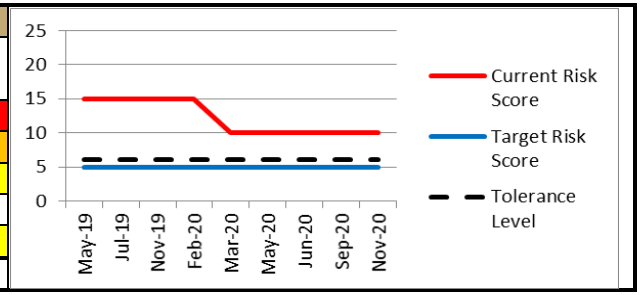
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance Current Level			Identified Gaps in Assurance:	How are the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

Performance indicators for Tier 1 targets.	Daily/weekly/monthly/ monitoring arrangements by management	1st				Lack of oversight at the Board and Committees.	Review reporting arrangements of emergency and elective waits.	Carruthers, Andrew	~~01/10/2018~~ 30/11/2020	Discussions continue with SBUHB for information on cardiac patients(on all pathways)to be provided to Hywel 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. This has not been progressed in 2020 due to Covid pressures.
	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								

Date Risk Identified:	Sep-18	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Nov-20
Strategic Objective:	N/A - Operational risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Jan-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/effect on complications for mother and baby resulting in long term, irreversible health effects.
Does this risk link to any Directorate (operational) risks?			

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



Rationale for CURRENT Risk Score:

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

Rationale for TARGET Risk Score:

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

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

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.		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 15/07/2019 31/03/2020 30/09/2020 31/12/2020	OCP completed for SCRUB and Band 3 team. Aim is to issue outcome by end of Sep20 with implementation by Dec20. The service have completed a risk assessment which is due to go to Operational QSE Sub-Committee, following which a decision will be made on implementation.
		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.

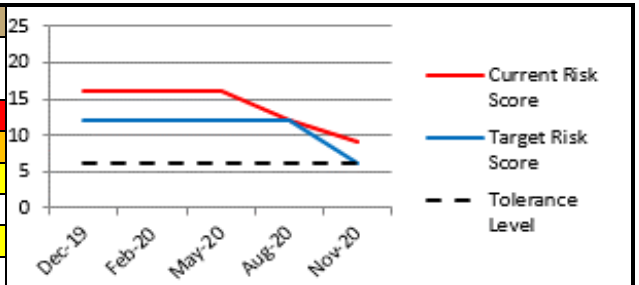
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**		
No of incidents reported where 30 minute response target is missed.	Maternity Services governance systems review of incident reports	1st			Executive Team - Jul18 Executive Team - Dec18 ARAC - Jun19
	Management audit of cases presented to QSEAC	2nd			
	Discussions with WG Chief Nursing Officer & UHB Medical & Nursing Director	3rd			

Gaps in ASSURANCES				
Identified Gaps in Assurance:	**How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
None identified.				

Date Risk Identified:	Mar-17	**Executive Director Owner:**	Thomas, Huw	**Date of Review:**	Nov-20
Strategic Objective:	3. Striving to deliver and develop excellent services	**Lead Committee:**	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Oct-20

Risk ID:	**371**	**Principal Risk Description:**	There is a risk that the UHB will not improve its delivery against the national completeness target for clinical coding (of 95% within month coding and 98% on a rolling 12 months) and that inaccurate/incomplete information will be used in decision-making in relation to service delivery and clinical strategy. This is caused by insufficient staff numbers within the Clinical Coding Department (reduced to 80% capacity due to COVID-19). This could lead to an impact/effect on the existing backlog of 13,000 episodes that require clinical coding (this increases by 2,000 per month with a projected backlog of 30,000 by end of 2020/21), the Welsh costing returns which use the derived Healthcare Resource Grouping (HRG) as a key element and that any reconfiguration of clinical services might not achieve the UHB's strategic goals to improve patient care.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Business objectives/projects
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×3=9
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	6
Trend:	



Rationale for CURRENT Risk Score:

Due to COVID-19,the coding backlog has reduced to 15,692 due to the reduced activity, however the team are only operating at 80% capacity. The backlog increases by 2,000 per month. This requires a number of actions to be taken, significant investment in contract coders at the end of the year. This affects the clinical information available for audit/research and the year end costing returns for the UHB.
Funding has been secured for the additional 4.5 WTE clinical coders and 2 WTE clerking staff, appointments have been made in August 2020 with a structured training plan in place to ensure compliance with the target within 18 months

Rationale for TARGET Risk Score:

Our current percentage compliance for July 20 was 74%, which is below the required target of 95% of episodes clinical coded within 1 month post discharge. Following the additional resources made available by the Health Board the following posts have been advertised and appointed:
- 4.5 Senior Clinical Coders (Band 4)
- 2.5 Clinical Coding Clerks

All staff have been appointed and have started.

Alongside this further work will be undertaken with Betsi Cadwaladr Health Board and Capita to ascertain the ability to automate some high volume cases, to reduce the pressure upon the clinical coding team.

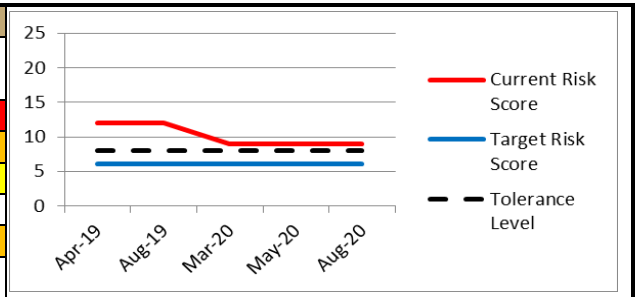
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Processes have been reviewed to identify any improvements that can be made to current working practices. The review has been unsuccessful in identifying any gains. # The coding backlog is monitored on a regular basis and reported via the IPAR and the Quality Indicators Group. Establishing the cost of contract coders to deal with the current backlog as a short term measure. # Overtime is being implemented to address some of the short fall in the completeness factor. # Reminders to end users of coded information that completeness levels does not meet national targets. # Notes are moved across the Health Board to support the teams that have less than required resources. # An outsourcing tender has been awarded to GSA for the coding of the Hywel Dda backlog, with a completion date of 27th June 2019, which is the requirement for the statutory costing returns.	Resourcing the clinical coding team, to take account of underlying growth A revised workforce plan for the succession planning for the department	Develop a workforce plan to address current shortfall and address future staffing/succession needs (current shortfall is calculated as 5.5wte clinical coders and 2.5 WTE clerks)	Beynon, Gareth	Completed	Funding for additional staff has been approved with posts due to be advertised.
		Additional funding has been provided to the Clinical Coding Team for 1 additional coder	Beynon, Gareth	Completed	The interviews for a fully trained coder were unsuccessful, therefore a further job advert was release for a trainee coder. Interviews for a trainee coder took place on the 10Dec19, and we appointed 2 trainee coders, however it should be noted that it will take 18 months for the individual to be fully trained and therefore the impact upon the coding backlog will not be seen until the individual is fully trained.
		A further tender will be placed out to market for a weekend contract coder	Beynon, Gareth	Completed	The contract weekend coders, began on 02Nov19 and are targeting the backlog cases. Due to COVID-19 the contractor is not currently available.

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
Number of episodes coded Number of episodes outstanding 95% of episodes coded within 1 month of discharge 98% of episodes coded in a rolling 12 months	Department monitoring of KPIs	1st			Information Governance Sub-Committee Jul18, Sep18, Nov18, Feb19, Apr19, May19, Jul19, Sep19 WAO Clinical Coding Follow-up Update - ARAC - Apr20	None identified				
	IGSC monitoring of Clinical Coding Targets	2nd								
	WAO Follow-up Report on Clinical Coding - Apr19	3rd								

Date Risk Identified:	Sep-18	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Aug-20
Strategic Objective:	N/A - Operational risk	**Lead Committee:**	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Oct-20

Risk ID:	**633**	**Principal Risk Description:**	There is a risk of the UHB not being able to meet the 1% improvement target per month for waiting times for 2020/21 for the new Single Cancer Pathway (SCP Performance targets tbc by WG and implementation is likely to be brought forward as a result of COVID-19). This is caused by the lack of capacity to meet expected increase in demand for diagnostics and treatment delays at tertiary centre. This could lead to an impact/effect on meeting patient expectations in regard to timely access for appropriate treatment, adverse publicity/reduction in stakeholder confidence and increased scrutiny/escalation from WG.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Quality/Complaints/Audit
Inherent Risk Score (L x I):	4×4=16
Current Risk Score (L x I):	3×3=9
Target Risk Score (L x I):	3×2=6
Tolerable Risk:	8
Trend:	⟷



Rationale for CURRENT Risk Score:

The impact of COVID-19 may increase the risk of being unable to meet the target due to recommendations from the Royal Colleges to suspend diagnostics and some surgery that are aerosol generating. During the pandemic, endoscopy was centralised in GGH. Endoscopy services have now been reinstated on all 4 hospital sites, but due to only having 50% of the pre-COVID lists and lists only having 30% of the usual capacity, this may still cause delays to investigations being carried out. High acuity elective cancer surgery with green pathway and green ITU/HDU commenced in PPH & BGH on 6 July 2020 with WGH due to commence surgery on the 10 August 2020. A full COVID-19 Cancer escalation plan is in place and is updated when new guidance is issued.

Rationale for TARGET Risk Score:

The aim is to treat patients within target waiting times (which are yet to be confirmed). Some treatments were changed or were suspended during COVID-19. The backlog is now being addressed, and patients are being contacted with regards to dates for their treatment. The tolerance level will be met if the UHB continues to meet the 1% per month improvement trajectory throughout 2020/21.

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**
Working with all Wales Cancer Network to gain full understanding of implications of new pathway. Implementation Group established, reporting to Cancer Board with awareness / engagement sessions held on each hospital site.	Anticipated significant gaps within key diagnostic services to address required levels of activity to support SCP - unlikely to be addressed by August 2019	Demand & capacity assessment work continuing. Solutions will necessitate regional cooperation to address anticipated capacity gaps.	Humphrey, Lisa	~~31/03/2020~~ 31/03/2021	Initial planned work with Delivery Unit suspended and will be under constant review in light of COVID and recovery planning phase.

Shadow monitoring in place. Further Demand & Capacity exercise planned 2020/21 with support from Delivery Unit. New Cancer tracking module in W-PAS now fully operational as of Dec19 with tracking team in place from Dec19 to allow patients to proactively tracked through treatment pathways. Routine daily communication feed from ED to cancer information team which helps identify the point of suspicion. COVID-19 escalation plan in place. Monitoring data of patients whose treatments have changed or suspended (some through patient choice) as a result of COVID-19. A 4-week follow up process has been implemented for these. Utilisation the private sector for surgery during COVID-19. Joint working with regional colleagues to offer patients on a tertiary pathway surgery locally. Resumed aerosol generated diagnostics cross all 4 hospital sites. Reinstated high acuity elective Cancer surgery with green pathway and green ITU/HDU has commenced on PPH and BHG sites as of 06/07/2020, and WGH planned from 10/08/20.	Full engagement for all supporting services. Performance is lower than USC/NUSC published performance. Key diagnostic information systems do not support effective demand / capacity planning. Need for new, streamlined optimal clinical pathways to reduce diagnostic demand and expedite assessment pathways.	See above re diagnostic services plus improved systems to support identification of 'date of suspicion'.	Humphrey, Lisa	~~31/03/2019~~ 31/08/2019 31/07/2020 31/10/2020	HB performance compares well with other HBs however below current USC/NUSC performance level. Ongoing work in progress with OPD, Diagnostic & ED teams along with the informatics department to improve real time identification of date of suspicion.Informatics are beginning to pick up routine reporting requests which were on hold due to COVID-19.
		Each MDT to review and adopt recommended optimal tumour site specific pathways	Humphrey, Lisa	~~31/08/2020~~ 30/09/2020	Each MDT is currently assessing implications of published proposed pathways. A Macmillan Cancer Quality Improvement Manager post which was developed to work with the teams with regards to implementing the new pathways is now vacant. Agreement over funding was delayed as a result of COVID-19. The recruitment process has started however there are small delays due to annual leave.
		Explore opportunities for alternative providers to address tertiary centre delays for cancer treatment.	Humphrey, Lisa	Completed	Some arrangements were agreed however these have been suspended due to COVID-19, however COVID has provided opportunities to enable new arrangements to be put in place with regional centres.

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**		
Deliverable indicator targets - 1% improvement per month during 2020/21.	Daily/weekly/monthly/ monitoring arrangements by management	1st			* Implementation of Single Cancer Pathway Report - BPPAC

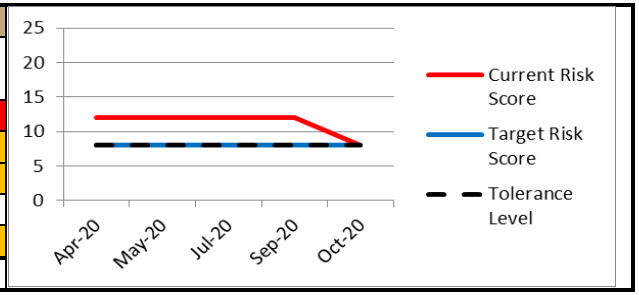
Gaps in ASSURANCES				
Identified Gaps in Assurance:	**How are the Gaps in ASSURANCE will be addressed** **Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
No gaps identified.				

Shadow performance data.	Executive Performance Reviews (suspended due to COVID-19)	2nd			- Feb20 * IPAR Report Mth3- Board - Jul20 * COVID-19 Impact on Cancer Services - Board - May20 * Cancer Updated to QSEAC Jun20 & OpQSESC Jul20					
	Service plans in response to COVID-19 overseen and agreed by Bronze Acute & Gold	2nd								
	IPAR Performance Report to PPPAC & Board	2nd								
	Monthly oversight by Delivery Unit, WG	3rd								

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

Risk ID:	**855**	**Principal Risk Description:**	There is a risk that the UHB's non-covid related services and support will not be given sufficient focus. This is caused by corporate and operational focus diverted to COVID-19 planning. This could lead to an impact/effect 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):	2×4=8
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	8
Trend:	



Rationale for CURRENT Risk Score:
In the early stage of the pandemic, to prevent deterioration urgent patients and those needing cancer, rheumatological and other services continued to receive care and processes were in place to maintain this. The likelihood score reflects this and also reflects the recently developed winter plan which aims to maximise all services (COVID and Non COVID) as far as our estates, workforce and IP&C arrangements allow. Impact of the risk is based on the fact that harm will be done if the risk materialises. Quarterly planning process now established and expansion/restarting of non-COVID services is being implemented.

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Ethics Panel established and asked to consider issues related to the care of non-COVID-19 patients. Clinicians are making case by case risk based decisions for high risk/vulnerable patients. All urgent and emergency work continuing at present. [illegible]	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.

All available capacity being utilised at the Werndale to support cancer and urgent planned care activity. Revised Strategic Plan Requirement issued by Gold to Tactical on 27/04/20 to include non-COVID planning. The Winter Plan sets out arrangements for non-COVID services during winter ensuring focus is maintained on these services during a challenging winter period. Transformation Steering Group established. Quarterly planning process to ensure essential services are maintained and other services are cautiously restored as progress of the pandemic allows.		Develop a quarterly approach to planning to maintain essential services and retain flexibility and adaptability to changes in community transmission rates of COVID-19.	Carruthers, Andrew	Completed	To be established through the Command and Control Structure
		Develop Quarter 2 plan in response to WG Q2 Operating Framework for Gold Group.	Carruthers, Andrew	Completed	Completed. Q2 Delivery Plan submitted to WG on 03/07/20. Board will receive plan retrospectively at Jul20 Board Meeting in Public. Delivery of Q2 plan to be undertaken by PPPAC.
		Develop Quarter 3&4 plan in response to WG Winter Preparedness Framework and Gold Command requirements.	Carruthers, Andrew	Completed	Completed - awaiting ratification by Board at its Public Meeting on 26 November 2020

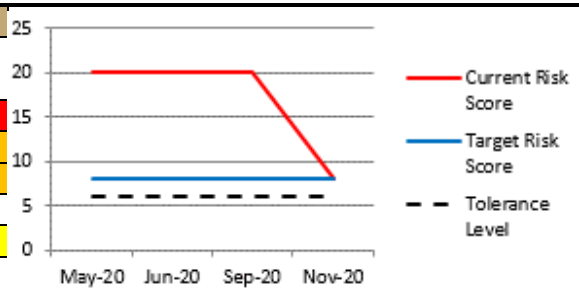
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**		
None identified.	Command and Control Structure developing and approving plans to re-establish and maintain essential services	2nd			Responding to the COVID-19 pandemic - Board (Apr20&May20)
	Board oversight of revised quarterly plans	2nd			

Gaps in ASSURANCES				
Identified Gaps in Assurance:	**How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
No performance measures. Internal and External Audit Plans in 20/21 are being reviewed to incorporate review of organisational response to COVID-19.	Develop KPIs following development and approval of plan to restart services.	Carruthers, Andrew	31/07/2020	The UHB is in the process of asking the medical advisory board to give us their view on international best practice in monitoring the population impact of this issue which will inform the KPIs we track.

Date Risk Identified:	Apr-20	**Executive Director Owner:**	Thomas, Huw	**Date of Review:**	Nov-20
Strategic Objective:	6. Sustainable use of resources	**Lead Committee:**	Finance Committee	**Date of Next Review:**	Jan-21

Risk ID:	**856**	**Principal Risk Description:**	There is a risk to the delivery of the Health Board's Financial Plan for 2020/21 of a £25m deficit. This is caused by 1. Costs of addressing our local COVID-19 needs may exceed funding available from UHB, Regional and WG sources. 2. Unidentified savings schemes included in the Financial Plan are also at risk of non-delivery due to both the operational focus being diverted to respond to COVID-19 and where identified schemes are not supportive of the response needed (e.g. bed closures). This could lead to an impact/effect on the Health Board's deficit position, reduction in stakeholder confidence and increased scrutiny from WG.
Does this risk link to any Directorate (operational) risks?	Yes		

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



Rationale for CURRENT Risk Score:

The additional costs incurred in Months 1-7 2020/21 in response to the pandemic were significant and current demand modelling and corresponding forecast would suggest a continuation and potential acceleration of these costs over the Winter months. However, in Month 6, Welsh Government confirmed non-recurrent funding to support the financial impact of the pandemic in addition to the cost reductions driven by lower patient activity. The net impact of the funding and cost reductions mean that the Health Board is currently forecasting to deliver a planned deficit of £25m.

However, the financial forecast is dependent on assurances provided by a range of teams across the Health Board and across the RPB on the drivers of spend. There is a risk that these assurances do not reflect future expenditure profiles and that the financial outturn differs from our current forecast.

Rationale for TARGET Risk Score:

The Health Board needs to demonstrate that it is able to manage its financial position effectively, cognisant of the risks which are inherent in the delivery of safe and timely care.

As the demand modelling matures, informed by actual activity in the Health Board or in other Health Boards in Wales, the level of risk may be considered to be reduced, however current indications are that the pandemic will continue for the remainder of the financial year. As further assurance is provided by partner organisations and further clarity from Welsh Government as to funding arrangements, the risk may be reduced.

Given the challenge in delivering the financial position this year, it is unlikely that the Health Board will achieve a risk which is in line with the tolerable risk for the year. Consequently, the target risk score exceeds the tolerable risk at this point. This is not an acceptable position, and further work is ongoing to manage this risk.

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**
1. Modelling of anticipated patient flows, and the resultant workforce, equipment and operational requirements is managed through Gold command. 2. Financial forecasting is an embedded monthly cycle, fully engaging budget holders through the Finance Business Partners. COVID-19 forecasting is now fully aligned to Directorates, where the accountability structure is better managed. System Engagement Meetings are held monthly for the higher risk Directorates. 3. Timely financial reporting to Directorates, Finance Committee, Board and Welsh Government on local costs incurred as a result of COVID-19, and cost reductions arising from changes in activity levels; this informs central and local scrutiny, feedback and decision-making. 4. Oversight arrangements in place at Board level and through the command structure. 5. Exploration of a number of funding streams being explored, including: Local Health Board funding arrangements; Funding arrangements through the Regional Partnership Board and Local Authority partners. Funding from Welsh Government's own sources or from HM Treasury via Welsh Government. 6. Opportunities Framework, refreshed to identify alternative ways of working in response to COVID-19 that may result in cost reductions/formal savings schemes identified.	The costs of addressing the Health Board's local needs may exceed available funding. Identification and assessment of sustainable opportunities arising from cost reductions due to changes in activity levels or other service changes in response to COVID-19.	Alignment of strategic response to current demand modelling indicators between Welsh Government, Gold Command and operational teams.	Carruthers, Andrew	Completed	A Q2 Operational Plan has been submitted to Welsh Government in July 2020, followed by the a Q3/4 Operational Plan in October 2020 as agreed by Gold Command. The Board approved the Plans at the July and October 2020 meetings respectively. A six month review meeting with Welsh Government and FDU was conducted in November to discuss the plans for the remainder of the financial year. Actions agreed will now form part of the normal monthly monitoring return process.
		Clarity as to what current escalation measures can be safely and appropriately de-escalated/decommissioned and which ceased/deferred services/activities can be recommenced.	Carruthers, Andrew	~~30/06/2020~~ 31/10/2020 31/03/2021	A Q2 Operational Plan has been submitted to Welsh Government in July 2020, followed by the a Q3/4 Operational Plan in October 2020 as agreed by Gold Command. The Board approved the Plans at the July and October 2020 meetings respectively. The local demand modelling continues to be updated frequently and the prevalence of COVID-19 will continue to be a fluid situation which will directly influence the Health Board's ability to safely deliver those services deemed non-essential in Welsh Government guidance.

Refine Finance structure following review of effectiveness and efficiencies of function following OCP.	Spratt, Andrew	Completed	Final transitional arrangements are now complete to transfer and process improve workstreams from Business Partnering to Process Improvement, and to create a distinct Management Accounting function with clear remit. Consultation complete and departmental structure changes communicated to Finance staff and relevant Service Leads - handover process pilots and final transition complete.
Accountability statements in relation to Budget 2020/21 replaced with a Delegations and Finance Delivery letter, in light of the COVID-19 pandemic.	Thomas, Huw	Completed	Letters issued May 2020, clarifying continuation of existing financial control principles and the importance of existing governance processes and frameworks. Also stating the significance of decision making in response to, and the accurate recording of the financial impact of, COVID-19.
Feedback/clarity from Welsh Government as to levels of additional revenue and capital funding available.	Thomas, Huw	~~01/07/2020~~ 31/10/2020 31/03/2021	In Month 6 Welsh Government confirmed a significant level of funding in response to the impact of the pandemic, partly to match specific types of costs such as Field Hospital set up and partly based on a capitation basis. The situation will remain fluid for the remainder of the financial year, dependent upon Welsh Government guidance and operational variation that has a financial impact.

		Further scrutiny is required of the assurances provided by a range of teams across the Health Board and across the RPB on drivers of expenditure forecast for the remainder of the financial year.	Thomas, Huw	31/12/2020	A schedule of the expenditure items with a forecast profile in excess of the YTD trend has been compiled and initial assurances provided from the relevant accountable officer. Each item will require further scrutiny and will be reported to the Finance Committee.

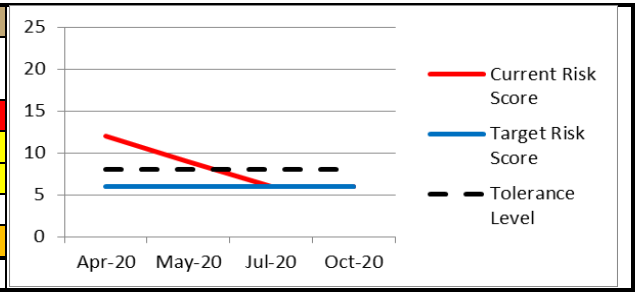
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Performance against planned response to COVID-19 In-month financial monitoring	Performance against plan monitored through Engagement meeting with Services	1st			* Month 6 Finance Report Finance Committee and Board October 2020 * COVID-19 Reporting Principles Paper - Finance Committee May 2020	None				
	Executive Performance Reviews	2nd								
	Finance Committee oversight of current performance	2nd								
	Transformation & Financial Report to Board & PPPAC	2nd								
	WG scrutiny through revised monthly Monitoring Returns (specific COVID-19 template) and through Finance Delivery Unit	3rd								
	WAO Structured Assessment 2020	3rd								

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

Executive Director Owner:	Moore, Steve	**Date of Review:**	Oct-20
Lead Committee:	People, Planning and Performance Assurance Committee	**Date of Next Review:**	Dec-20

Risk ID:	**854**	**Principal Risk Description:**	There is a risk that UHB's response to COVID-19 proves to be larger than needed for actual demand. This is caused by incorrect modelling assumptions or changes in the progression of the pandemic. This could lead to an impact/effect on abortive costs and possible reputational damage.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Adverse publicity/reputation
Inherent Risk Score (L x I):	5×3=15
Current Risk Score (L x I):	2×3=6
Target Risk Score (L x I):	2×3=6
Tolerable Risk:	8
Trend:	⟺



Rationale for CURRENT Risk Score:
Likelihood recognises that limits to our ability to grow our bed base reduce the risk of over capacity and our modelling is informing the scale of gap. It also reflects revised planning assumptions from Welsh Government (WG) for winter COVID-19 demand which will be close to available Field Hospital capacity. The WG funding process for COVID-19 has been clarified and our current forecast outturn is in line with pre-covid plans at £25m.

Rationale for TARGET Risk Score:
Planning has been based on current planning assumptions and the Public Health Plan being effective. Target risk score has been met.

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

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

Modelling cell established to provide regular updates on planning numbers, linked into the Welsh Government modelling group and other Health Boards. Welsh Government direction to risk over provision rather than under provision will limit reputational damage. All developments subject to a business case approach to ensure value for money is considered alongside other issues. Board oversight and sign off of decision-making at all levels of the Command Structure. Good Communications with Community Health Council, local politicians and Local Authorities. Regular media engagement (internal/external). Revised Strategic Planning Requirements Directive from Gold to Tactical on 27/04/20 includes field hospitals available as alternative sites. WG informed of COVID-19 related costs on regular basis. Financial Framework/Business Case approval process in place and the Finance Committee is providing assurance to Board.					

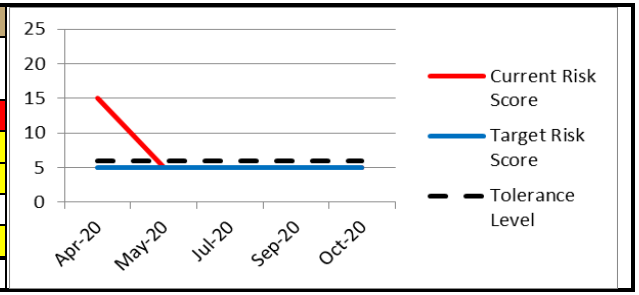
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Delivery of £25m deficit at year end.	Response to COVID-19 reviewed through Command and Control Structure	2nd			Responding to the COVID-19 Pandemic - Board - Apr20, May20, Jun20,	Internal and External Audit Plans in 20/21 are being reviewed to				

Board oversight of Response to COVID-19	2nd			Jul20 & Sep20 Finance Report Month M06 - FC - Oct20 Q1 Covid-19 Costs - FC - May20	incorporate review of organisational response to COVID-19.				
Finance Committee (FC) review of COVID-19 costs as part of monthly finance report	2nd								
WG support (to date) of UHB response to COVID-19	3rd								
KPMG Review of Field Hospital Provision - Expected Sep20	3rd								

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

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

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



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

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

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
A strong Command & Control structure has been implemented and judged fit for purpose by our assigned Military Liaison Officer. Planning numbers have been clearly communicated from Gold to Tactical and Bronze groups at the earliest opportunity. An Ethics Panel has been established to consider the challenges ahead and provide guidance. QSEAC will scrutinise PPE and areas of concern such as oxygen supply	Inability to directly control lift of lockdown measures.				

and ventilators. Modelling cell established to provide regular forecasts of the progress of the pandemic at local level. Functional capacity forecasting tool provides time to respond to changes in forecasting. Field hospital capacity has now been secured for the Q3/4 period and is sufficient to accommodate patients up to the peak level of configuration set out by Welsh Government. A workforce plan to support this is being finalised including additional recruitment (which is currently underway). Comprehensive Prevention and Response Plan agreed with the 3 local authorities to ensure Track, Trace and Protect (TTP) is effective in reducing transmission rates.					

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