(1)	(2)	(3)			(4)	(5)			(6)	(7)	(8)
Ref	Risk Description/Objective	Inherent Risk Score			Risk control measures / proposed mitigating actions	Residual Risk Score			RAG status & Residual score trend direction	Proximity	Owner
		I	L	O		I	L	O			
NHS SERVICE PLANNING											
1	**DHSS MEG Financial Performance 2015-16** If a robust financial plan for the HSS MEG is not developed to support the management of HSS revenue budgets (Central & NHS), the Department will not be in a position to robustly monitor and control delegated budgets. If HSS revenue budgets are unable to achieve financial balance for the 2015-16 year, it is likely that the HSS MEG will breach its ambit and DEL controls.	5	5	25	The HSS MEG has a modest revenue contingency of c.£27m for 2015-16. A review of commitments against central budgets is currently being undertaken before budgets are formally delegated. Integrated Medium Term Plans for 2015-16 to 2017-18 have been received from NHS organisations and are currently going through a process of challenge and review. Current indications are for a financial challenge in the NHS of c.£100m in 2015-16. Monthly bilateral meetings are being held between the Minister for HSS and the Minister for Finance and Government Business	5	5	25	Red ↑		NR
2	**Service Reconfiguration** If Local Health Boards do not address fragilities in service delivery patterns promptly, the quality of patient care will be compromised, and change will be forced through on a reactionary, rather than on a planned and sustainable basis.	5	5	25	A cross Departmental Service Change Programme Board is in place to provide programme and risk management, and interdependencies with other Departmental policies and programmes. This provides an internal government structure to ensure that risks and issues are captured effectively. Service Change Guidance to LHBs and CHCs is	5	4	20	Red ↑	Grey	Frances Duffy

					now being reviewed and updated following a commissioned Lessons Learned review of the first phases Service change is a standing agenda item at each monthly NHS Chief Executives meeting with EDT allowing us to take a joint strategic overview of the pace and progress of change across Wales. EDT to review high risk service regularly and decide appropriate assurance measures and mitigating actions. Regular engagement with LHB and Collaborative leads on service change has been established and maintained The IMTP Guidance and assessment process will provide the main vehicle for ongoing monitoring of service change within each LHB						
3	**Integrated Medium Term Plans** If NHS organisations do not have approved IMTPs then there is a risk that the NHS in Wales does not deliver the required quality and service improvements within the resources available.	**5**	**4**	**20**	The 2015/16 NHS Planning Guidance was issued on 31 October and provided increased clarity on expectations for planning and delivery. The Assessment of final IMTPs is ongoing and due to conclude in early May 2015. There are a number of organisations who, based on our assessment will not have approvable IMTPs in 2015/16 These organisations have been asked to concentrate on providing, within the next few weeks, the detailed granularity on: - Deliverables for 2015/16 - A timelines of milestones for strengthening their organisational approach to medium term planning during 2015/16 Discussions are ongoing in the Planning Board to	**5**	**3**	**15**	**Red ↔**	**Black**	**NR**

					determine the levels and nature of support required for the organisations that will not have approved IMTPs. Support and/or intervention will be tailored to reflect the specific needs of those organisations, reflecting current interventions and escalation levels. Advice will be sent to the Minister to agree a course of action for each and secure resources to improve the actions. A programme of work supporting the strengthening of planning skills and capacity has been initiated.						
4	**Support to the BCU LHB** If we do not provide sufficient appropriate support to the BCU LHB following the escalation of the organisation to "targeted intervention" then both the performance (including financial stability) and safety of services provided by the LHB will be put at risk	**5**	**4**	**20**	Name Redacted commissioned to lead a stage 1 diagnostic review with expert financial support. The outcome of stage 1 will determine the actions required to support the organisation. Further external support will be identified as required. Senior engagement with the LHB strengthened to ensure immediate actions are undertaken to address quality, governance and performance issues in parallel to the stage 1 review. DH&SS Directors team providing support as required and regularly taking stock of progress. Delivery Unit undertook reviews of services to provide support and assurance on operational delivery. Joint meetings with WG and DU to support development of plans for RTT delivery remain ongoing.	**5**	**3**	**15**	**Red** ↔	**Black**	EDT Directors
5	**Delivery of Together for Health**	**5**	**4**	**20**	Together for Health commitments are distributed	**4**	**3**	**12**	**Amber**	**Grey**	Jo Jordan /

	If we do not deliver the commitments within the TfH vision, the quality of patient care will not improve, NHS services will not be put on a sustainable footing for the future and there will be a reputational risk to the Government.				across the Department – with Executive Director Leads - and are included separately as individual risks in Directorate and Divisional risk registers. A Together for Health risk register is in place and monitored centrally. Commitments are monitored through the Ministerial Advisory Group on a bi-monthly basis. Regular updates reported to the National Delivery Group.				↔		Tracey Breheny
6	**DHSS MEG Financial Performance 2014-15** If a robust three year financial plan for the HSS MEG is not developed to support the management of HSS programme budgets (Central & NHS), the Department will not be in a position to robustly monitor and control delegated budgets. If NHS programme budgets are unable to achieve financial balance for the 2014-15 year, it is likely that the HSS MEG will breach its ambit and DEL controls.	**5**	**5**	**25**	The Finance Minister announced an extra £200m for the 2014-15 financial year on 30 September 2014. An additional £40m for 2014-15 was announced as part of the second supplementary budget. With this extra money, and identified central savings, the DHSS MEG will be able to achieve financial balance if NHS organisations are able to maintain their current forecasts through the remaining months. The Department has also found significant central savings that will help balance the DHSS MEG. The provisional year end outturn is a modest surplus for the MEG. We have instigated formal intervention within BCU to provide additional support and identify what further action can be taken to address the reported financial deficit.	**5**	**1**	**5**	**Green** ↓	**Black**	**NR**
FINANCE											
7	**Insufficient investment in Informatics Services** If there is insufficient investment in	**5**	**5**	**25**	NHS organisations included IM&T elements in the three-year plan process. Issues will be highlighted through regular	**5**	**3**	**15**	**Red** ↓	**Black**	**NR**

	Informatics Services in health and care organisations then the viability and benefits of delivering integrated services and the delivery of the national informatics programme will be brought into question.				meetings with NWIS and escalated through the Programme Level Agreement mechanism and the National Informatics Management Board e.g. the HCAIs case management and surveillance IT system (ICNet) an essential component in the range of actions to reduce cases to the irreducible minimum. Minister has emphasised the "once for Wales" approach. A refreshed eHealth and Care strategy is being developed in conjunction with health boards, NHS trusts and local authorities in Wales. A draft version of the strategy document was presented to NIMB at its meeting on 26th March in line with the agreed timescale. The draft strategy will now be discussed at a workshop with NHS CEO's and senior DHSS officials on 30 April.						
8	**All Wales NHS Capital Programme Investment** If the All Wales Capital programme does not have clearly articulated investment objectives and funding is not targeted at identified priorities, then there is a risk that strategic transformation in the NHS will not be supported, organisations will not be able to maintain statutory requirements in relation to estate condition or that the regular replacement of clinical equipment will not take place.	**3**	**5**	**15**	NHS bodies were asked to submit prioritised infrastructure investment requirements as part of their Integrated Medium Term Plans linked to the service changes within. Investment objectives for the capital programme agreed with the Minister and evidence obtained from NHS organisations in respect of alignment to these. Internal/expert panel in place which is considering evidence of how unapproved schemes meet agreed investment objectives.	**3**	**5**	**15**	**Red** ↔	**Grey**	**NR** Val Whiting
9	**Intermediate Care Fund (ICF)** If the regions are not able to spend	**5**	**5**	**25**	Regions have been required to submit a detailed profile of expenditure, and regular reporting on a quarterly basis which is closely monitored.	**5**	**3**	**15**	**Red** ↔	**Grey**	Albert Heaney **NR** **NR**

	the funding available through the ICF then there will be considerable reputational damage (across a number of Ministerial portfolio areas) as the ICF was part of the political agreement to the overall Welsh Government budget for 2014/15. Effect Whilst budget responsibility is with Local Government and Housing and Regeneration, the Social Services and Integration Directorate has overall policy responsibility for delivery.				Regions have also been providing copies of their monthly board reports to ensure we have the latest available information on expenditure to date and projected commitments for assurance that the full budget will be effectively utilised. Regions were asked to identify additional proposals, in case there was slippage in expenditure. Quarter 3 returns have been received, potential underspend is still expected (in the region of £1m) but regions are continuing to take action to minimise this. Quarter 4 figures and final end year report are due shortly. Announcement of continued funding for ICF will help reduce the risk of underspend.						
10	**NHS Continuing Healthcare** (CHC) If revised arrangements are not implemented effectively for reviewing NHS CHC retrospective claims then there is considerable risk of slippage resulting in a negative impact on the citizens affected, reputational risk to Ministers and reputational harm to the NHS.	**4**	**4**	**16**	*Phase 2 - Retrospective claims managed by individual Health Boards and the National Powys Project.* Proposals were developed and agreed through an externally led Executive Group (chaired by Name Redacted Name Redacted) to manage the backlog of retrospective claims. Additional funding has been provided to Health Boards to ensure capacity in place to deal with retrospective claims. Regular monthly monitoring of progress is in place. Andrew Goodall agreed with Chief Executives in January 2015 that the Powys project will take on handling of all retrospective claims.	**4**	**3**	**12**	**Amber** ↓	**Grey**	Albert Heaney NR NR

					Phase 3 Claims (Claims arising from the 31 July 2014 cut-off date for post 2003 claims) The National Project will also be used to support the handling of any claims arising from the 2,400 expressions of interest received. Any delays in dealing with Phase 2 claims will have a knock on effect in dealing with Phase 3.						
11	**Resource Allocation Review** If the resource allocation review is not delivered to the Finance Regime timescales previously communicated to PAC , there is a risk to the delivery of the Together for Health commitment for the delivery of a new Finance Regime and associated political reputational issues for both the Minister and HSS	**4**	**5**	**20**	Meeting held with Minister of 13 October 2014 detailing the Phase 1 work on updating the current direct needs formula with the latest updates to the data sets that drive the formula and likely impacts The scope, approach and resources to take forward the Phase 2 of the Resource Allocation Review to be discussed with the Minister in early 2015/16. In view of the changes to the Welsh Health Survey alternative data sources, for population needs, are being evaluated. This will inform and underpin the Phase 2 work.	**4**	**3**	**12**	**Amber** ↔	**Grey**	EDT
DELIVERY											
12	**NHS Delivery in Unscheduled and Planned Care:** If NHS organisations do not plan and deliver actions to re-balance pressures and improve system efficiencies, there is a risk that targets will continue being missed and patient health care will be compromised and this continued failure will become a reputational risk to the Minister.	**5**	**5**	**25**	To ensure health boards deliver against unscheduled care and planned care policy areas – assurance is sought through the following governance arrangements: Monthly Integrated Delivery Board with DHSS policy leads, Quality Group and DU. Linked to Quality and Delivery meetings with all NHS organisations. Timing requirements based on escalation, and their three year planning status. These groups are supported by targeted intervention, continued challenge around plans and evidence of improved delivery.	**4**	**5**	**20**	**Red** ↔	**Grey**	Simon Dean/ NR

					Unscheduled care Daily Executive level conference calls-for urgent and emergency care, with Chief Executive level calls initiated in response to USC pressures supported by daily monitoring and use of unscheduled care Dashboard. These are followed up when necessary with letters requesting additional assurance on actions Quarterly seasonal planning events to support planning across health and social care and for WG to gain assurance. *RTT and Cancer* We review and report weekly RTT PTLs and cancer delivery against trajectories. Health boards provide monthly updates on their mitigation against delivery. While health boards did not deliver against targets at the end of the year, we continue to challenge them to provide evidence of mitigation and evidence to indicate they are managing any clinical risk that may arise from long delays. A National Planned Care Programme Board has been established and is targeting solutions for ophthalmology, orthopaedics and ENT. Ophthalmology Implementation Plan was issued in January 2015. Orthopaedic plan is currently in draft form. Monthly updates on actions against tier 1 priority areas including, RTT, USC and cancer requested from each health board indicating how they are addressing any slippage and actions they are taking to ensure performance improves. Evidence of delivery plans in the IMPTs for 2015/16 onwards are being reviewed and					

					challenged to demonstrate the health board's proposed plans to address both backlog reduction and achievement of targets in future years.						
13a **13b**	**If the pace of implementing the NHS 111 service, incorporating primary care Out of Hours, is not maintained or increased, and the financial and human resource not identified and secured, there is a risk that:** • the Ministerial commitment to deliver a pilot 111 service in ABMU in October 2015 will not be met and there would be reputational issues for the Minister, the Welsh NHS and Welsh Government. • The fragility within GP OOHs and A&Es would persist or increase, and • The opportunities to improve the co-ordination of unscheduled care services and support Primary Care investment would be lost. **The I.T architecture for 111 is the key enabler to an effective, safe high quality 111 service. If the proposed interim solution for the IT architecture is not secured, delivered and robustly tested before the 111 service pilot goes live in October 2015 then there is a risk that:** • the proposed model will be undeliverable;	4	5	20	ABMU has agreed to be the pilot site for the first phase of roll out in October 2015 and has a local implementation board; the lead NHS Chief Executive has provided assurance to the Minister that the timeframe is achievable. Project Director appointed 5 January 2015 and other project support arrangements developed. The Implementation Board meeting monthly since Nov 2014. Weekly updates/meetings between the project lead and officials. Demand projections have been delivered by ABCi in March. The project has identified six work-streams to cover the implementation and areas of risk: 1. Governance; 2. Workforce; 3.Model; 4.Service Development, Standards and dataset; 5. Stakeholder engagement/Communications; 6. Technical. Additional specialist support for the project has been secured which will also provide leadership for the work-streams. NWIS has recently committed to lead the Technical work-stream (additional impartial technical expertise needs to be made available) (see risk 13b)	4	4	16	**Red** ↔	**Grey**	Simon Dean/ **NR** **NR**

	• there will be an adverse impact on other services.				Nominations for HB leads for both 111 and Directories of Services have been sought but the response has been poor and a reminder has been issued to Chief Executives. The Minister has agreed £200k funding in total to provide project support for 14/15 and 15/16 (awaiting formal submission). Deputy Minister is meeting the Project Director 27 April 2015. Full Project costings are being collated and agreed, while sources of funding are being identified and agreed. Progress has been made in discussions with existing suppliers to develop an interim Patient Management System. Positive progress has been made in bringing both suppliers to the table. However any further exploration and/or development is likely to be subject to charging. It is hoped that colleagues in NHS24 and 111 West Midlands will be in a position to share their systems specifications to enable more rapid progress towards developing full specification for procurement. Detailed plans to implement the telephony solution are progressing well. The assessment process to select the Host organisation has continued. It is anticipated that a recommendation will be communicated to the Minister by end of April to enable a decision by mid-May. Without a host organisation we are unlikely to deliver and test robustness of the national service. An evaluation project and benefits realisation criteria/measures are being agreed.					

14	**Medical Contracts:** If the Welsh Government does not align its strategy on the future consultant contract with England and NI, there is a risk that Wales will be left behind with an outdated and unaffordable contract that does not offer best value for the Welsh NHS. Equally it will not attract the top talent into Wales.	**4**	**5**	**20**	NHS Employers/WG have been represented at the UK contract discussions however the negotiations have collapsed for consultants and Drs in Training. Oral evidence was given to the DDRB on 9th March, presenting the case for contract reform and 7 day services. The DDRB will report after the UK May election, at which point Wales, England and NI will need to determine a strategy for contract reform if negotiations are not reinstated.	**4**	**4**	**16**	**Red** ↔	**Black**	**NR**
15	**NHS Workforce Planning – Capacity and Capability** If messages around the need for change are not supported by guidance and support for workforce planning, then there is a risk that LHB's and Trusts will not develop consistent and detailed models in line with the required service changes. This would lead to a focus on short term management within the existing financial envelope by local health boards and trusts and the actions necessary for longer term sustainability not being identified. This risk being realised would play a contributory factor in the annual IMTP submissions produced by NHS organisations not being up to the required standard and the NHS in Wales no longer being affordable in the long term	**5**	**4**	**20**	Discussions with Head of Workforce Modernisation & Strategy (WEDS) took place in 2014/15 to determine the level of support currently offered to the service (as is picture). As a result arrangements have been put in place to establish closer relationships between WG and WEDS in order to maximise the benefit of new initiatives, including a network of workforce planners across the service. The requirements of Directors of Workforce and OD are also being factored into work being taken forward by the Planning Division, with the support of WEDS and Academi Wales, to increase the professional focus of planning in NHS Wales. The WEDS forward work programme is currently being considered and a number of items relating to workforce planning are to be included. Areas to be covered are Workforce Planning Skills Development, Horizon Scanning and All Wales Workforce Modelling, Application & Development of Workforce Planning Approaches and Workforce Intelligence & Analysis. Once the work programme has been agreed, and an as is picture of workforce planning capacity an capability established, a paper providing an	**4**	**4**	**16**	**Red** ↑	**Black**	**NR**

					overview of the current situation along with a forward plan will be drafted for agreement by the Director W&OD and discussion by EDT (Qtr 2).						
16	**Recruitment and Workforce Planning** If CAFCASS Cymru is unable to recruit to vacant posts, then this will impact negatively on the delivery of our statutory functions because of staff shortages. This will lead to: • An increase in safeguarding risks/concerns for children/young people involved in Family proceedings • professional staff (CC Family Court Advisers) undertaking basic administrative duties in the absence of being able to recruit business support staff • Significant reputational risks to the Minister and WG if CAFCASS Cymru is placing children/young people at risk due to delays in the timely allocation of cases referred by the Family Court. The age profile of the organisation poses a significant risk due to the projected turnover of staff. If CAFCASS Cymru does not	**5**	**5**	**25**	Present a robust business case(s) as required to the Perm Sec to request permission to advertise externally to fill business critical posts which cannot be filled through internal recruitment. The Permanent Secretary has not approved the business case for the external recruitment of Business Support staff We will continue the process of checking Solutions, People Seeking Moves Board and internal recruitment. Working with HR Business Partners, regularly review the age profile of specialist practitioner posts to monitor and plan for staff changes, and to accurately inform business cases for recruiting replacement staff. An Action Plan in place which considers PMR related information, future planning, career profiling and partial retirement plans.	**5**	**3**	**15**			Gillian Baranski

	consider and forward plan for succession arrangements and maintaining workforce capacity, then this could lead to staff shortages and a loss of knowledge and expertise when significant groupings of staff leave.										
17	**Quality and Safety** If we do not learn the lessons from Trusted to Care and other inquiries and reviews, WG will be open to serious reputational damage. If we do not effectively collate, disseminate and share learning on patient-related serious incidents and investigations then this can adversely affect patient safety. If we do not identify and manage the service areas considered to be high risk or those under political scrutiny, where stakeholders are lobbying intensely or where the services themselves are not delivering, or a combination of these factors, then there is a risk of reputational damage.	**5**	**4**	**20**	**Trusted to care** steering group with independent members established to ensure report recommendations met and learning from spot checks are taken forward. Meeting monthly. **Welsh Government Oversight** - strengthened Quality and Safety Assurance Group chaired by the Deputy Chief Medical Officer which meets monthly to oversee information and intelligence about the performance of NHS organisations. This enables interaction and if necessary escalation with Health Boards and Trusts. A quality dash board is now in place for each NHS organisation which continues to mature. **Escalation** - A protocol for sharing of information and escalation of issues between WG/HIW and WAO has been agreed, published and commenced 1 April 2014. **Serious incident reporting framework** being reviewed to increase focus on timely investigation and learning through the development of patient safety alerts/ notices and process to track compliance. New process in place to disseminate learning through the development of **patient safety alerts/ notices and process to track compliance.** **Series of reviews undertaken during 14/15** (Concerns/mortality/HIW) recommendations will	**5**	**3**	**15**	**Red** ↔	**Grey**	Ruth Hussey / NR Janet Davies

					now be taken forward to improve quality assurance and learning mechanisms.						
18	**Delivery of GP Access (Top 5 Government Commitment)** If the PfG commitment to deliver access to planned care from GP services on a Saturday morning is not delivered by 2016, then there would be significant reputational risk to the government.	**5**	**4**	**20**	While the new national primary care plan reinforces the PfG commitments to access to GP care for working people after 6.30pm and on Saturday mornings, the plan also seeks to rebalance expectations. It emphasises people can expect to have access to the right care at the right time from the right person, close to home. While the plan recognises the leading role of GPs, they deliver care as an integral part of a multi professional, integrated primary care team where professionals deliver prudent care using their time and expertise to best effect. The plan also reinforces the importance of integration between in and out of hours GP services. Agreed changes to the GP contract for 2015/16 and 2016/17 include a commitment from GPC Wales to work with LHBs to identify ways to improve access to GP services, in particular, to improve patient experience in accessing services within core hours and the first point of contact experience, to highlight principles of good practice and to communicate to patients the benefits of My Health on Line and on line appointments. Agreement also reached to make it a contractual requirement during 2016/17 for practices to offer on line appointments and repeat prescriptions. A pilot initiative, where patients may seek treatment at a designated GP practice as an Out of Area Non-registered day patient has been developed. Health Boards have confirmed 14 pilot GP practices in Swansea, Cardiff, Newport and Wrexham will be participating. The scheme is has been operational since December 2014.). Tier 1 targets being rolled through to 2015-16	**4**	**4**	**12**	**Amber** ↔	**Grey**	Ruth Hussey / **NR**

					Delivery Framework. Regular ongoing discussions with LHB Directors of Primary, Community & Mental Health and key stakeholders including BMA/GPC Wales. GP access will be monitored through LHB Heads of Primary Care bi monthly meetings from April 2015. Key access statistics being measured include tier 1 targets and the PFG enhanced access after 6.30pm. . Officials have secured assurance from each LHB that patient reasonable need has been robustly assessed and where need has been assessed there is an expectation that extended opening times are being provided. Officials will be monitoring access after 6.30pm bi monthly through LHBs Heads of Primary Care. Improving access to appointments with a GP on a Saturday morning via the out of hours centres is currently being developed for 2015/16.						
19	**Supply of Suitably Qualified Workforce** If we do not have appropriate arrangements in place to commission and train an appropriate level of healthcare workers, then the NHS workforce will not have the correct skills to deliver against under the delivery models required for a prudent healthcare approach.	**4**	**4**	**16**	The Healthcare Professional Education Investment (HPEI) Review has been commissioned to con explore the nature and approach to education and training, including whether the current level and target of this investment is appropriate. The review panel will deliver their final report to the Minister for Health and Social Services shorty. Education commissioning numbers are agreed through a collaborative approval between WED's and local health boards. Additional information about Wales wide initiatives is also fed into the process, i.e. Flying Start. Regular monitoring meetings with the Deanery and Workforce Education Development Group to	**4**	**3**	**12**	**Amber ↔**	**Grey**	**NR**

					monitor delivery against the funding agreements in place SLA and funding agreements. Regular meetings with NHS Workforce Directors and medical workforce managers. Routine (monthly) monitoring and reporting of all medical vacancies.						
LEGISLATION											
20	**Welsh Government Legislation (Current Assembly Bills, Acts and future legislation)** **Welsh Government Legislation (Current Assembly Bills, Acts and future legislation)** If we do not deliver DHSS legislation announced by the First Minister in the Welsh Government Legislative Programme/plan adequately for potential future legislation, then the relevant manifesto commitments will not be fulfilled causing extreme political and reputational damage to the Welsh Ministers. **Assembly Bills** • Public Health Bill. Overall Bill delivery timetable tight; • implications of Kirsty Williams AM Safe Nurse Staffing Levels Private Members Bill. **Implementation of Acts** • Human Transplantation	**5**	**4**	**20**	Resources attached to Bills regularly reviewed and Central Legislation Support Team staff deployed to those Bills with the greatest priority need. Additional CLST support provided for Regulation and Inspection of Social Care Bill; Public Health Bill and tobacco legislation work; MUPA Bill delivery and legislation policy work; and Safe Nursing Levels PMB. Reporting progress and key issues regularly to EDT so that where required collective solutions can be found. CLST attendance at Bill/Act implementation Project Boards and wider WG colleagues to provide support and monitor progress. Bi-monthly meetings of DHSS Joint Policy Integration and Legislation Assurance Programme Board, with Assembly Legislation Managers Monitoring meetings in between. Regular progress reported to Implementation Project Boards.	**5**	**2**	**10**	**Amber** ↔	**Grey**	Jo Jordan / **NR**

	(Wales) Act 2013, which is coming into force on 1 December 2015; • Social Services and Well-being (Wales) Act 2014, which is to come into force in April 2016. **Future legislation** • Publication of a Green Paper on potential future legislation on Quality of NHS care/NHS governance/NHS functions; • Public Health No. 2 Bill.				Additional CLST support also provided to Human Transplantation Act and Social Services and Well-being Act implementation. LF on Green Paper on potential future legislation on Quality of NHS care/NHS governance/NHS functions setting out suggested shape and content of the Bill/Bills submitted to the Minister. Green Paper being progressed in light of Minister's response.						
POLICY											
21	**Resilience** If DHSS fails to recognise the potential for emergencies, including the spread of a major infectious disease or other major risks, CBRN threats and major incidents resulting in a lack of health preparedness to respond effectively, then there is a risk to the health of the population, NHS services and DHSS/WG reputation and credibility **NB:** Pandemic Flu is the top national risk. Expert opinion is that, regardless of the 2009 H1N1 pandemic, there is a high probability of another influenza pandemic where half the population could experience symptoms more severe than the H1N1 Virus. H5N1 and H7N9 avian influenza viruses are causing human fatalities and have pandemic potential should either	**5**	**3**	**15**	Maintaining the DHSS Health Resilience Branch to address health resilience and contingency arrangements, underpinned by professional advice and support. Establishing health countermeasures arrangements that are precautionary and proportionate to national risk assessments. DHSS Arrangements for Responding to Emergencies maintained and a health presence provided in ECCW during significant incidents, such as fire strikes, fuel shortages. Maintaining current NHS emergency planning guidance and UK, Wales and NHS emergency planning networks. Supporting and co-ordinating NHS training and exercise initiatives. Engaging in the Prevent, Protect and Prepare strands of CONTEST. Annual assessment of NHS emergency preparedness undertaken.	**4**	**3**	**12**	**Amber** ↔	**Grey**	Ruth Hussey / Irfon Rees / **NR**

	virus change to be more easily transmitted between humans. The Middle East Respiratory Syndrome Coronavirus is also causing concern because it has a high fatality rate and human transmission has been demonstrated in certain circumstances. Ebola is also of on-going concern.										
22	**Statutory Equality, Welsh Language and UNCRC Impact Assessments** If we do undertake impact assessments nor consider their implications in policy development for Equality, Welsh language and United Nations Convention for the Rights of the Child and raise staff awareness of the Equality Act 2010, the Welsh Language Act 1993 and the Welsh Language Measure 2011 then we will not meet statutory requirements within Health & Social Services and face external challenge from the Welsh Language Commissioner's Office and the Equality and Human Rights Commission. We will be unable to do this effectively if the DHSS policy leads do not contribute to and engage with the DHSS Joint Policy Integration and Legislation Assurance Programme Board and policy log as the central mechanism to support this.	**4**	**4**	**16**	Policy Log compiled and updated bi-monthly to identify key forthcoming polices which are likely to require analysis of their impact on equality groups and WL. DHSS Joint Policy Integration and Legislation Assurance Programme Board or Sub-Group used to challenge whenever policies meet our statutory requirements. All policy papers being presented to EDT for consideration now need to demonstrate that policy compliance issues have been considered. Guidance for staff on DHSS policy compliance arrangements issued on 27 Feb 2014. Ongoing support offered by DHSS Equality lead and DHSS Central Legislation Support Team. Regular advice given by Equality Manager to policy leads in ensuring equality characteristic are documented in policy and advice given by WLPU on compliance with the Welsh language scheme/standards. New Welsh Language Impact Assessment in place (mandatory SF requirement). Staff are reminded regularly about Eliesha one	**4**	**3**	**12**	**Amber** ↔	**Grey**	Jo Jordan / Tracey Breheny

					day training courses for EIA. Periodic bespoke DHSS EIA awareness raising/ training sessions organised by the DHSS Equality lead.						
23	**Ebola preparedness in Wales** If DHSS fail to provide effective leadership and co-ordination to the preparedness response to the Ebola Outbreak in West Africa there are risks to the health of suspected Ebola patients and NHS Wales' healthcare workers; to public confidence in Health Services in Wales; relationships with the UK Government and other devolved administrations. Failure to provide effective leadership and co-ordination has the potential to damage Welsh Government's reputation and credibility, nationally and internationally	**5**	**3**	**15**	Continued close working relationships with Public Health Wales, Local Health Boards, Local Authority and other LRF partners. Contingency and resilience arrangements in place within DHSS and single point of contact established via health protection mailbox. Regular communications with the service including engagement with key clinical and public health leads. Continued collaboration with the other UK Governments through regular meetings at both ministerial and official level. Agreed communication plans to respond promptly to media enquiries/reports. Regular internal briefings to ensure both Ministers and senior officials across the organisation are fully engaged and updated on the response. Hold exercises to test response mechanisms within Wales and as a part of the UK-wide response.	**5**	**2**	**10**	**Amber ↔**		Ruth Hussey/ Irfon Rees

Notes:

Col (1) Reference number.

Col (2) Risk description including cause and consequence in the "If" ….. "then" format.

Col (3) Inherent risk score - Exposure arising from a risk before any action has been taken to manage it.

Col (4) Include measures already in place and future actions if known. Only actions in place can be used in determining the residual score.

Col (5) Residual risk score - Assessment of risk with control measures implemented.

Col (6) RAG status – Red, Amber, Green (Red 15-25, Amber 4-14, Green 1-3). Change in residual score = indicate whether the score is new or has move up, down or stayed the same since the last EDT review. Use arrow symbols to record this.

Col (7) Proximity – Reflect the possible timing of the risk materialising i.e is the threat / opportunity stronger at a particular time using the

scale below (use words or shading): **Black** - Short term 0-3 months; Grey - Medium term 4-12 months; Blue - Long Term 13 months+
Col (8) Risk Owner – Named EDT member and / or Lead Official.

I = Impact (An assessment of the consequences of the risk materialising, scored 1-5)
L = Likelihood (An assessment of the probability of a risk materialising, scored 1-5)
O = Overall Score (Impact x Likelihood)