Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

HEALTH & SAFETY ASSURANCE COMMITTEE
PWYLLGOR ANSAWDD IECHYD A DIOGELWCH

DYDDIAD Y CYFARFOD: DATE OF MEETING:	06 July 2021
TEITL YR ADRODDIAD: TITLE OF REPORT:	Corporate Risks Assigned to Health & Safety Assurance Committee (HSAC)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Director of Operations Mandy Rayani, Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Wilson, Board Secretary Charlotte Beare, Head of Assurance and Risk

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

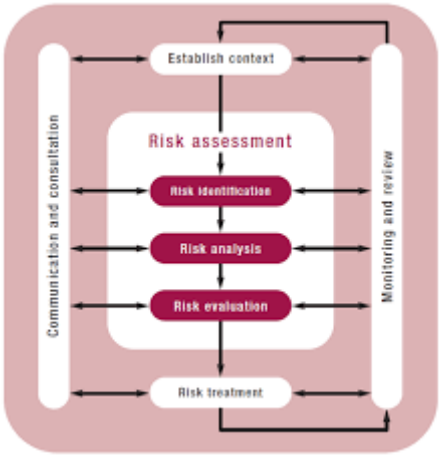
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Health & Safety Assurance Committee (HSAC) is asked to request assurance from Executive Directors that the corporate risks in the attached report are being managed effectively.

Cefndir / Background

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



(Risk Management Process, ISO 31000)

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

- Seeking assurance on the management of principal risks included in the Board Assurance Framework (BAF)/ Corporate Risk Register (CRR) and providing assurance

to the Board that risks are being managed effectively, reporting areas of significant concern - for example, where risk appetite is exceeded, lack of action, etc.

- Reviewing principal and operational risks over tolerance and, where appropriate, recommending the 'acceptance' of risks that cannot be brought within Hywel Dda University Health Board's (HDdUHB's) risk appetite/ tolerance to the Board.
- Providing annual reports to Audit & Risk Assurance Committee (ARAC) on the effectiveness of the risk management process and management of risks within their remit.
- Identifying through discussions any new/ emerging risks and ensuring that these are assessed by management.
- Signposting any risks outside their remit to the appropriate UHB Committee.
- Using risk registers to inform meeting agendas.

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

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

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

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

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

Asesiad / Assessment

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

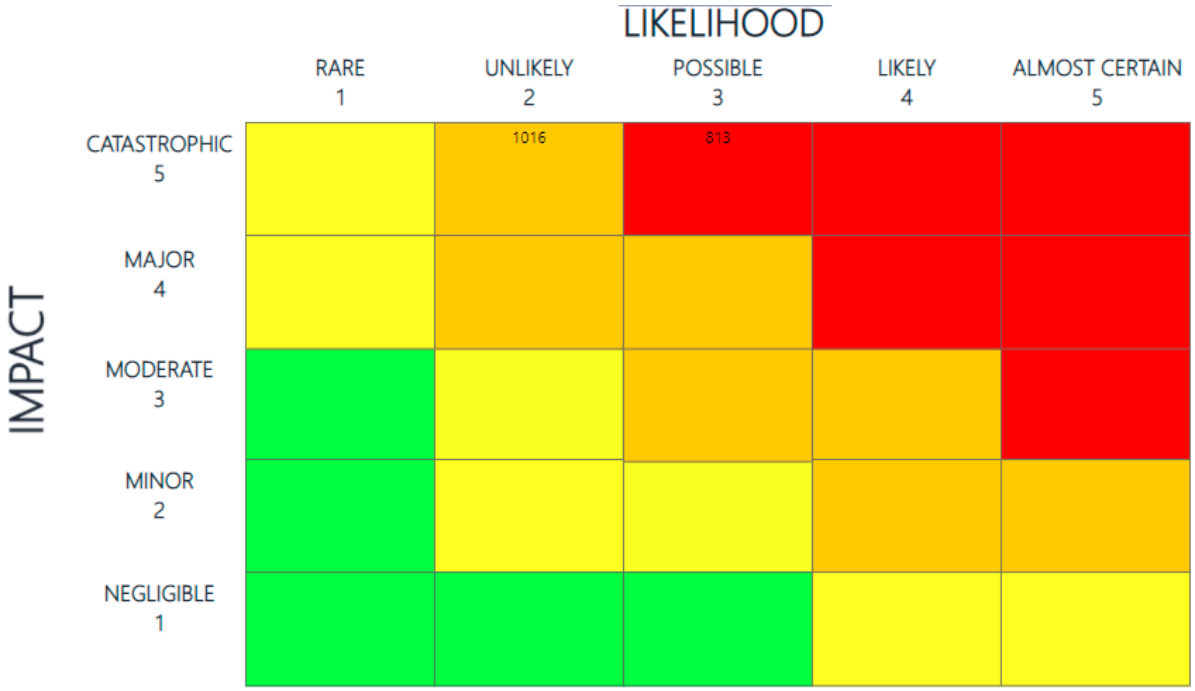
The Terms of Reference state that the Committee will:

5.1.3 Provide assurance that risks relating to health, safety, security, and fire are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate), and provide assurance that effective risk assessments are undertaken and addressed.

There are 2 corporate risks aligned to HSAC (out of the 21 that are currently on the CRR), as the potential impacts of these risks relate to the health and safety of patients, staff and visitors.

A summary of these 2 corporate risks can be found at Appendix 2. Each risk has been entered onto a '*risk on a page*' template which includes information relating to the strategic objective, controls, assurances, performance indicators and action plans to address any gaps in controls and assurances.

The heatmap below includes the risks currently aligned to HSAC and has been obtained from the Risk Performance dashboard. The information reflects the risk information extracted from Datix as of 10th June 2021 based on the 2 corporate risks assigned to the HSAC.



Below is a summary of changes since the previous report to HSAC (17th February 2021):

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

Note 1 – New/ Escalated risks

Since the previous report, no new risks have been added to the CRR and aligned to HSAC.

Note 2 – Closed/ De-escalated risks

No risks have been de-escalated from corporate level since the previous report.

Note 3 - No change in risk score

There has been no change in the following risk scores since these were reported to the previous HSAC meeting.

Risk Reference & Title	Previous Risk Report to Board (LxI)	Risk Score Feb-21 (LxI)	Date of Review	Update
Risk 813 – Failure to fully comply with the requirements of the Regulatory Reform Order (Fire Safety) 2005 (RRO)	3x5=15	**3x5=15**	14/06/21	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. The UHB also needs to 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 September 2019 for Withybush General Hospital and Glangwili General Hospital on 17th April 2020.
Risk 1016 - Increased COVID-19 infections from poor adherence to Social Distancing	2x5=10	**2x5=10**	25/01/21	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. The risk has been reduced to reflect the staff and public's positive response to social distancing measures as well as the HSE informal feedback and lack of enforcement from its visit on 20th January 2021.

Argymhelliad / Recommendation

The Health & Safety Assurance Committee is asked to seek assurance that:

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

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

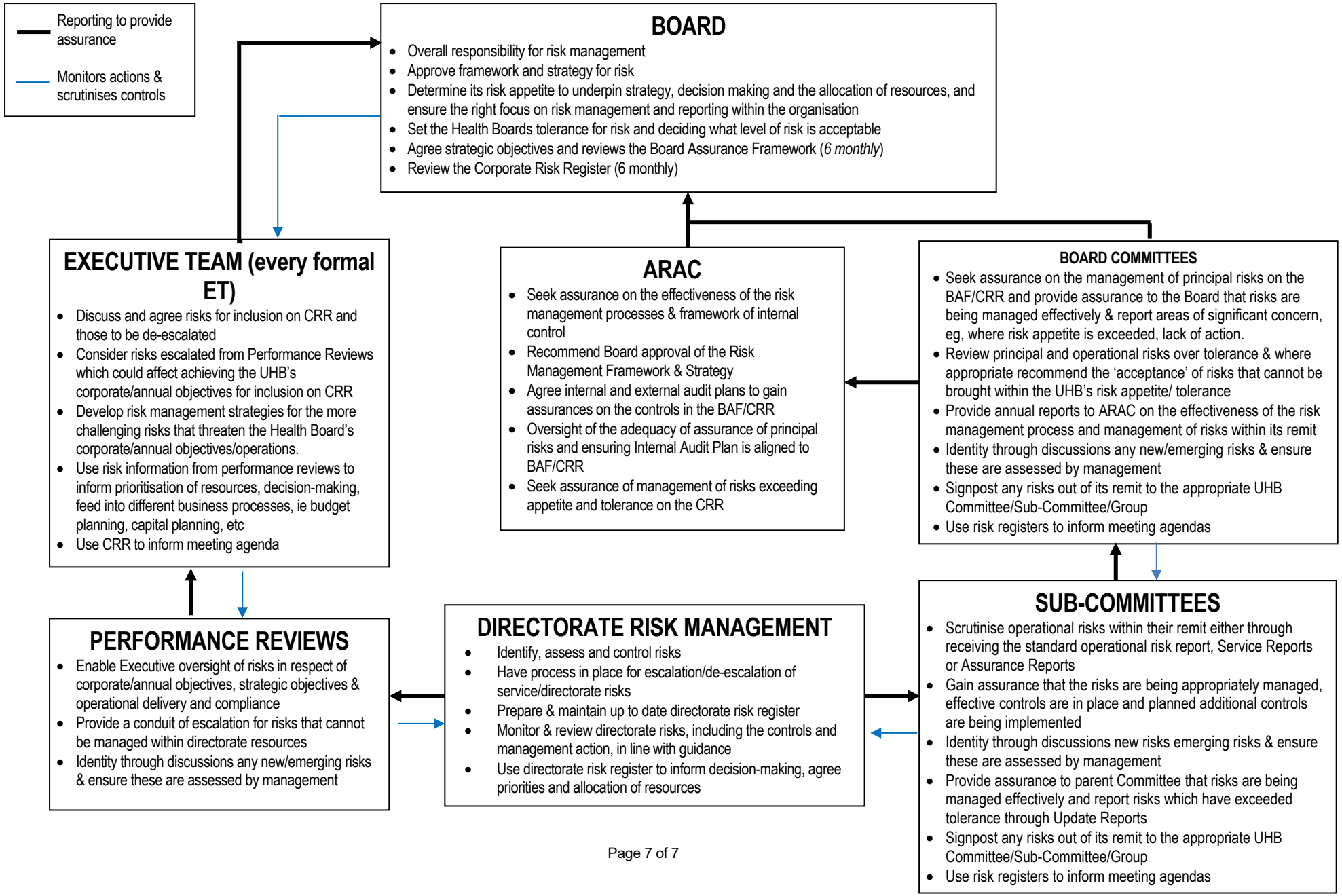
Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.1.3 Provide assurance that risks relating to health, safety, security, and fire are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate), and provide assurance that effective risk assessments are undertaken and addressed.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Contained in the report
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Nodau Gwella Ansawdd: Quality Improvement Goal(s):	All Quality Improvement Goals Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Underpinning risk on the Datix Risk Module from across the UHB's services reviewed by risk leads/owners
Rhestr Termau: Glossary of Terms:	Current Risk Score - Existing level of risk taking into account controls in place Target Risk Score - The ultimate level of risk that is desired by the organisation when planned controls (or actions) have been implemented Tolerable risk – this is the level of risk that the Board agreed for each domain in September 2018 – Risk Appetite Statement
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd Iechyd a Diogelwch: Parties / Committees consulted prior to Health and Safety Assurance Committee:	Not applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from report however impacts of each risk are outlined in risk description.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from report however impacts of each risk are outlined in risk description.
Gweithlu: Workforce:	No direct impacts from report however impacts of each risk are outlined in risk description.
Risg: Risk:	No direct impacts from report however organisations are expected to have effective risk management systems in place.
Cyfreithiol: Legal:	No direct impacts from report however proactive risk management including learning from incidents and events contributes towards reducing/eliminating recurrence of risk materialising and mitigates against any possible legal claim with a financial impact.
Enw Da: Reputational:	Poor management of risks can lead to loss of stakeholder confidence. Organisations are expected to have effective risk management systems in place and take steps to reduce/mitigate risks.
Gyfrinachedd: Privacy:	No direct impacts
Cydraddoldeb: Equality:	Has EqIA screening been undertaken? No Has a full EqIA been undertaken? No

Appendix 1 – Committee Reporting Structure



Risk Ref	Risk (for more detail see individual risk entries)	Included on BAF	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Jun-21	Trend	Target Risk Score	Risk on page no...
813	Failure to fully comply with the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO)	3	Carruthers, Andrew	Statutory duty/inspections	8	3×5=15	3×5=15	→	1×5=5	3
1016	Increased COVID-19 infections from poor adherence to Social Distancing	*	Rayani, Mandy	Safety - Patient, Staff or Public	6	2×5=10	2×5=10	→	2×5=10	8

Assurance Key:

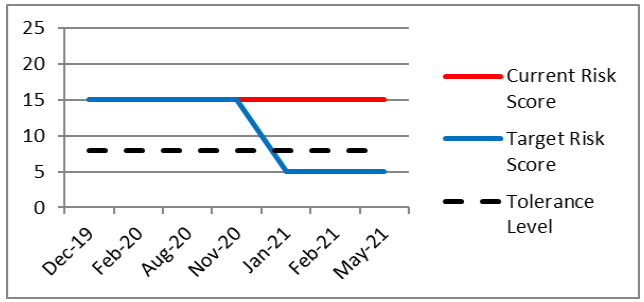
3 Lines of Defence (Assurance)		
1st Line	Business Ma	Tends to be detailed
2nd Line	Corporate O	Less detailed but
3rd Line	Independen	Often less detail but truly

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

NB Assurance Map will tell you if you have

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

Date Risk Identified:	okt-19			**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	jun-21
Strategic Objective:	3. Striving to deliver and develop excellent services			**Lead Committee:**	Health and Safety Assurance Committee	**Date of Next Review:**	jul-21
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/affect on the safety of patients, staff and general public, HSE investigations and further fire brigade enforcement, fines and/or custodial sentences, adverse	**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):	1×5=5		
				Tolerable Risk:	8		
Does this risk link to any Directorate (operational) risks?				**Trend:**	⇔		



Rationale for CURRENT Risk Score:	**Rationale for TARGET 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.	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	**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	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.
	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.	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~~ 30/06/2021	Additional surveys across the estate are being scheduled to assess the scale of fire backlog. 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.

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.	Evans, Paul	~~31/03/2020~~ ~~30/06/2020~~ ~~28/01/2021~~ 30/06/2021	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 June 2021
Undertake a review of fire training to address identified shortfall in training provision and site fire management responsibilities.	Evans, Paul	~~31/03/2020~~ ~~31/12/2020~~ ~~20/01/2021~~ 30/06/2021	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 71%, which is not considered a concern at this stage and will now improve following the e-learning implementation. This will be reviewed monthly.

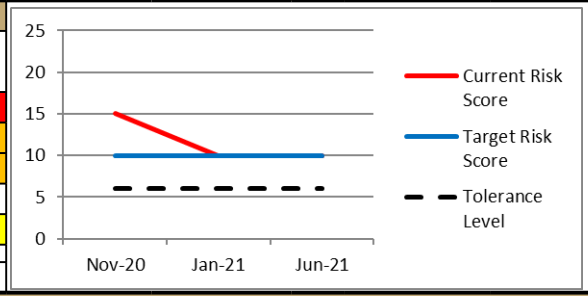
						Clarify responsibilities and identify management ownership for fire safety to facilitate an improved fire safety management culture across all sites. Revised date agreed as part of fire safety governance review.	Evans, Paul	~~30/09/2020~~ 31/01/2021 30/06/2021	General Managers (GMs)and Responsible Persons 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	Completed	CAD officer now in post for West region and started his work programme. CAD officer for East commencing in Feb 2021.
						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	Completed	An update template has already been produced and discussed amongst the fire and operational maintenance teams. The compliance paper is tabled at all Fire Safety Group meetings. This is now being taken forward as the model for the department. Next review of this is on the 27th Jan 2021.
ASSURANCE MAP						**Gaps in ASSURANCES**			
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**	**Control RAG Rating (what the assurance is telling you about your controls**	**Latest Papers (Committee & date)**	**Identified Gaps in Assurance:**	**How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
Maintain 95% high risk PPM compliance. Maintain a zero	Bimonthly review of outstanding actions from fire risk assessments	1st			IA Fire Precautions Report - ARAC Jun18	General site management checks/walkarounds on all sites	Responsibilities of site management to undertake routine workarounds to be implemented level 5 training	Evans, Paul	~~30/09/2020~~ ~~31/12/2020~~ ~~20/03/2021~~ 30/06/2021	Site management training (level 5) training for all responsible managers which will be introduced by March 21 - delay due to Covid 19 .

number of outstanding fire risk assessments.	Site Fire wardens reporting fire safety issues	1st			Fire Action Update - H&SC - May20				
	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:**	jun-21
Strategic Objective:	5. Safe, sustainable, accessible and kind care	**Lead Committee:**	Health and Safety Assurance Committee	**Date of Next Review:**	aug-21

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/affect 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.

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):	2×5=10
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	⟷



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

Rationale for CURRENT Risk Score:

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	**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 # Personal protective equipment (PPE) # Reducing room capacities to allow for social distancing # Use of IT systems e.g. Microsoft Teams to reduce the need for face to face meetings # Reduction in travelling between sites # Home working being encouraged where possible # Accommodation facilities for medical staff have been risk assessed and alterations made in line with social distance measures. # Additional accommodation has been considered at Trinity St David's College University campus to assist with social distance arrangements. # SD information on patient appointment letters, leaflets # Meet and greet staff at main entrances # One way pedestrian walkways # Controlled access into Surgical wards and theatres # Hospital bed screens installed in identified wards in order to maximise inpatient capacity and minimise bed losses # Safety monitoring forms and routine audit process in place to monitor compliance. # Additional accommodation in Trinity St David's Campus to improve social distancing. # Patient visiting arrangements recently updated including agreed timeslots and management arrangements.	If staff, visitors or patients do not adhere to the social distance guidance or use the 'Key Control' measures provided. Staff returning to work on sites may lead to a reduction to the availability of staff room and changing facilities as these spaces return to their original use. Longer term working from home/agile working will need further consideration for ensuring compliance with DSE Regulations.	Replace floor signs due to wear and tear	Harrison, Tim	31/07/2021	Work underway
		Increase screens in outpatient areas in GGH to provide additional protection for patients whilst maintaining capacity	Davies, Damian	31/07/2021	Work is underway.
		Information messages to be included on telephone networks to remind patients of the need to socially distance	Hackett, John	31/07/2021	Work is underway.
		Review current home working guidance and request an update from the Agile/Homeworking Group regarding compliance with the DSE Regulations and Work Equipment Regulations.	Harrison, Tim	30/09/2021	Guidance is under review.

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								
	HSE visit 20/01/21 reveiwed social distancing measure as part of their reevaluation of existing improvement notices - final report received - notice of contravention at BGH. Issues addressed	3rd								

RISK SCORING MATRIX

Likelihood x Impact = Risk Score

Likelihood	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	This will probably never happen/recur (except in very exceptional circumstances).	Do not expect it to happen/recur but it is possible that it may do so.	It might happen or recur occasionally.	It might happen or recur occasionally.	It will undoubtedly happen/recur, possibly frequently.
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
	* time-framed descriptors of frequency				
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	**(0-5%*)**	**(5-25%*)**	**(25-75%*)**	**(75-95%*)**	**(>95%*)**
	*used to assign a probability score for risks related to time-limited or one off projects or business objectives.				
Risk Impact Domains	**Negligible - 1**	**Minor - 2**	**Moderate - 3**	**Major - 4**	**Catastrophic - 5**
Safety of Patients, Staff or Public	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention.	Moderate injury requiring professional intervention.	Major injury leading to long-term incapacity/disability.	Incident leading to death.
	No time off work.	Requiring time off work for >3 days	Requiring time off work for 4-14 days.	Requiring time off work for >14 days.	Multiple permanent injuries or irreversible health effects.
		Increase in length of hospital stay by 1-3 days.	Increase in length of hospital stay by 4-15 days.	Increase in length of hospital stay by >15 days.	An event which impacts on a large number of patients.
			Agency reportable incident.	Mismanagement of patient care with long-term effects.	
			An event which impacts on a small number of patients.		
Quality, Complaints or Audit	Peripheral element of treatment or service suboptimal.	Overall treatment or service suboptimal.	Treatment or service has significantly reduced effectiveness.	Non-compliance with national standards with significant risk to patients if unresolved.	Totally unacceptable level or quality of treatment/service.
	Informal complaint/inquiry.	Formal complaint.	Formal complaint -	Multiple complaints/ independent review.	Gross failure of patient safety if findings not acted on.
		Local resolution.	Escalation.	Low achievement of performance/delivery requirements.	Inquest/ombudsman inquiry.
		Single failure to meet internal standards.	Repeated failure to meet internal standards.	Critical report.	Gross failure to meet national standards/performance requirements.
		Minor implications for patient safety if unresolved.	Major patient safety implications if findings are not acted on.		
		Reduced performance if unresolved.			
Workforce & OD	Short-term low staffing level that temporarily reduces service quality	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.

	(< 1 day).		Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
		Reduced performance levels if unresolved.	Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty.	Prosecution.
				Improvement notices.	Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
				Critical report.	Severely critical report.
Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage
					Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on

RISK MATRIX

IMPACT ↓	LIKELIHOOD →				
	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
	1	2	3	4	5
CATASTROPHIC 5	5	10	15	20	25
MAJOR 4	4	8	12	16	20
MODERATE 3	3	6	9	12	15
MINOR 2	2	4	6	8	10
NEGLIGIBLE 1	1	2	3	4	5

RISK ASSESSMENT - FREQUENCY OF REVIEW

RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	Extreme	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.	This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly.
8-12	High	Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Urgent action should be taken. A number of control measures may be required.	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	Moderate	Not normally acceptable. Efforts should be made to reduce risk, providing this is not disproportionate. Establish more precisely the likelihood & harm as a basis for determining the need for improved measures.	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	Low	Risks at this level may be acceptable. If not acceptable, existing controls should be monitored & reviewed. No further action or additional controls are required.	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.