Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	09 August 2022
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Corporate Risks Assigned to the Quality, Safety and Experience Committee (QSEC)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Director of Operations Phil Kloer, Medical Director
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

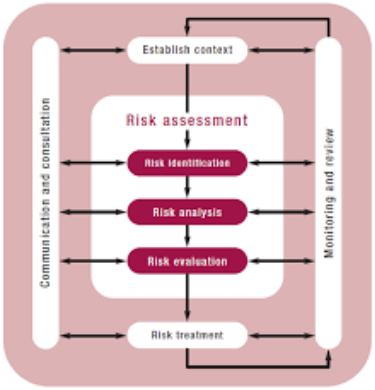
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Quality, Safety and Experience Committee (QSEC) is asked to request assurance from Executive Directors that the corporate risks in the attached report are being managed effectively.

Cefndir / Background

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



(Risk Management Process, ISO 31000)

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

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

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

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

- Associated with the delivery our annual plan; or
- Significant operational risks escalated that are of significant concern and require corporate oversight and management.

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

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

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

Asesiad / Assessment

The QSEC 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:

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

There are 7 risks currently aligned to QSEC (out of the 15 that are currently on the CRR) as the potential impacts of the risks relate to the safety of patients, quality of services and patient outcomes. A summary of corporate risks can be found at Appendix 2.

Each of these risks have been entered onto a 'risk on a page' template, which includes information relating to the strategic objective, controls, assurances, performance indicators and action plans to address any gaps in controls and assurances. These can be found at Appendix 3.

Changes since the previous report to QSEC (June 2022):
The Committee is requested to seek assurance from risk owners (Executive Directors) that each risk is being managed effectively and will be brought within the UHB tolerance.

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

Total number of risks	7	
New risks being reported	1	*See note 1*
De-escalated/Closed risks	0	
Increase in risk score ↑	0	
Reduction in risk score ↓	0	
No change in risk score →	6	*See note 2*

The 'heat map' below includes the risks currently aligned to QSEC:

HYWEL DDA RISK HEAT MAP

	LIKELIHOOD →				
IMPACT ↓	**RARE 1**	**UNLIKELY 2**	**POSSIBLE 3**	**LIKELY 4**	**ALMOST CERTAIN 5**
CATASTROPHIC 5					1027
MAJOR 4			1337	1340 684 129	1032 1349
MODERATE 3					
MINOR 2					
NEGLIGIBLE 1					

Note 1- New risks being reported
Since the previous report, 1 risk has been realigned to QSEC from the Operational Quality, Safety and Experience Sub-Committee (OQSESC).

Risk Reference & Title	Lead Director	Current risk score	Date	Rationale for Current Risk Score (Extracted from Datix)
1349 (Previously aligned to OQSESC) - Ability to deliver ultrasound services at WGH	Director of Operations	**5x4=20**	02/03/22	Service failure has already occurred with a likelihood of recurrence due to a lack of trained obstetric sonographers, particularly post March 2022 due to staff retirements. The service remains fragile despite

				being granted a locum for 2 months. In-sourcing an ultrasound service as at July 2022, with staff due to commence in post August 2022 for a rolling three month period, therefore a temporary solution due to funding.

Note 2 - No change in risk score
There have been no changes to any risk scores since they were reported at the previous meeting.

Risk Reference & Title	Executive Director	Previous Risk Score (Jun-22)	Current Risk Score	Date of Review	Update (Extracted from Datix)
1027 - Delivery of integrated community and acute unscheduled care services	Director of Operations	**5x5=25**	**5x5=25**	27/07/22	Levels of emergency demand continue to increase significantly. This is not related to COVID-19 *per se* but is driven by post pandemic demand and the broader impacts of COVID-19. Workforce deficits, handover delays, 4 and 12 hour performance and bed occupancy rates are all demonstrating significantly worrying trends. The indirect impact of COVID-19 has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. The situation remains at high levels of risk escalation across our acute sites on a daily basis.
1032 - Timely access to assessment and diagnosis for Mental Health and Learning Disabilities clients	Director of Operations	**5x4=20**	**5x4=20**	07/07/22	The service are experiencing significant waiting times as a result of increasing demand levels which are now back to pre-pandemic levels, compounding the backlog due to Covid restrictions. Due to increasing DNA ('did not attend') rates (c25%),

					ongoing recruitment challenges and increasing demand, there is an impact on the services' ability to see the same volume of service users as they were previously able to. The Integrated Autism Service (IAS) is funded on fixed term basis which can make staff retention challenging along with having to train new incoming staff. The risk score has recently increased due to compliance with WG targets which has deteriorated over recent months particularly in relation to part 1 of the measure for Children and Adolescent Mental Health Services (CAMHS).
684 - Lack of agreed replacement programme for radiology equipment across UHB	Director of Operations	**4x4=16**	**4x4=16**	19/07/22	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 Referral to Treatment time (RTT) target and impact to patients can include delays in diagnosis and treatment. Presently equipment downtime is frequently up to a week which can put significant pressures on all diagnostic services. Commissioning of agreed equipment has also been delayed as a result of COVID and this remains dependent external factors. Radiology has been

					asked to increase its service provision to other Directorates which it is currently unable to provide due to limitations on current equipment, however the demountable CT-scanner will provide much needed resilience at GGH. Whilst some contingency has been provided by a scanner in a demountable unit this does not provide full cover for acute care (not suitable for complex care). The risk score has been reduced to 16 reflecting that some equipment has been installed and is operational. A costed plan along with a rolling programme for the installation of additional equipment is in place. The next batch of equipment for replacement has been prioritised and identified, however no funding has yet been secured (for the financial year 2023/24). A paper has been prepared for the August Capital Sub-Committee meeting to discuss this programme further.
129 - Ability to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda patients	Director of Operations	**4x4=16**	**4x4=16**	30/05/22	The service will be completing a full review of this risk in August 2022. As of July 2022, fragility of service delivery continues. Rotas continue to be fragile, particularly at weekends. Any further absence on out of hours provision is likely to rapidly result in further deterioration of the current position.

					Availability of daytime work, relaxation of COVID-19 restrictions, will potentially lead to less availability of locums available for out of hours (OOH). The UHB currently has approximately 45 GPs (down from 100, 5 years ago) who regularly work the rotas, and an additional 10-20 GPs who only work bank holidays rotas due to enhanced rates. Advanced Nurse Practitioner (ANP) staff have reduced from 4 to 1 which covers 4 hours over a weekend period (0.1 WTE).
Risk 1340 - Risk of avoidable harm for HDUHB patients requiring NSTEMI pathway care	Director of Operations	**4x4=16**	**4x4=16**	03/08/22	NICE guidelines for Acute Coronary Syndromes (NG185) recommend 'coronary angiography (with follow-on PCI if indicated) within 72 hours of first admission (presentation) for people with unstable angina or Non-ST-Elevation Myocardial Infarction (NSTEMI) who have an intermediate or higher risk of adverse cardiovascular events' (recommendation 1.1.6). In support of this recommendation/target, we aim to identify and refer patients to Morriston Cardiac Centre for angiography within 24 hours of admission/ presentation. For 2021, the median wait between admission/presentation and angiography for HDUHB patients was 213.5 hours (8.9 days) and the median time between

					admission/presentation and referral was 39.5 hours. For context, the 2021 position is a deterioration from that maintained in 2019 where the PPH Treat and Repatriate Service supported a median admission/presentation to angiography wait of 120 hours (5 days) - this service was suspended at the outset of COVID-19 due to PPH site pressures. A comprehensive review of January to June 2022 performance data is scheduled for July 2022, at which point, the 'current risk score' will be reviewed.
1337 - Risk of reputational harm if the health board is found to have not managed the Llwynhendy TB outbreak as well as it could have	Medical Director	**3x4=12**	**3x4=12**	08/06/22	The outbreak investigation has been re-opened four times in response to new cases of Tuberculosis (TB), leading to a rapid internal review carried out by Public Health Wales (PHW) in 2019, to identify immediate actions and to make recommendations for the ongoing management of the outbreak. One of the key recommendations of the review was to commission, jointly with PHW, an external review of the outbreak and its management, to inform the approach to the management of TB disease in Wales. The Board agreed to proceed with the external review, the start of which was delayed by COVID-19. The review commenced in April 2022 with an anticipated completion

					during autumn 2022. The risk score has been reduced as no significant findings have been reported to date.

Argymhelliad / Recommendation

The Committee is requested to seek assurance that:

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

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

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.2 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Contained within the body of the report
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
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	9. All HDdUHB Well-being Objectives apply

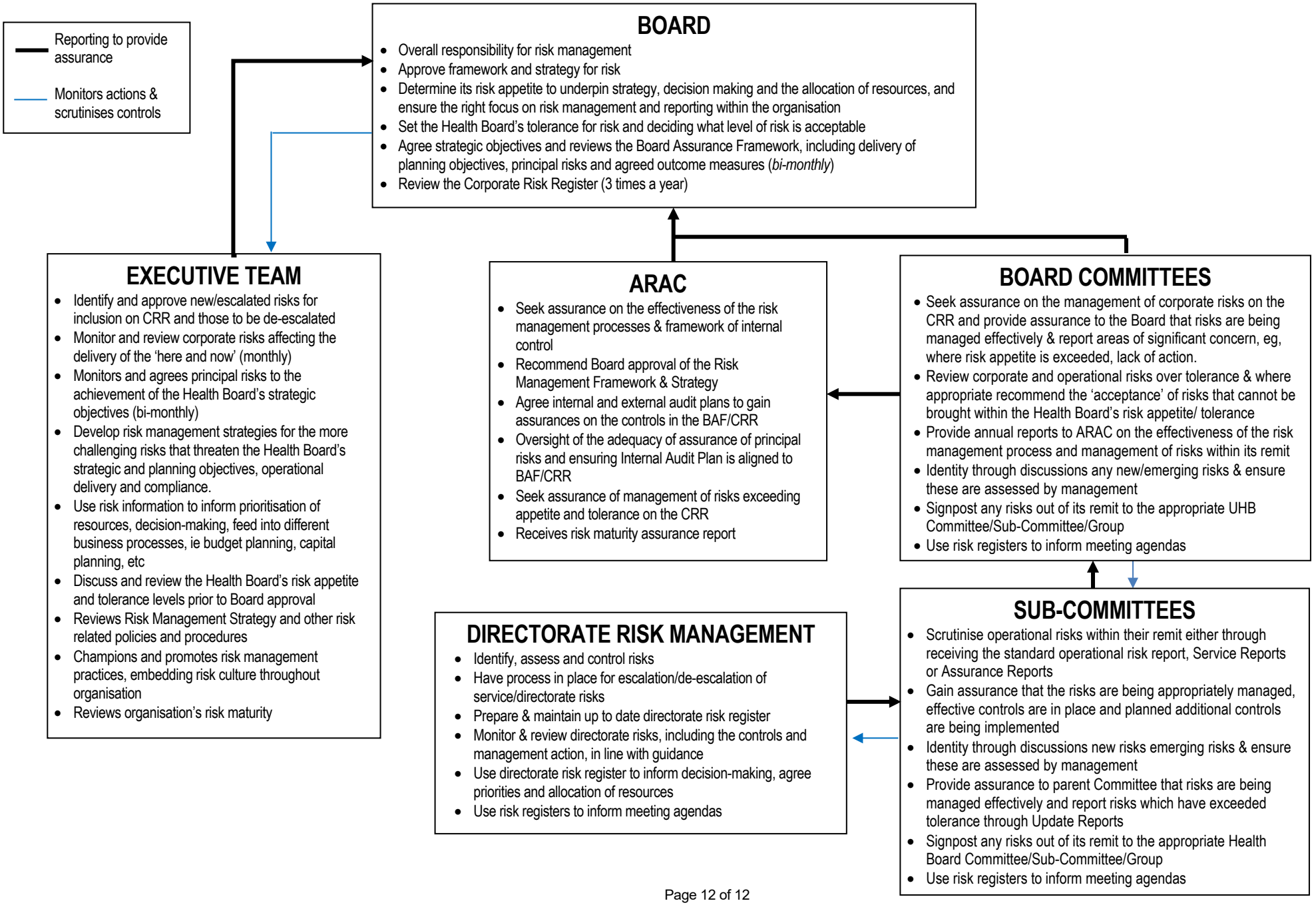
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Underpinning risk on the Datix Risk Module from across the UHB's services reviewed by risk leads/owners
Rhestr Termau: Glossary of Terms:	Current Risk Score - Existing level of risk taking into account controls in place

	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, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	N/A

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)	Risk Owner	Domain	Tolerance Level	Previous Risk Score	Risk Score Jul-22	Trend	Target Risk Score	Risk on page no...
1027	Delivery of integrated community and acute unscheduled care services	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×5=25	5×5=25	→	3×4=12	6
1032	Timely access to assessment and diagnosis for Mental Health and Learning Disabilities clients	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	5×4=20	→	3×4=12	11
1349	Ability to deliver ultrasound services at WGH	Carruthers, Andrew	Safety - Patient, Staff or Public	6	5×4=20	5×4=20	*Realigned from OQSESC*	3×4=12	17
684	Lack of agreed replacement programme for radiology equipment across UHB	Carruthers, Andrew	Service/Business interruption/disruption	6	4×4=16	4×4=16	→	3×4=12	21
129	Ability to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda patients	Carruthers, Andrew	Service/Business interruption/disruption	6	4×4=16	4×4=16	→	3×3=9 Accepted	24
1340	Risk of avoidable harm for HDUHB patients requiring NSTEMI pathway care	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×4=16	4×4=16	→	1×4=4	30
1337	Risk of reputational harm if the health board is found to have not managed the Llwynhendy TB outbreak as well as it could have	Kloer, Dr Philip	Adverse publicity/reputation	8	3×4=12	3×4=12	→	2×4=8	33

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 (< 1 day).	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.
			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 environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
Health Inequalities/ Equity	Minimal or no impact on our attempts to reduce health inequalities/improve health equity	Minor impact on our attempts to reduce health inequalities or lack of clarity on the impact we are having on health equity	Moderate impact on our attempts to reduce health inequalities or lack of sufficient information that would demonstrate that we are not widening the gap. Indications that we are having no positive impact on health improvement or health equity	Major impact on our attempts to reduce health inequalities. Validated data suggesting we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity

RISK MATRIX

	LIKELIHOOD →				
IMPACT ↓	**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.

Assurance Key:

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

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

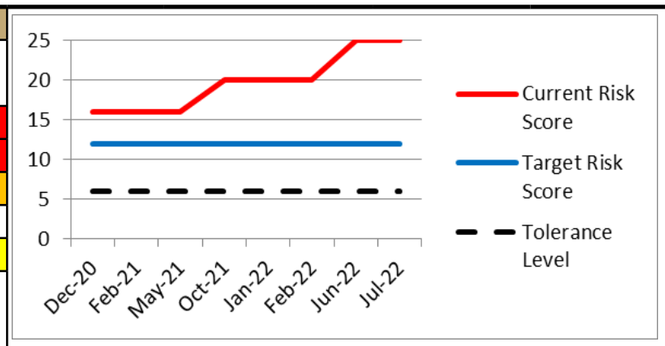
NB Assurance Map will tell you if

K - Control RAG rating	
LOW	Significant concerns over
MEDIUM	Some areas of concern ov
HIGH	Controls in place assessed
INSUFFICIENT	Insufficient information a

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jul-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Aug-22

Risk ID:	**1027**	**Principal Risk Description:**	There is a risk to the consistent delivery of timely and high quality urgent and emergency care. This is caused by significant fragility across the urgent and emergency care (UEC) system (acute, primary care, community and social care services), related to workforce compromise and increasing levels of demand and acuity. This is not related COVID-19 per se but is driven by post-pandemic demand and the broader impacts of COVID -19. This could lead to an impact/affect on the quality of care provided to patients, significant clinical deterioration, delays in care and poorer outcomes, increased incidents of a serious nature relating to ambulance handover delays and overcrowding at Emergency Departments and delayed ambulance response to community emergency calls, increasing pressure of adverse publicity/reduction in stakeholder confidence and increased scrutiny from regulators

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):	5×5=25
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6



Does this risk link to any Directorate (operational) risks?	1406, 1210, 750, 205, 86, 820, 232, 1298, 1281, 906, 1380, 1116, 878, 839, 1167, 1223, 111, 114, 199, 523, 136, 200, 1115, 1078, 572, 1295, 1231, 966, 967, 565,	**Trend:**	⟷

Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
Levels of emergency demand continue to increase significantly. This is not related to COVID-19 per se but is driven by post pandemic demand and the broader impacts of COVID -19. Workforce deficits, handover delays, 4 and 12 hour performance and bed occupancy rates are all demonstrating significantly worrying trends. The indirect impact of COVID-19 has resulted in increasing levels of frailty in the community and consequent demand on our 'front door'. The situation remains at high levels of risk escalation across our acute sites on a daily basis.	There is a significant challenge across the Urgent and Emergency Care system. The combined impact of the multi-faceted pressures which underpin this risk have led to an incremental increase in the overall level of pressure as reflected in deteriorating delays for ambulance handover, access to urgent and emergency care and delayed discharges. The extent to which these combined pressures impact upon the timeliness and quality of care provided is related to the overall availability of staffing resources on a daily / weekly basis, which in turn is influenced by increasing levels of staff sickness/absence.

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**
# Comprehensive daily management systems in place to manage unscheduled care risks on daily basis including multiple daily multi-site calls in times of escalation which include efficient handover from WAST into ED. # Reviews of patients admitted to surged areas to ensure patient acuity and dependency is monitored and controlled. # Surge beds continue as per escalation and risk assessment of site demand and acuity (where staffing allows). A daily review of the use of surge beds via patient flow meetings to facilitate step down of beds. # Discharge lounge takes patients who are being discharged. # The staffing position continues to be monitored on a daily basis in accordance with safe staffing principles and specifically reviews COVID-related absence and forward forecast. # Regular reviews of long stay patients over 7 days at weekly meetings across all hospital sites. # Regular advice on discharge planning and complex care management is provided to ward based staff through Community Discharge Liaison teams, Social services and the Long Term Care Team support. # Delivery plans in place supported by daily, weekly and monthly monitoring arrangements. # Escalation plans for acute and community hospitals (within limits of staffing availability). # Winter Plans developed to manage whole system pressures. # Joint workplan with Welsh Ambulance Services NHS Trust. # 111 implemented across Hywel Dda. # Transformation fund bids in relation to crisis response being implemented across the Health Board. # IP&C support for care homes to avoid outbreaks. # Ability to deploy Health Board staff where workforce compromise is immediately threatening to continuation of care for residents. # Care Home Risk & Escalation Policy to be applied to support failing care homes as required. # Domiciliary Care Risk and Escalation Policy approved by Integrated Executive Group and implemented across Health Board # COVID-19 IP&C Outbreak policy in place to coordinate management of infection outbreaks, led by site HoNs (supported by IP&C teams). # Integrated whole system, urgent and emergency care plan agreed. # Establishment of a Discharge to Assess (D2A) Group which reports to the Unscheduled Care group. # Establishment of a D2A Escalation Transfer panel which provides senior oversight of delays, assesses risk of the delay to the patient and organisation in terms of flow compromise # To optimise step down bed capacity in the community across care homes and community hospitals	# Fragility of Care Home Sector exacerbated by COVID related issues such as financial viability, staffing deficits, recruitment and retention of workforce. # Significant paucity of domiciliary care/social care availability due to recruitment and retention of staff # Nurse staffing availability to ensure safe levels of care as a consequence vacancies. # Post-COVID-19 fatigue is exacerbating workforce capacity and availability of bank and agency staff who would be available. # COVID-19 incidence continues to further exacerbated workforce capacity and availability of bank and agency staff who would be available. # Inability to offload ambulances to release them back for use within community. # Increased pressures at ED as a result of WAST ambulance response policy resulting in very poorly patients self-presenting. # Better understanding of ED presentations to ensure development of alternative pathways in primary care / community to prevent ED attendance # Effective and timely	To consider alternative models of medical oversight i.e service level agreement with local GPs and HB salaried community GPs	Dawson, Rhian	Completed	Pending confirmation indemnity for the local GPs to deliver.
		Refer CRR 1406 detailing actions to address insufficient workforce to support delivery of essential services.	Gostling, Lisa	31/03/2023	Ref CRR 1406 for detailed progress.
		Explore service provision in the community for people pending ambulance conveyance, and where conveyance is not possible to manage ambulance handover delays	Dawson, Rhian	Completed	Completed.
		Recruit additional workforce in line with safe staffing requirements for 28 beds in Amman Valley Hospital	Dawson, Rhian	Completed	Completed.
		Development of enhanced Bridging Service and to actively recruit HCSWs to support domiciliary care services	Lorton, Elaine	Completed	Completed.
		Create live UEC performance dashboard.	Dawson, Rhian	Completed	UEC live performance dashboard in place.
		Recruitment to UEC Programme Management Office	Dawson, Rhian	~~31/01/2022~~ ~~31/03/2022~~ 30/09/2022	Recruitment process underway.

homes and community hospitals # SRO in place to lead agreed Urgent and Emergency Care (UEC) programme # Supernummery HCSWs aligned to the acute response teams to support failing community care capacity # Support for complex discharge caseload management tool (SharePoint) appointed # Reminders issued to management on importance of robust management of staff sickness and the use of COVID-19 Risk Assessment to help manage staff absences. # SDEC models continuously reviewed and refined to maximise impact on admission avoidance. # Staff are encouraged to participate in the UHB's ongoing COVID-19 vaccination programme. # Alternative models of medical oversight i.e service level agreement with local GPs and HB salaried community GPs. # Service provision in the community for people pending ambulance conveyance, and where conveyance is not possible to manage ambulance handover delays. # Increased bedding capacity in community hospitals. # UEC live performance dashboard in place. # Local streaming hub. # Direct referral into SDEC in WGH and GGH. # Operational joint meeting with WAST to identify and taking forward key action to help address conveyance.	# Effective and timely communication to the public at times of pressure but also of safe alternatives to hospital admission / ED presentation that will contribute to changing public mind set / expectation and culture in terms of use of NHS resource and 'Home First' # Education and training for best practice in frailty management mandated to effect culture of 'unsafe to admit' for our very / severely frail # Supporting staff to be able to better manage family dispute relating to expectation eg home of choice, transfer pathways to short term placement in care home pending home care availability # Development of a 'tool' that supports staff to assess risk across the whole system to support decision making when discharge appears to be 'risky' to the individual patient. This includes decision making for 'further rehabilitation required in the acute environment' (why not at home?), further blood analysis to confirm medically fit to discharge, home care not available but family happy to take in the interim. # For all patients with LOS > 21 days the need for escalation and 'senior think tank' # If there is a paucity of home care to the extent that we are unable to provide > 28 hours per	Implementation of 111 First and local streaming hub as well as enhancing Same Day Emergency Care (SDEC) provision to reduce conveyance and conversion	Dawson, Rhian	31/03/2023	Recruitment underway. £3.4m awarded by WG for UEC Programme.
		Explore and gain approval for funding for 2wte COTE consultants	Dawson, Rhian	Completed	Completed
		To implement the Standard for Discharge to Assess in accordance with the WG Disharge Guidance	Dawson, Rhian	Completed	Plan to be developed.
		Review ambulance handover procedure in conjunction with WAST and HB Review Escalation Policy	Passey, Sian	~~31/03/2022~~ 31/10/2022	Senior level discussions with WAST have been undertaken in respect of ambulance handovers. All sites endeavour to comply with Red Release policies wherever possible. The policy is still in draft however HDUHB have been asked to share the policy with an all Wales group which has been established following the recent HIW WAST Review with the aim of setting developing a shared set of principles and policy, with each HB developing local SOPs.
		Review Escalation Policy	Jones, Keith	Completed	HB Escalataion Policy reaffirmed. Sites regularly operating at Red (Level 4) status with limited non-urgent elective surgery undertaken at the four sites due to urgent and emergency care pressures.
		Review nursing models to support increasing capacity and environments for patients	Passey, Sian	Completed	Continuous discussions with Heads of Nursing and regular operational consideration given to scoping patient profile and pathways. In conjunction with primary care colleagues additional capacity in Amman Valley Hospital.
		To undertake a quality improvement project to map flow across GGH unscheduled system supported by Improvement Wales.	Perry, Sarah	~~31/12/2022~~ 31/12/2023	Work has started.

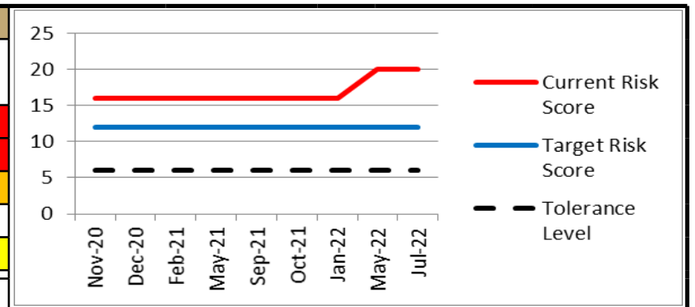
week (calls four times per day) - why are we advocating this level of commissioning? # Clarity regarding roles and responsibilities for discharge planning and coordination # The availability of live data at Cluster, County and Site level with sufficient analytical support # the ability to risk stratify for people at moderate to high risk of admission in the community to implement proactive anticipatory care plans to support avoidance of exacerbation / decompensation and hence increased risk of hospital admission # Optimising our bedded facilities in the community i.e we should aim for 'step up' from community and from 'front door' hospitals (within 72 hours) rather than as a 'step down' from acute hospitals after long length of stay. LOS should be no more than 10 days # Bespoke recruitment targeted at critical posts that will deliver improvements in UEC eg ANPs, APPs, PAs etc. and accept risk to permanently fund such posts i.e should not be	To codesign schemes with Local Authorities that put urgent capacity into the system to reduce bed occupancy rate for frail, complex patients	Lorton, Elaine	31/10/2022	First meeting scheduled on 18/05/22.
	Review extant Escalation Policy to incorporate the whole UEC system	Jones, Keith	31/12/2022	HB Escalation Policy reaffirmed. Sites regularly operating at Red (Level 4) status with limited non-urgent elective surgery undertaken at the four sites due to urgent and emergency care pressures.
	Incorporate and deliver actions that will address control gaps into the Health Board's UEC Plan	Dawson, Rhian	31/03/2025	Launch of the UEC Improvement Programme on 16/06/22 to galvanise a collective approach to improvement.
	Review wider nursing establishment requirements across 25A wards (outside of NSLA) to support increasing capacity and environments for patients.	Passey, Sian	30/09/2022	Continuous discussions with Heads of Nursing and regular operational consideration given to scoping patient profile and pathways. In conjunction with primary care colleagues additional capacity in Amman Valley Hospital (completed). A review has been completed of nursing models within EDs which will be submitted to Executive Team for discussion.
	To review the West Wales Care Partnership Regional Discharge 2 Assess policy and develop action plan to ensure effective implementation of Policy Goal 5 (optimal hospital care following admission)	Passey, Sian	31/10/2022	Work is underway.

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. A suite of unscheduled care metrics have been developed to measure the system performance.	Medically optimised and ready to transfer patients are reported 3 times daily on situation reports	1st				None identified.				
	Daily performance data overseen by service management	1st								
	Delivery Plans overseen by Unscheduled Care Improvement Programme	2nd								
	Bi-annual reports to SDOPC on progress on delivery plans and outcomes (and to Board via update report)	2nd								
	IPAR Performance Report to SDOPC & Board	2nd								
	WAST IA Report Handover of Care	3rd								
	11 x Delivery Unit Reviews into Unscheduled Care	3rd								
	Delivery Unit Report on Complex Discharge	3rd								

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jul-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Aug-22

Risk ID:	**1032**	There is a risk that the length of time MH&LD clients (specifically S-CAMHS, ASD, memory assessment and psychology services for intervention) are waiting for assessment and diagnosis will continue to increase. This is caused by an increase in referrals and increasing DNA rates (c25%). There is also difficulty in recruiting suitably trained staff. This could lead to an impact/affect on increasing delays in accessing appropriate diagnosis and treatment, delayed prevention of deterioration of conditions and delayed adjustments to educational needs
Does this risk link to any Directorate (operational) risks?		138, 140, 1249, 1286, 1287,

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):	5×4=20
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
The service were experiencing significant waiting times as a result of increasing demand levels which are now back to pre-pandemic levels, compounding the backlog due to Covid restrictions. Due to increasing DNA rates (c25%), ongoing recruitment challenges and increasing demand there is an impact on the services' ability to see the same volume of service users as they were previously able to. Integrated Autism Service (IAS) is funded on fixed term basis which can make staff retention challenging along with having to train new incoming staff. The risk score has increased due to compliance with WG targets which has deteriorated over recent months particularly in relation to part 1 of the measure for CAMHS Services.	The Directorate is prioritising implementation of WPAS in key areas within MHLD and this will enable improved reporting and waiting list management and enable forward trajectories of improvement in waiting times to be determined. The target risk score will be dependent on securing recurring funding for the IAS as well as having access to appropriate clinical venues and other agencies being able to undertaken their associated assessments.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that 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**
Use of IT/virtual platforms such as AttendAnywhere when appropriate. Clinical prioritisation regarding assessment and treatment of service users by engaging in a dynamic process of reviewing waiting lists in line with any other referrals that may be received in respect of that service user. Additional funding provided for recruitment however national shortage of required skills - 3 new staff have been recruited into the ASD team. Services are in contact with individuals to provide information regarding mainstream/Tier 0 support, wellbeing at home and guidance should their situation deteriorate. Regular meetings with Women and Children's Service to strengthen interdepartmental working. Process in place to ensure individuals on waiting lists are being contacted periodically through the wait for assessment/treatment to monitor any alteration in presentation.	Continued lack of IT impacts on staff who have to work from home not having full accessibility. Estates issues ongoing with no access to clinical areas in some localities to see CYP and unable to access GP or LA sites thus restricting clinical sessions. Telephone assessments ongoing, virtual assessment offered but uptake not good for ASD and SCAMHS client group. Reliant on locally held data until reporting available via WPAS team. Currently with Software	Identify alternative venues/space to hold clinics, including repurposing current MH&LD Estate in line with clinical priorities identified.	Carroll, Mrs Liz	~~31/03/2021~~ ~~31/12/2021~~ 30/09/2022	Working with the Estates Department and exploring options with external partners. Regular meetings with Estates to look at accessing/leasing/enhancing the current MH estates with a view to increase MH estate footprint. Within the service there is progress in terms of identifying clinical space due to the challenges experienced in accessing additional accommodation outside of the Directorate. Linking with wider Health Board, including corporate teams/Local Authority use of hubs. Works completed in Bro Cerwyn and staff have now returned. Units within the MH&LD footprint have been repurposed. IT are updating infrastructure to enable most efficient use of available space.

Papers have been presented at the Quality Safety and Experience Assurance Committee with a further update paper provided for the December 2021 meeting outlining control measures to manage the waiting times that the Directorate have at present. A paper was presented at Board Seminar in June 2022 to provide assurance on current waiting times and control measures. Service Delivery Manager appointed and in place. Continual review of vacancies via MHLD QSE meetings resulting in the consideration of alternative staffing models when recruitment drives do not materialise. Workforce Redesign Group has been established.	Development Team.	Head of Service to ensure outcome measures are in place to measure effectiveness/quality of services provided	Carroll, Mrs Liz	~~31/12/2020~~ ~~30/06/2022~~ 31/12/2022	Directorate have been asked to participate in Health Board wide Task & Finish group. The Directorate will raise the importance of Service User/Carer input into this group to ensure the patient experience is represented to inform the outcome. Outcome measures will form part of this project. Outcome measures are used in Integrated Psychological Therapies Services. It will be established if the service are able to report on the outcome measures as part of the Quality report for the area. This work needs to be aligned to the all Wales work in relation MH outcomes.
		Services will be in contact with individuals to provide information regarding community support, well being at home and guidance should their situation deteriorate.	Carroll, Mrs Liz	~~31/03/2022~~ 30/09/2022	Work underway across all services who have waiting times, be they intervention or assessment. Use of HB Third Party Contractor has begun and initial letters sent to those waiting appointments with the Memory Assessment Service, Integrated Autism Service and Adult ADHD. Public facing webpages with QR codes are also being developed to give further guidance and support whilst individuals are waiting. Template letters being developed within further areas.
		Funding for Interim Clinical Psychologist lead post to assist with the waiting lists and service development has been identified fixed term for 12 months and will work in conjunction with the new ASD Service Delivery Manager (in post 6 March) to address waiting lists.	Carroll, Mrs Liz	~~31/03/2022~~ 30/09/2022	Interim Clinical Psychologist due to take up post by end of July 2022.

Health Board is engaging in work with WG to benefit from additional support re waiting lists, demand and capacity planning and service mapping to meet the national standards and new Autism Code.	Carroll, Mrs Liz	~~30/04/2021~~ 31/12/2022	WG ASD Evaluation and recommendation document had been expected to be received at the end of March but has now been delayed until the end of July. The Code of Practice Recommendations are being presented to the Quality Safety Experience Group in June 2022. Service Delivery Manager will take a lead role in developing the implementation plan for the MH&LD Directorate and across the Health Board as part of a Task and Finish Group.
Directorate has funded 12 month fixed term post to accelerate the transition of the entire Directorate on to WPAS with a view to this improving waiting list management and demand and capacity planning. A further two posts have been funded within the Informatics service.	Amner, Karen	31/12/2022	Mapping work continuing for IAS service with the new Service Delivery Manager, MAS, Admiral Nursing and Perinatal. Data migration of Integrated Psychological Therapies spreadsheets completed 10.4.22 and service now inputting data at source. Training sessions continue to be available.
Directorate to rationalise working from home/agile working in order to maximise the potential office / clinical space	Carroll, Mrs Liz	~~31/03/2022~~ 30/09/2022	Directorate is awaiting delivery of additional IT kit to support home/agile working. Directorate continues to seek regular updates from Digital Services in relation to delivery timeframe.
Explore opportunities for outsourcing for CAMHS ASD and Psychological Therapies.	Carroll, Mrs Liz	~~30/09/2022~~ 30/03/2025	Tender document has been drafted and has been sent to procurement with a planned implementation date of October 2022 until March 2025
Directorate is working with the Health Board Performance Team to provide a more detailed report as to the current actions being taken by the Directorate. This work is aligned to the migration of services to WPAS on a priority basis.	Carroll, Mrs Liz	31/03/2023	New action.

ASSURANCE MAP			Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Welsh Government performance indicators along with internal monitoring arrangements will be used to ensure the actions are having the desires effect or whether there is more that needs to be done.	Management monitoring of referrals			Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC (Oct21) MHLD progress update on Planning Objective 5G - Board (Mar22)	System to improve analysis of patient experience	There are outcome measure in place within Psychological Therapies following intervention with a plan to develop a Task and Finish group to look at themes and areas which may require further improvement.	Carroll, Mrs Liz	Completed	Directorate have been asked to participate in Health Board wide Task & Finish group. The Directorate will raise the importance of Service User/Carer input into this group to ensure the patient experience is represented to inform the outcome. Outcome measures will form part of this project.
	Monthly MH&LD Business Planning and Performance Group overseeing performance								
	MH&LD QSE Group overseeing patient outcomes								
	Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC								
	W-PAS Internal Audit (reasonable assurance)								
	An update was requested by the Chair and provided for the August Quality, Safety, Assurance Committee.								

Date Risk Identified:	Feb-22	**Executive Director Owner:**	Carruthers, Andrew	**Date of**	Jul-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Committee	**Date of**	Aug-22

Risk ID:	**1349**	**Principal Risk Description:**	There is a risk of failing to deliver the ultrasound service at WGH. This is caused by a lack of appropriately trained obstetric staff, with no additional capacity on site to absorb displaced patient slots. The obstetric ultrasound examination unit operating at reduced capacity due to: *Lack of robust plan to replace sonographers who have now retired. *National shortage of radiographers within the general area. *Staff working arrangements changing, with several now going part time *Increased obstetric demand - specifically for 3rd trimester scans in line with the WAG targets of reducing still birth rates. *The loss of a general ultrasound scan room due to air exchange fears and the pandemic, therefore further reducing capacity to undertake scans. This could lead to an impact/affect on increasing routine ultrasound waiting lists (which is already breaching 40 weeks in some cases), adverse peri-natal outcomes, failure to provide routine obstetric screening nuchal translucency (NT), and anomaly scans, failure to provide growth scans (the HB is not working in line with Growth Assessment Protocol (GAP) grow guidelines), non-adherence to RCOG and NICE guidelines, increased stress for staff creating a negative working culture, increased risk of staff developing Repetitive Strain Injury (RSI)	**Risk Rating:(Likelihood x Impact)**		**No trend information available.**
				Domain:	Safety - Patient, Staff or Public	
				Inherent Risk Score (L x I):	5×4=20	
				Current Risk Score (L x I):	5×4=20	
				Target Risk Score (L x I):	3×4=12	
				Tolerable Risk:	6	
Does this risk link to any Directorate (operational) risks?				**Trend:**	*New risk*	

Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
Service failure has already occurred with a likelihood of recurrence due to a lack of trained obstetric sonographers, particularly post March 22 due to staff retirements. The service remains fragile despite being granted a locum for 2 months. In-sourcing an ultrasound service as at July 2022, with staff due to commence in post August 2022 for a rolling three month period, therefore a temporary solution due to funding.	The actions below will not in themselves reduce this risk significantly. Support is required to undertake the demand and capacity and the current establishment reviews. It is likely that these reviews will lead to a need for further investment and additional funding to establish a sustainable service model to include a robust perpetual training programme, that will enable the Health Board to met expected diagnostic waiting times targets.

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	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
*Continual recruitment campaigns *Ability to request assistance from other sites when peak staff shortages experienced at WGH *Review of current workforce issues by senior management, and SBARs drafted for relevant Bronze and Silver * Met with recruitment to improve advertising of posts. * Outpatient referrals are being sent to other sites. * Some weekend working in place during Apr22 where there are gaps in service during the week. * In addition to the Site Lead Superintendent Radiographer, it has been agreed that sonographers from other sites will provide cover when possible, and a locum for 2 months has been agreed. * Fortnightly Task and Finish meetings with Maternity Services.	National shortage of sonographers. Inability to attract people to work in West Wales. Inability recruit locum sonographers to provide short term respite. Ability of other sites to release capacity when required. Ceasing in enhanced payments for staff for additional shifts	Approach PHW about the possibility of the Health Board failing to provide an obstetric screening service	Lingwood, Gill	31/03/2022	Discussions with obstetrics service have taken place to
		Explore the possibility of sending obstetric patients to other sites.	Lingwood, Gill	Completed	Radiology Staffing Task and Finish Group met on 31/03/22 and it was established that it is not currently practical to send obstetric patients to other sites. In addition to the Site Lead Superintendent Radiographer, sonographers from other sites providing cover, a locum for 2 months has been granted, however the service is still fragile due to sickness and annual leave. Update-
		Train midwives to be able to scan obstetrics	Lingwood, Gill	31/03/2023	It takes a year to complete sonography training in obstetrics and a further year for general ultrasound. Currently we have one midwife training who will qualify in January 2023 and follow a period of preceptorship. A Radiographer will commence training in January 2023. We
		Convert existing sonographer vacancy to backfill the release of radiographer to train in ultrasound from Jan23	Lingwood, Gill	31/03/2023	Post is at vacancy approval stage on Trac. However it

An update paper to written for OPDP to inform of the plan to sustain services in the short to medium term.	Roberts-Davies, Gail	Completed	Initial update paper presented to OPDP on 11th May 2022. Verbal update to be given at OPDP on 25th May and ongoing. Discussion with Head of Radiology confirmed that the initial action
Developing a mini competition document to test the market for insourcing ultrasound company for at least 12 months	Roberts-Davies, Gail	~~30/04/2022~~ ~~30/07/2022~~ 31/10/2022	The mini-competition doc was approved and advertised. The closing date for submissions was 12:00 on 25/05/2022. Unfortunately no companies on the Welsh framework responded. One company on the Crown framework indicate that they
Seek support to undertake a demand and capacity (D&C) review and detailed establishment review of the radiology service.	Roberts-Davies, Gail	~~30/06/2022~~ ~~30/08/2022~~ 30/11/2022	Initial meeting with Lightfoot to take forward D&C work, with further meetings planned. Initial contact made with workforce planning team re establishment review work. However the outputs of both reviews will likely lead to a need to invest/additional funding. Lightfoot will not be supporting this work due to contact end. Work is beginning with informatics to create a Radiology dashboard and we are currently

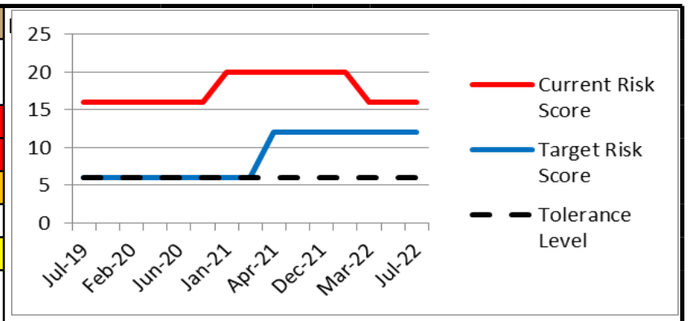
ASSURANCE MAP	Control RAG	Latest	Gaps in ASSURANCES

Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level	Rating (what the assurance is telling you about your controls	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
Non-Obs ultrasound - currently >over 40 weeks	Management review of sonography and SCP diagnostic waiting times	1st			Sonography Report to Acute Bronze and Operation Planning and Delivery					
	Monthly review of USC performance undertaken monthly (currently 42% of USC breaching), included in the IPAR & reported to WG	1st								
	IPAR overseen SDODC & Board	2nd								

Date Risk Identified:	Jan-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Jul-22
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Aug-22

Risk ID:	**684**	There is a risk radiology service provision from breakdown of key radiology imaging equipment (specifically insufficient CT capacity UHB-wide, and the general rooms and fluroscopy room in Bronglais). This is caused by equipment not being replaced in line with RCR (Royal College of Radiologists) and other guidelines. This could lead to an impact/affect on patient flows resulting from delays in diagnosis and treatments, delays in discharges, increased waiting times on cancer pathways, increased staffing costs to minimise the impact on patients when breakdowns occur and increased number of breaches over 8 weeks due to increased downtime.
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):	3×4=12
Tolerable Risk:	6
Trend:	



Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
The UHB's stock of imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites which has a significant impact on the UHB's ability to meet its RTT target and impact to patients can include delays in diagnosis and treatment. Presently equipment downtime is frequently up to a week which can put significant pressures on all diagnostic services. Whilst activity has decreased due to COVID, scanning of COVID patients requires more time than non-COVID patients, which will become an issue as requests for diagnostics for non-COVID patients increase as other services resume. Commissioning of agreed equipment has also been delayed as a result of COVID and this remains dependent external factors. Radiology has been asked to increase its service provision to other Directorates which it is currently unable to provide due to limitations on current equipment, however the demountable CT-scanner will provide much needed resilience at GGH. Whilst some contingency has been provided by a scanner in a demountable unit this does not provide full cover for acute care (not suitable for complex care). The risk score has been reduced to 16 reflecting that some equipment has been installed and is operational. A costed plan along with a rolling programme for the installation of additional equipment is in place. The next batch of equipment for replacement has been prioritised and identified, however no funding has yet been secured (for FY 2022/24). A paper has been prepared for the	Until a formal replacement programme in place, it will not be possible to bring this risk within tolerance and therefore the target score has increased to 15 as it should be possible that when the new equipment is commissioned, this will slightly reduce the risk. With more modern equipment, breakdowns will be less likely and less significant in terms of downtime together with a reduced impact on the diagnostic services at the remaining hospital sites. Improved business continuity plans will also help reduce the impact of equipment breakdown across the UHB.

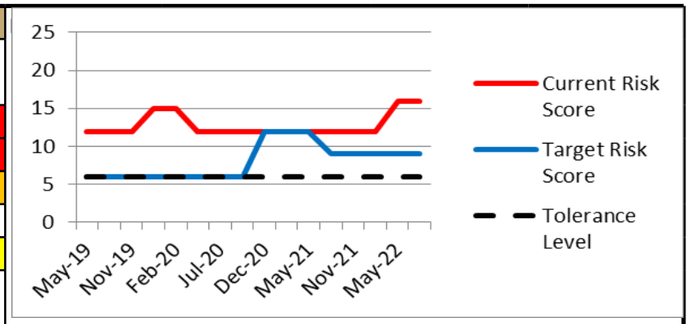
Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective,	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # Replacement programme has been re-profiled by risk, usage and is influenced by service reports.Some funding has been secured from AWCP for some replacements but does not cover all outdated equipment nor the future requirements. # Escalation process in place for service disruptions/breakdowns. # WG Funding agreed for 2 x CT scanners (GGH & WGH) - now installed # Additional CT secured in the form of a mobile van in December 2020. # Newly created National Imaging and Capital Priorities Group ensures there is a robust governance process to support a national, sustainable clinically focused capital equipment programme across Wales. This will ensure that all HB's in Wales agree to a prioritisation process which will allow for timely equipment procurement and delivery to support healthcare demands across Wales.	Limitation of spare parts for some older equipment leading to extended outages. This issue may be compounded by Brexit. Increased use of site contingency plans puts pressures on patient flows, discharges, diagnosis at other sites. Reliance on AWCP for replacement of equipment.	Work with planning colleagues about sourcing capital funding through DCP and AWCP.	Roberts-Davies, Gail	Completed	Two business cases have been funded by WG. Further Business Cases for the further 3 CT scanners and or General Rooms (depending on priority) to be submitted in 2022/23.Submit updated paper to CEIMTSC to outline current priorities and funding requirements from DCP and AWCP. 21/12/2021 - discussion with the
		Installation of CT Scanner at Withybush General Hospital	Roberts-Davies, Gail	Completed	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise. As of 25/05/2022 the installation of this equipment is currently running to schedule.
		Installation of scanner at Prince Philip Hospital	Roberts-Davies, Gail	31/10/2022	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise.
		Installation of CT Scanner at Bronglais General Hospital	Roberts-Davies, Gail	28/02/2023	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise.
		Installation of DR room in Prince Philip Hospital	Roberts-Davies, Gail	31/10/2022	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise.
		Installation of DR room in Glangwili General Hospital	Roberts-Davies, Gail	30/11/2022	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise.
		Installation of DR room in Withybush General Hospital	Roberts-Davies, Gail	31/12/2022	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise.
		Installation of fluoroscopy room in Bronglais General Hospital	Roberts-Davies, Gail	28/02/2023	Timeline is in line with draft scheme of work, and at this time could be subject to delays should issues arise.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators		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				Radiology Equipment SBAR - Executive Team - Mar19 Further updates CEIMT Feb20 Further updates CEIMT Sep20	Lack of process of formal post breakdown review.				
	IPAR report overseen by PPPAC and Board bi-monthly									
	Internal Review of Radiology Service Report (Reasonable Rating									
	WAO Review of Radiology - Apr17									
	External Review of Radiology - Jul18									

Date Risk Identified:	Apr-17	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	May-22
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Jun-22

Risk ID:	**129**	There is a risk of the inability to deliver the statutory requirement to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda patients This is caused by a lack of available of labour supply as GPs near retirement age and pay rate differentials (50% reduction over last 5 years) across Health Boards in Wales impact the UHB's ability to recruit in the mid-long term. This, combined with increased demand for face-to-face and longer complex consultations and increasing pressures in day-today primary care impacting the ability of GPs to be available for OOH shifts. In addition, some clinicians may preferentially work in other urgent emergency care initiatives such as 111 First shifts/SDEC, as they are potentially much lighter (already seen in SBU). This could lead to an impact/affect on a detrimental impact on patient experience, as patients would need to go to an ED/MIU to receive treatment for a primary care complaint to be managed. The unscheduled care pathway including WAST / primary care could continue to suffer ongoing disruptions due to unmet demand for the OOH service seeking alternative management. This may also result in unforeseen deterioration of an unmanaged condition in a patient, thus becoming more complex to resolve if not dealt

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):	4×4=16
Target Risk Score (L x I):	3×3=9
26/11/2020 - Board 'Accept' Target Risk	
Tolerable Risk:	6



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

Trend: ⟺

Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
As of May 22, fragility of service delivery continues, exacerbated by the forthcoming bank holidays. Rotas continue to be fragile, particularly at weekends. Any further absence on out of hours provision is likely to rapidly result in further deterioration of the current position. Availability of day time work, relaxation of COVID-19 restrictions, potentially leading to less availability of locums available for OOH. The Health Board currently have approximately 45 GPs (down from 100, 5 years ago) who regularly work the rotas, and an additional 10-20 who only work bank holidays rotas due to enhanced rates. ANP staff have reduced from 4, to 1 which covers 4 hours over a weekend period (0.1 WTE).	Service rota positions remain variable with continued shortfalls in clinical cover variably affecting service provision. Generally the rotas continue to be unstable, particularly at the weekends, and this is further compounded by the need for salaried staff to take annual leave and sessional staff to have time off to rest (particularly following the pressures of the Covid-19 pandemic). The August 2021 Bank Holiday rotas were still markedly reduced, despite the offer of Christmas rates (our highest hourly rates), which reflects exhaustion and burn out of clinicians. The situation has deteriorated further as at May 2022, with the service at Level 4 for three of the four bank holidays over May/June 2022, with enhanced rates being offered to fill rotas. Medium term actions are still required, especially in terms of service modernisation. Work to develop a long term plan for OOH Services has now recommenced following Covid-19 in order to reduce this risk on a permanent basis so to ensure the out of hours service provision is not interrupted. Workforce and service redesign are being considered. The Clinical Lead has concerns regarding the future stability of the service, and a need for a greater workforce development plan from central government is really required. TCS must include a more realistic workforce plan to future proof the whole Health Board. The potential adverse affects of the pandemic, plus the seasonal impacts RSV and Flu, are currently being considered, which should include further updates to the Exec Team. Target score has been reduced from 12 to 9 to reflect the 5 salaried GPs, on the assumption that they will complete recruitment. There is less of an improvement from this recruitment as it is being diluted by the loss of other GPs due to retirement and taking up roles in other areas.

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**
# 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. # Health Professional feedback form in use between clinicians, service management and 111 (WAST) leads. # WAST Advance Paramedic Practitioner (APP) resource enhanced to provide more flexibility. # Rationalisation of overnight bases in place since March 2020, now subject to service review. # Workforce and service redesign requirements flagged as part of IMTP. # Deputy Medical Director meetings on a weekly/bi-weekly basis, helps to ensure governance of the service. # Regular review of risk register with Assurance & Risk Officer. # Home working provision in place for GPs. # Agreed pathway for PPH Minor Injury Unit in place. # GP Hub in place where locum sessions can be accessed centrally to support service provision. # Ongoing recruitment campaigns in order to bolster the	The ability to influence workforce participation remains limited due to the lack of contractual agreements (reliance on sessional staff). 5 new salaried GP may allow us to influence this positively. The Clinical Lead has concerns regarding the future stability of the service, and a need for a greater workforce development plan from central government is really required. TCS must include a more realistic workforce plan. Need for formalised workforce plan and redesign is still required - reflected in IMTP submission. In relation to service demand, activity has	Ensure Transforming Clinical Services Programme incorporates a long term, viable plan for OOH.	Rees, Gareth	~~30/09/2020~~ ~~31/12/2021~~ ~~31/12/2022~~ 31/05/2023	May 2022 - Whilst work to develop a longer term viable plan for OOH was commenced in early 2020, this work has been delayed due COVID-19. Awaiting decision/direction on integration into TCS, and consideration should be given to developing a new MDT model to replace the existing GP OOH model currently utilised. The service leads are engaged in discussions to develop the service following an internal review and the pending Peer Review will give further direction of needs and opportunities in line with the Government Six Goals Strategy.

MDT model and maintaining service stability. # Use of telephone consultations for service delivery alongside remote working, which has increased by 60% due to the pandemic.	increased a little over the summer 2021, but still have the same % of referrals to A&E and 999, with no increase in % of admissions. Covid continues to influence the risk-position with frequent short notice absences and limited opportunity to find cover in these circumstances. The focus on delivery of care via the telephone advice method is the significant factor in stabilising the risk at this time however there is a slow return to seeing more patients face to face with calls completed as telephone advice now reduced to 60-70%. Any reduction in capacity remains likely to require an increase in the risk level as the service delivery will be adversely affected.	Review the rationalisation of overnight temporary service change.	Richards, David	~~31/05/2021~~ ~~30/09/2021~~ ~~31/12/2021~~ ~~30/06/2022~~ 31/12/2022	May 22 - The closing of two bases overnight was an attempt to encourage doctors to work in the three remaining bases with two clinicians in GGH. This strategy has not been as successful as planned as there has been a continual decline of doctors which may have been brought forward by the rationalisation. The development of a MDT model will increase the capacity of the OOH service with potential to reopen the bases temporarily closed overnight. To allow the MDT to incorporate Advanced Practitioners and Physicians Associates from all backgrounds, the professional leadership for paramedics will need to be addressed The DMD for Primary Care is taking forward the discussion of the HB needing a clearly defined lead for Paramedics to allow a true MDT approach in OOH and throughout the HB. This conversation is ongoing with the Director and Assistant Director of PC being appraised. The current position is a barrier for recruitment of a true MDT including paramedics. Once addressed the recruitment and enrolment process will initially take 4-6 months.

Implement 'RotaMaster' which will help with rostering going forward. Our issues with 'offer and accept', plus IR35, will be mitigated with the completion of this project.	Richards, David	Completed	May 2022 - Rotamaster has been implemented and is in use.
Implement Locum Hub Wales.	Richards, David	Completed	Completed- Locum Hub Wales was live as of Jul21, however usage is currently limited due to geographical restrictions and other non Health Board issues, including issues with the system and small pool of Clinicians available who are already working in our Health Board. Remote working would be available but is of low utility when we need face to face cover.
Recruit Health Board wide GP posts.	Richards, David	Completed	Since Jan22, 8 (6WTE) GPs have been recruited, one has deferred, and others are awaiting to start. Recruitment is a continual process and has been added as an existing control, and as such can be closed as an action.

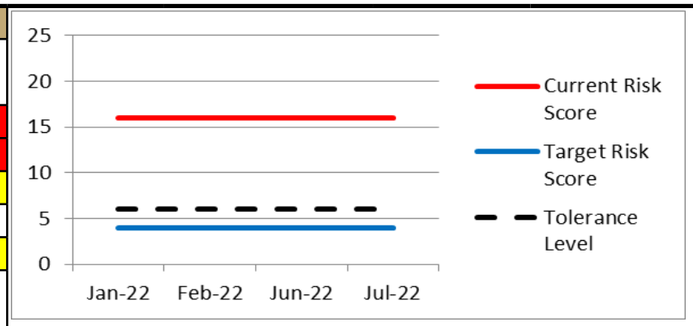
		Short term (1-2 years), the aim is to recruit Advanced Practitioners of all grades, with the potential opportunity to provide applicants with appropriate training and career development eg prescribing training within the available budget.	Richards, David	31/12/2023	Future growth of the MDT model will be on an incremental, opportunistic basis to prevent destabilising the wider system, as clinicians become available, or express an interest to join the service. Discussions still on-going within OOH, however the service is not in regular communication with the wider TCS programme or Workforce in order to develop and progress with a viable workforce plan. The need of a defined/named professional lead for paramedics is being taken forward by the DMD for PC and CL for OOHs. Once in place recruitment to begin developing a MDT will be achievable in 4-6 months. Further direction as a result of the recent internal review plus Peer Review will aid this process.
		In the long term (2-5 years), in cooperation with TCS, Workforce and national groups, to develop a programme to grow our clinical workforce, and to evolve and utilise a self-sufficient service which is fit for purpose, within available budget.	Richards, David	31/12/2026	Future growth of the MDT model will be on an incremental basis. Discussions still on going within OOH, however the service is not in regular communication with the wider TCS programme or Workforce in order to develop and progress with a viable workforce plan. The Clinical Lead is actively seeking opportunity to re-engage with the TCS (or its successor) programme.
		Investigate the further use of digital technology and platforms to deliver the OOH service alongside current practices eg Attend Anywhere	Richards, David	31/12/2022	Options on other possible facilities or programmes identified after a successful roll out in other services. Follow up work to be undertaken on these.
		Further work to strengthen the workforce support from 111 programme team in addressing OOH fragilities available	Richards, David	31/12/2022	Peer review scheduled for July 2022, the outcomes of which may influence / guide and support from 111

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators		Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Bi-monthly IPAR. (Monthly updates to IPAR including areas of concern and statistics). National Standards and Quality Indicators- submitted monthly to WG. Issues raised, and performance Matrix reviewed, at National OOH forum (bi-monthly, attended by WG).	Daily demand reports to individuals within the UHB				QSEAC OOH Update Sep19 & Feb20 QSEAC - Peer review - Feb20 QSEAC- Review of risk 129 - Oct20 QSEAC- Review of risk 129 Apr21 QSEAC- OOH paper June20 ET- Risk to OOH business continuity - Sep19 ET- OOH resilience - Nov19 & Jan20 BPPAC Quarterly monitoring Nov19 BPPAC - update on the OOH Services peer review paper Dec19	Lack of meaningful performance indicators.	Assess NHS 111 performance metrics to understand how they may influence Hywel Dda OOHs performance, and if a viable alternative - which may support improvement in shift fill.	Davies, Nick	Completed	New 111 Wales performance metrics are being prepared and will soon be circulated for review.
	Twice a week sitreps and Weekend briefings for OOH									
	Monitoring of performance against 111 standards									
	Issues raised at fortnightly meeting with Primary Care Deputy Medical Director and Associate Medical Director									
	Monthly report to Joint Operations Group (WAST, 111 team & 111 Health Boards)									
	QSEAC monitoring									
	Issues raised, and performance Matrix reviewed, at National OOH forum (bi-monthly, attended by WG)									
	WG Peer Review Oct 19									

Date Risk Identified:	Jan-22	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Aug-22
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Sep-22

Risk ID:	**1340**	There is a risk of avoidable harm (death and serious deterioration in clinical condition and outcomes) for HDUHB patients requiring NSTEMI pathway care. This is caused by a combination of delayed pathway referral from HDUHB to SBUHB and Cardiac Catheter Laboratory capacity constraints at Morrison Hospital, which is further compounded by transport and logistical challenges in transferring patients in a timely manner, particularly from WGH and BGH. This could lead to an impact/affect on delayed NSTEMI 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 Morriston Hospital resulting in cardiology/unscheduled care flow pressures within HDUHB acute sites. NSTEMI pathway inadequacy is also resulting in poorer patient experience due to anxieties associated with delayed treatment/prolonged hospitalisation, together with

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):	1×4=4
Tolerable Risk:	6
Does this risk link to any Directorate (operational) risks?	
Trend:	⟷



Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
NICE guidelines for Acute Coronary Syndromes (NG185) recommend 'coronary angiography (with followâ€'on PCI if indicated) within 72 hours of first admission(presentation) for people with unstable angina or NSTEMI who have an intermediate or higher risk of adverse cardiovascular events' (recommendation 1.1.6). In support of this recommendation/target, we aim to identify and refer patients to Morriston Cardiac Centre for angiography within 24 hours of admission/presentation. For 2021 the median wait between admission/presentation and angiography for HDUHB patients was 213.5 hours (8.9 days) and the median time between admission/presentation and referral was 39.5 hours. For context, the 2021 position is a deterioration from that maintained in 2019 where the PPH Treat and Repatriate Service supported a median admission/presentation to angiography wait of 120 hours (5 days) - this service was suspended at the outset of COVID-19 due to PPH site pressures. Comprehensive review of Jan-June 2022 performance	The former PPH Treat and Repatriate Service achieved significant improvements for this pathway by a reduction in the median admission/presentation to angiography waiting time from 312 hours (13 days) to 120 hours (5 days) between January 2019 and April 2019. As a service we are aiming to deliver a NICE-complaint pathway and comply with the 72 hour recommendation/target. HDUHB Cardiology Pathway Transformation Project has identified 4 key areas for improvement in the NSTEMI pathway, these are: 1. Reduce length of time from presentation to referral to a median time of 24 hours (potential workforce and system/process solutions) 2. Re-instate NSTEMI Treat and Repatriation service and/or identify steps to improve patient transportation and logistics 3. Increase regional capacity at Morriston Cardiac Centre to meet the 72 hour NICE guidelines 4. If point 3 above is not realised, explore options to commission NSTEMI pathway angiography service from an alternative provider/s across Wales.

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**
# All patients are risk-scored by HDUHB Teams on assessment and referral onto NSTEMI pathway. # 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. # Increased numbers of patients waiting / prolonged transfer delays are identified on daily Sitrep Calls and escalated by HDUHB Cardiology Clinical Lead / SDM to SBUHB Cardiology Clinical Lead / Cardiology Manager. # All patients are risk-scored by cardiac team at SBUHB on receipt of patient referral from HDUHB and discussed at weekly Regional MDT. # Weekday telephone call between SBUHB Cardiology Coordinator and all 4 hospital Coronary Care Units (CCUs) to review patients awaiting transfer, in particular the progress on identified work-up actions. # Bi-monthly operational meeting with Swansea Bay UHB (SBUHB) to monitor activity/patient flow and address associated risks/issues. # Reporting arrangements in place to monitor emergency and elective waiting times. # NSTEMI Pathway Improvement workstream within HDUHB Cardiology transformation project # NSTEMI Pathway Improvement workstream within ARCH Cardiology Programme	Continuing delays in referring HDdUHB patients to Morriston Cardiac Centre for angiography Compromised logistics and patient pathway flow (particularly for BGH and WGH) due to absence of a Treat and Repatriation service and/or effective patient transportation Inadequate Cardiac Catheter Laboratory capacity at Morriston Cardiac Centre	Introduce a number of system and process solutions to reduce presentation to referral to a median time of 24 hours: 1- Staff awareness and education initiative to highlight urgency and timeliness of NSTEMI patient pathway management; 2- A Clinical Decision Tool to aid early patient identification and referral; 3- Pilot of daily HDdUHB/SBUHB Teams call to review/prioritise patient referrals and need for HDdUHB Cardiologist/SBUHB Interventionist telephone referral; 4- Pilot of a weekend HDdUHB Cardiologist on-call advice line to support referral process.	Smith, Paul	~~31/08/2022~~ 31/03/2023	Service and NSTEMI Project group are progressing additional risk actions required: 1: NSTEMI/ACS awareness update presented at HDUHB-wide Grand Round Medical Meeting in April ’22 – ACTION CLOSED; 2: A Clinical Decision Tool to aid early patient identification drafted and for approval at ARCH ACS Meeting in September ’23 – PROGRESSING; 3: Pilot of daily HDdUHB/SBUHB Teams call to review/prioritise patient referrals in discussion – decision taken by ARCHACS Group not to progress – ACTION CLOSED; 4 Pilot of a weekend HDdUHB Cardiologist on-call advice line running during April and May ’22. Report of outcomes due September ’22 – PROGRESSING; 5: Pilot of Chest Pain Nurse NSTEMI patient review and processing of referrals at GGH and PPH currently in development, to initiate September ’22 – PROGRESSING.
		Introduce workforce solutions to support the reduction of presentation to referral to a median time of 24 hours: 1 Consultant Cardiologist 3 Band 8a ANPs 1 Band 4 Pathway Coordinator	Smith, Paul	31/08/2022	Indicative investment highlighted in IMTP - HDdUHB detailed business case development presented at ARCH Regional Recovery Group on 17th March '22. Re-fresh due to re-presentation at May '22 ARCH Regional Recovery Group.
		Re-instate of NSTEMI Treat and Repatriation service and/or identify steps to improve patient transportation and logistics.	Smith, Paul	31/12/2022	PPH NSTEMI/ACS Treat & Repatriate Pathway SBAR re-submitted to PPH Triumvirate in April ’22. PPH Cardiology Workstream currently reviewing scope to re-operationalise the NSTEMI/ACS Treat & Repatriate pathway at PPH.

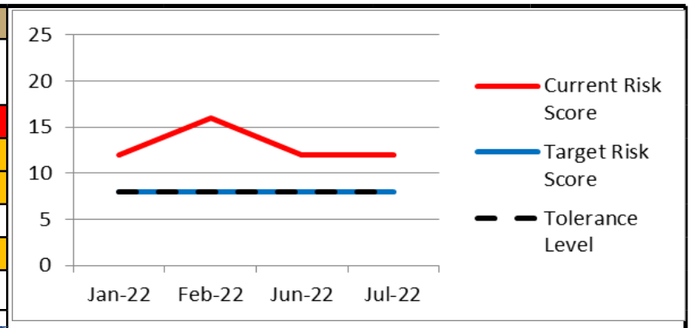
		Increase regional capacity at Morriston Cardiac Centre to meet the 72 hour NICE guidelines.	Smith, Paul	31/12/2022	Supported by ARCH, SBUHB submitted SBAR outlining plans for increased capacity and delivery of 7 day Cardiac Cath Lab service at ARCH Regional Recovery Group on 17th March '22. Re-fresh business case for presentation at May '22 ARCH Regional Recovery Group.
		Explore options to commission NSTEMI pathway angiography service from an alternative provider/s across Wales	Smith, Paul	Completed	ARCH Regional Cardiology Project Group and HDdUHB ACS Working Group currently pursuing a plan that will see the required Cardiac Cath Lab service from Morriston Cardiac Centre. HDUHB Commissioning and Contracting Team have approached Cardiology NSTEMI/ACS centres/facilities across Wales and on the Wales/England borders and there is no available capacity to support HDUHB NSETMI/ACS pathway.

ASSURANCE MAP			Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	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
	Daily/weekly/monthly/ operational monitoring arrangements by management			Cardiac Waiting Lists - QSEC (Feb22)	None Identified.				
	Audit of NSTEMI pathway undertaken by Cardiology Clinical Lead/SDM on monthly basis								
	IPAR Performance Report to SDOPC & Board								
	Monthly oversight by WG								

Date Risk Identified:	Oct-21	**Executive Director Owner:**	Kloer, Dr Philip	**Date of Review:**	Jun-22
Strategic Objective:	3. Striving to deliver and develop excellent services	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Aug-22

Risk ID:	**1337**	There is a risk of reputational harm if the health board is found to have not managed the TB outbreak in Llwynhendy as well as it could have. This is caused by the findings of the forthcoming HB and PHW commissioned external review into the outbreak and its management since 2010, and whether each stage was conducted in accordance with best practice guidance in place at the time of each phase of the outbreak. This could lead to an impact/affect on stakeholder confidence in the Health Board's ability to manage future outbreaks, local and national media interest, and additional scrutiny from key stakeholders such as WG	
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Adverse publicity/reputation
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	3×4=12
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	8
Trend:	



Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
The outbreak investigation has been re-opened four times in response to new cases of TB, leading to a rapid internal review carried out by PHW in 2019, to identify immediate actions and to make recommendations for the ongoing management of the outbreak. One of the key recommendations of the review was to commission, jointly with PHW, an external review of the outbreak and its management, to inform the approach to the management of TB disease in Wales. The Board agreed to proceed with the external review, the start was delayed by COVID-19. The review commenced in April 2022 with an anticipated completion during Autumn 2022. The risk score has been reduced as no significant findings have been reported to date	The development of a cohesive TB database to enable cross-referencing of contacts is also key requirement to mitigate 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**
PHW Health Protection support supporting outbreak and contacting Paediatric cases who previously not attended All contacts have been contacted at least once and families of the deceased have been formally communicated with advising of the review Treatment plans put in place where required A Project team has been established to support the review panel, led by a Project Manager and include administrative support, Communications and Information and Communications Technology Health Board commitment to be open about the findings from the Review with stakeholders and the public and ensure these are addressed. Public Service Ombudsman for Wales (PSOW) kept informed on progress of review Communication strategy agreed through the TB Joint Oversight Group to support the publication of the final report in the Autumn of 2022.	Ability to identify everyone as a contact from TB outbreak from different sources Having an agreed effective response to TB aligned to PHW to ensure that management of an outbreak is within an agreed process	Development of TB Database to enable cross-referencing of contacts	Tracey, Anthony	~~31/03/2022~~ 30/09/2022	A system has been developed however further work is required to enable is cross-reference contacts.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators		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
	TB Operational Task & Finish Group facilitating the external review				An External Review of the Llwynhendy Tuberculosis Outbreak - Board (Sep21)	External review of TB outbreak and management to inform the approach to the management of TB disease in Wales	To commission, jointly with PHW, an external review of the outbreak and its management, to inform the approach to the management of TB disease in Wales.	Kloer, Dr Philip	~~31/05/2022~~ 31/12/2022 (TBC)	In response to the COVID-19 pandemic, a decision was taken early in 2020 to pause the review. Professor Mike Morgan has recently been appointed as the chair of the external review panel and has been formally commissioned, on 16Aug21, to oversee the review. The review has commenced with anticipated completion in autumn 2022.
	TB oversight group for operational response co-chaired by HB and PHW Medical Directors									
	Internal review presented to an In-Committee Board meeting in Nov19									