Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	05 October 2021
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Corporate Risks Assigned to the Quality, Safety & Experience Committee (QSEC)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Director of Operations Alison Shakeshaft, Director of Therapies & Health Science
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

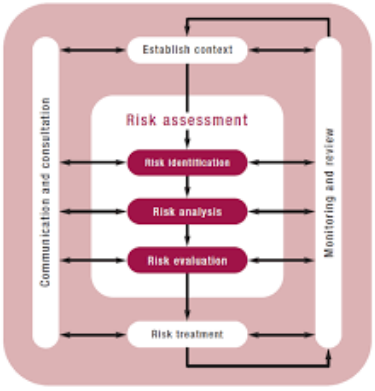
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Quality, Safety & 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 principal risks on the Board Assurance Framework (BAF)/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 of the Health Board objectives; 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 6 risks currently aligned to QSEC (out of the 13 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 2021):
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	6	
New / escalated risks	0	*See note 1*
De-escalated/Closed risks	4	*See note 2*
Increase in risk score ↑	0	*See note 3*
Reduction in risk score ↓	1	*See note 3*
No change in risk score →	5	*See note 4*

Note 1 – New Risks
Since the previous report, no new risks have been added to the CRR and aligned to QSEC.

Note 2 – De-escalated/Closed Risks
Since the previous report, two corporate risks aligned to this Committee have been de-escalated and two closed.

Risk Ref & Title	**Exec Lead**	**Closed/ De-escalated**	**Date**	**Reason**
Risk 291 - Lack of 24 hour access to Thrombectomy services	Director of Operations	De-escalated	15/09/21	The Executive Team agreed to de-escalate risk as all actions have been completed and whilst the risk is still considered high, recognised this as a national issue and potentially part of a wider issue associated with access to tertiary centres.
634 - Overnight theatre provision in Bronglais General Hospital	Director of Operations	De-escalated	04/08/21	The Executive Team agreed to de-escalate this risk to Directorate level as way forward has been agreed. Risk will be closed when new system has been fully implemented.
853 - Risk that Hywel Dda's response to COVID-19 will be insufficient to manage demand	Director of Operations	Closed	04/08/21	The Executive Team agreed to close this risk as COVID-19 is part of the environment the Health Board operates within and the risk has been at tolerance since May 2020.
855 - Risk that the UHB will be unable to address the issues that arise in non-covid related	Director of Operations	Closed	15/09/21	The Executive Team agreed to close risk following review by the Director of Operations and confirmation that COVID-19 is captured within other

services and support functions				corporate and operational risks related to non-COVID-19 related services.

Note 3 – Increase/Decrease in Current Risk Score
Since the previous report to QSEC in June 2021, there have been the following changes to current risk scores.

Risk Reference & Title	Executive Director	Previous Risk Score (Feb-21) (LxI)	Risk Score May-21 (LxI)	Date of review	Update
750 - Lack of substantive middle grade doctors affecting Emergency Department (ED) in WGH	Director of Operations	**4x4= 16**	**3x3=9** ⬇	13/09/21	At present this risk has been reduced due to being able to fill posts with agency, however at a higher rate. Without agency, there are still 4 WTE vacancies. A job plan is in progress.

Note 4 - No change in risk score
There have been no changes in the following risk scores since they were reported to the previous meeting.

Risk Reference & Title	Executive Director	Previous Risk Score (Feb-21)	Risk Score May-21	Date of Review	Update
117 - Delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery	Director of Operations	**4x5=20**	**4x5=20**	15/09/21	The Health Board has historically experienced delays in transferring patients to Swansea Bay UHB (SBUHB) tertiary cardiac service for a range of cardiac investigations, treatments and surgery, in particular transfer delays for ACS/NSTEMI patients requiring tertiary centre angiography/ coronary revascularisation within 72 hours of presentation to local secondary care hospital (NICE). The Acute Coronary Syndrome (ACS)/ Non-ST Segment Elevation Myocardial Infarction (NSTEMI) 'treat and

					repatriate' service was established in January 2019 and provided 6 ring-fenced beds at Prince Phillip Hospital (PPH) and improved transfer times for Bronglais General Hospital (BGH) and Withybush General Hospital (WGH) patients in particular. Cessation of the Treat and Repatriate service due to COVID-19 acute site pressures at PPH in 2020 has seen a return to increased numbers of patients awaiting prolonged periods for transfer from all 4 acute hospital sites, which is further compounded by acute sites pressures at Morriston Hospital - the risk likelihood has consequently been increased from 2 to 4 to reflect current waiting times averaging 16.9 days based Q4 2020/21 audit.
Risk 684 - Lack of agreed replacement programme for radiology equipment across UHB	Director of Operations	**5x4=20**	**5x4=20**	30/04/21	This risk has been recently reviewed by the Head of Service. The risk score remains at 20 as, although funding has been agreed for 2 out the 5 required CT scanners for HDdUHB, these will not be commissioned until the end of Q3 and Q4. Therefore, the benefits will not be realised and the likelihood of business disruption will not decrease until these are in place. 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 replacement programme is still heavily reliant on funding from the All Wales Capital Programme.
Risk 1032 - Delivery of Q3/4 Operating Plan - Timely access to assessment and diagnosis for Mental Health and Learning Disabilities clients	Director of Operations	**4x4=16**	**4x4=16**	13/05/21	Referrals for Autism Spectrum Disorder (ASD) have continued throughout the pandemic at approximately the same level as pre-COVID-19. The service is experiencing significant waiting times as a result of demand levels. Due to the constraints to undertake the required face to face assessments, the implementation of social distancing and, in some instances patients reluctance to attend clinics due to the risk of COVID-19, has an impact on the services' ability to treat the same volume of service users as they were previously able to. In addition, the estate footprint does not lend itself to accommodate the social distance requirements and in some instances is not therapeutically beneficial. Certain elements of some assessments, also being restricted due to other agencies, such as education, providing limited services. The Integrated Autism Service (IAS) is funded on a fixed term basis, which can make staff retention challenging in addition to having to train new incoming staff.

Risk 129 - Ability to deliver a GP Out of Hours (OOH) Service for HDdUHB patients	Director of Operations	**4x3=12**	**4x3=12**	14/05/21	The COVID pandemic combined with the temporary overnight service changes has brought some respite to the service fragility, and this is reflected in the current risk score. Generally the rotas continue to be unstable, particularly at the weekends. Any further absence on out of hours provision is likely to rapidly result in further deterioration of the current position. As of September 2021 there has been no notable change/definite trend in the service fragility. Rotas continue to be fragile, particularly at weekends. The potential adverse effects of a third wave are currently being considered, combined with other seasonal pressures, including the potential effect of RSV (respiratory syncytial virus). 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 used to develop plans to re-open bases and provide better care, therefore the effect of the recruitment could be diluted through the expansion of the service.
Risk 628 - Fragility of therapy provision across acute and	Director of Therapies and Health Science	**3x4=12**	**3x4=12**	12/05/21	Therapy service provision across acute, community and primary care continues to be challenging, as outlined

	community services					in the risk description. However, there have been improvements following additional resourcing (Major Trauma, Nutrition, Rehabilitation, Lymphoedema, Dementia, Musculoskeletal (MSK), Winter Funding), Long COVID, workforce redesign and over recruitment of Band 5 graduates (Physiotherapy, Occupational Therapy, Podiatry, and Speech and Language Therapy). The impact to service provision by the COVID-19 pandemic and rehabilitation requirements have added an additional challenge to workforce models, however have also enabled the roll out at scale of digital and virtual consultations. Across therapy services, current demand is largely being met for new patient referrals, apart from those clinical areas where physical delivery of hands on treatment is impacted by the demands of physical distancing and Infection Prevention and Control (IP&C) requirements. Post COVID-19 Recovery modelling suggests additional demand to support patients displaying ongoing symptoms post 12 weeks Acute COVID-19 infection, with complex rehabilitation

					needs. Further work is underway to understand the potential additional demand for rehabilitation for those indirectly affected by the interruption of access to routine service provision.

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

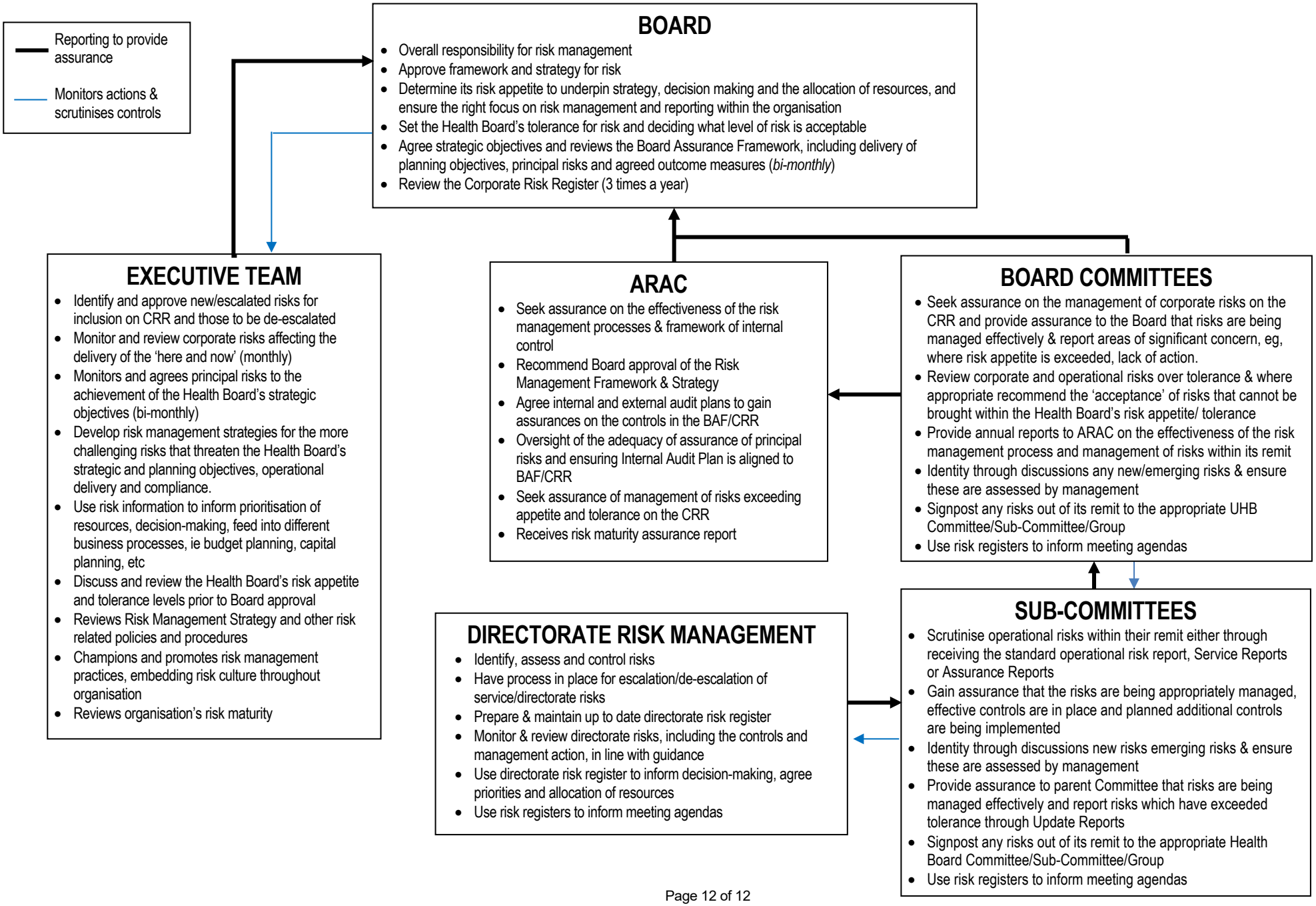
Gwybodaeth Ychwanegol: **Further Information:**

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 Sep-21	Trend	Target Risk Score	Risk on page no...
684	Lack of agreed replacement programme for radiology equipment across UHB	Carruthers, Andrew	Service/Business interruption/disruption	6	5×4=20	5×4=20	→	3×4=12	3
117	Delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×5=20	4×5=20	↑	2×5=10	6
1032	2021/22 Operating Plan Delivery - Timely access to assessment and diagnosis for Mental Health and Learning Disabilities clients	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×4=16	4×4=16	→	3×4=12	10
628	Fragility of therapy provision across acute, community and primary care services	Shakeshaft, Alison	Safety - Patient, Staff or Public	8	3×4=12	3×4=12	→	3×4=12	14
129	Ability to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda patients	Carruthers, Andrew	Service/Business interruption/disruption	6	4×3=12	4×3=12	→	3×3=9 Accepted	18
750	Lack of substantive middle grade doctors affecting Emergency Department services in WGH, with the risk of service closure.	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4×4=16	3×3=9	↓	2×4=8	24

Assurance Key:

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

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

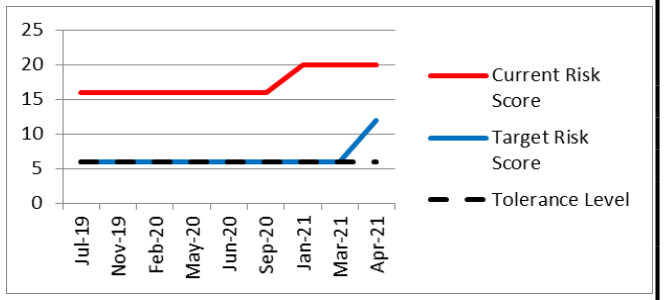
NB Assurance Map will tell you if you have

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

Date Risk Identified:	Jan-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Apr-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	May-21

Risk ID:	**684**	**Principal Risk Description:**	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 Radiographers) 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.

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



Does this risk link to any Directorate (operational) risks? 644

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. The risk score remains at 20 as a funding has been agreed for 2 out 5 required CT scanners for Hywel Dda, however these will not be commissioned until end of Q3 and Q4 therefore the benefits will not be realised and the likelihood will not decrease until these are in place. 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).	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:	**Gaps in CONTROLS**			
(The existing controls and processes in place to manage the risk)	**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**

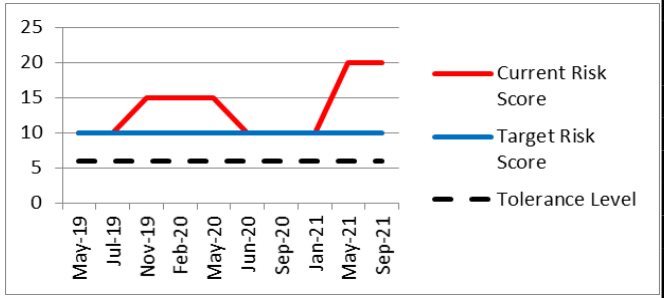
# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg 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) - to be commissioned by Dec21 and Mar22. # Additional CT secured in the form of a mobile van in December 2020.	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.	Evans, Amanda (Inactive User)	~~30/06/2019~~ ~~01/04/2020~~ ~~31/12/2020~~ ~~31/03/2021~~ 31/03/2023	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.
		Monthly project meeting to discuss commissioning of agreed equipment with estates, planning and manufacturers.	Evans, Amanda (Inactive User)	~~31/12/2020~~ ~~30/08/2021~~ 31/03/2022	Commissioning equipment is dependent on lockdown measures in and outside of UK and contractor availability to undertake work. Some equipment has already been commissioned, however still awaiting completion of project on MRI in WGH. The commissioning of the 2 CT scanner has been added to project meeting.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Reduction of waiting times to under 6 weeks by Mar22. Reduction in overtime costs to nil by Mar22.	Monthly reports on equipment downtime and overtime costs	1st			Radiology Equipment SBAR - Executive Team - Mar19 Further updates CEIMT Feb20 Further updates CEIMT Sep20	Lack of process of formal post breakdown review.				
	IPAR report overseen by PPPAC and Board bi-monthly	2nd								
	Internal Review of Radiology Service Report (Reasonable Rating	3rd								
	WAO Review of Radiology - Apr17	3rd								
	External Review of Radiology - Jul18	3rd								

Date Risk Identified:	Feb-11	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Sep-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Oct-21

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

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):	4×5=20
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	



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

Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
The UHB has historically experienced delays in transferring patients to Swansea Bay UHB (SBUHB) tertiary cardiac service for a range of cardiac investigations, treatments and surgery, in particular transfer delays for ACS/NSTEMI patients requiring tertiary centre angiography/coronary revascularisation within 72 hours of presentation to local secondary care hospital (NICE). The ACS/NSTEMI Treat & Repatriate service established in January 2019 provided 6 ring-fenced beds at PPH and improved transfer times for BGH and WGH patients in particular. Cessation of the Treat & Repatriate service due to COVID acute site pressures at PPH in 2020 has seen a return to increased numbers of patients awaiting prolonged periods for transfer from all 4 acute hospital sites, which is further compounded by acute sites pressures at Morriston Hospital - the risk likelihood has consequently been increased from 2 to 4 to reflect current waiting times averaging 16.9 days based Q4 2020/21 audit.	The target score was reduced to 10 in March 2019 on account of the anticipated benefits of the Regional N-STEMI 'Treat & Repat' arrangement. The service initiated in January 2019 saw a reduction in transfer wait from an average of 10.7 to 4 days by April 2019. Whilst the PPH 'Treat & Repat' service is currently suspended, it is anticipated that resumption of this approach would yield the same improvement.

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**
# 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. # Medical and nursing staff review patients daily and update the Sharepoint referral database as appropriate to communicate and escalate changes in level of risk/priority for patients awaiting transfer. # Bi-monthly operational meeting with Swansea Bay UHB (SBUHB) to monitor activity/patient flow and address associated risks/issues. # 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. # Reporting arrangements in place to monitor emergency and elective waiting times.	Lack of capacity in tertiary centre to manage a range of specialised cardiac investigations, treatments and surgery. Lack of cardiac catheter capacity in HDUHB to reduce reliance on tertiary centre angiography. Lack of theatre / pacing workforce capacity in HDUHB to reduce reliance on tertiary centre pacing. Lack of CT Coronary Angiography capacity in HDUHB to reduce reliance on in-house and SBUHB angiography. Suspension of PPH ACS/N-STEMI 'Treat & Repat' pathway in 2020.	Increase in-house CT Coronary Angiography (CTCA) capacity. As a less invasive/lower risk diagnostic, this will release and prioritize in-house and tertiary Percutaneous Coronary Angiography capacity for those patients who require it and thereby reduce transfer delays.	Smith, Paul	~~31/01/2019~~ 31/12/2021	SBAR development delayed due to COVID pressures. Cardiology Clinical Lead and SDM currently working with in-house CTCA Steering Group to support SBAR development for reporting to Acute Bronze, or similar meeting. Development of CTCA is a key priority within the ARCH Cardiology Programme in 2021/22.
		Develop long term Regional Cardiology Plan.	Carruthers, Andrew	~~30/09/2019~~ 31/12/2022	Decision taken not to establish a regional Cardiac Network/Collaborative in 2019. Development of long term regional plan for cardiology historically overseen by Joint Regional Planning and Delivery Forum and Committee and ARCH workstreams, but progress delayed/activity suspended during COVID. Cardiology Clinical Lead and SDM engaging with the ARCH Cardiology Programme re-established in Aug21. ACS, CT Coronary Angiography, Cardiac MRI, Pacing and Cardiac Physiology workforce identified as the key priority areas for 2021/22.

Increase in-house cardiac pacing capacity as part of a broader plan to repatriate the pacing LTA from SBUHB.	Smith, Paul	~~31/10/2019~~ 31/12/2021	Pacing SBAR approved by Execs in Sep19 supporting repatriating Simple Bradycardia Pacing (LTA)from SBUHB. Initial plan to phase repatriation from Spring 2020 impeded by COVID. Cardiology Clinical Lead / SDM to oversee refresh of SBAR/review of feasibility in support of repatriating this activity/pathway. Review of regional pacing service / development of HDUHB pacing service is a key priority within the ARCH Cardiology Programme for 2021/22.
Re-establish HDUHB ACS/N-STEMI Treat & Repatriate Pathway	Smith, Paul	~~01/07/2021~~ 30/11/2021	Cardiology Clinical Lead/SDM currently drafting SBAR outlining a plan to support restoration of ACS Treat & Repatriate pathway to address current delays/immediate risks in the short-term. Plan to complete SBAR by Sep21. SBAR development currently on hold pending imminent discussions re regional ACS pathway at ARCH ACS Group scheduled for 7th Oct. ACS is a key priority within the ARCH Cardiology Programme for 2021/22.

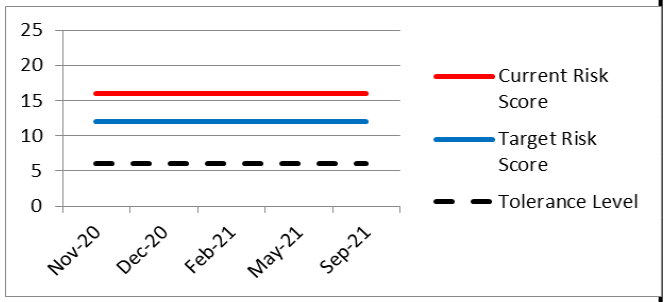
					Review ACS/NSTEMI Pathway and longer term plans/requirements to achieve NICE NG185 ACS recommendations.	Smith, Paul	12/03/2021	Cardiology Pathway Transformation Project commenced Jun21 and is currently prioritising ACS pathway review in conjunction with current focus on ACS by Clinical Effectiveness Team and Value Based Healthcare Team. Cardiac Network ACS Peer review to be conducted in Nov21.
					Increase in-house diagnostic Percutaneous Coronary Angiography. This will address current in-house capacity deficit due to patient social distancing as well as reduce reliance on tertiary pathway and thereby reduce transfer delays.	Smith, Paul	31/12/2021	SBAR development currently on hold pending imminent discussions re regional ACS pathway at ARCH ACS Group scheduled for 7th Oct. ACS is a key priority within the ARCH Cardiology Programme for 2021/22.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	**Sources of ASSURANCE**	**Type of Assurance (1st, 2nd, 3rd)**	**Required Assurance / Current Level**			**Identified Gaps in Assurance:**	**How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps**	**By Who**	**By When**	**Progress**
Performance indicators for Tier 1 targets.	Daily/weekly/monthly/ monitoring arrangements by management	1st				Lack of oversight at the Board and Committees.				
	Audit of N-STEMI referral undertaken by Cardiology Clinical Lead/SDM on	1st								
	IPAR Performance Report to BPPAC & Board	2nd								
	Monthly oversight by WG	3rd								

Date Risk Identified:	Nov-20	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Sep-21
Strategic Objective:	5. Safe and sustainable and accessible and kind care	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Oct-21

Risk ID:	**1032**	**Principal Risk Description:**	There is a risk that the length of time MH&LD clients (specifically ASD, memory assessment and psychology services for intervention) are waiting for assessment and diagnosis will continue to increase during 2021/22. This is caused by new environmental (due to social distancing measures) constraints to undertake required face-to-face assessments and patients' reluctance to attend clinics due to the risk of COVID, as well as certain elements of some assessments being restricted due to other agencies, such as education, providing limited services at present. 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.

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):	4×4=16
Target Risk Score (L x I):	3×4=12
Tolerable Risk:	6
Trend:	⟷



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

Rationale for CURRENT Risk Score:

Referrals for ASD have continued throughout the pandemic at approximately the same level as pre-Covid. The service were experiencing significant waiting times as a result of demand levels. Due to the constraints to undertake the required face to face assessments, the implementation of social distancing and, in some instances patients reluctance to attend clinics due to the risk of COVID, has an impact on the services' ability to see the same volume of service users as they were previously able to. In addition, the estate footprint does not necessary lend itself to accommodate the social distance requirements and in some instances is not therapeutically beneficial. Certain elements of some assessments also being restricted due to other agencies, such as education, providing limited services.

Integrated Autism Service (IAS) is funded on fixed term basis which can make staff retention challenging along with having to train new incoming staff.

Rationale for TARGET Risk Score:

The Directorate is aiming to restore pre-COVID levels of assessment and intervention. This 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,	**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 community support, well being 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. Paper was presented at the June Quality Safety and Experience Assurance Committee with a further update paper provided for the August meeting outlining control measures to manage the waiting times that the Directorate have at present.	Social distancing measures reducing the available space/offices that can be used to meet clients face-to face. Certain elements of some assessments also being restricted due to other agencies, such as education, providing limited services. 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	Assess and source further IT requirements.	Carroll, Mrs Liz	Completed	Some further IT equipment has been received and distributed on a priority basis. The Directorate will now need to rationalise working from home/agile working in order to maximise the potential office/clinical space.
		Identify alternative venues/space to hold clinics.	Carroll, Mrs Liz	~~31/03/2021~~ 31/12/2021	Working with the Estates Department and exploring options with external partners. Regular meeting 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/Local Authority use of hubs.

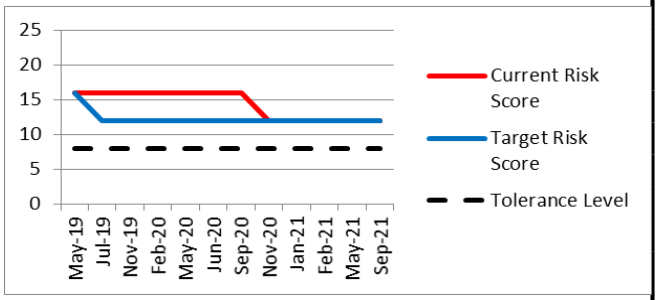
	ongoing, virtual assessment offered but uptake not good for ASD client group.	Head of Service to operationalise	Carroll, Mrs Liz	~~31/12/2020~~ 31/12/2021	Directorate have been asked to participate in Health Board wide Task & Finish group. The Directorate will raise the importance of Service User/Carer input into this group to ensure the patient experience is represented to inform the outcome. Outcome measures will form part of this project. Service specific template letters are being developed and initial conversations held with Informatics colleagues to progress.
		Appointment of Service Delivery Manager.	Carroll, Mrs Liz	Completed	Service Delivery Manager has now taken up post.
		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	Completed	This process has been enacted.
		Identify funding for Interim Clinical Psychologist lead post to assist with the waiting lists and service development.	Carroll, Mrs Liz	~~31/03/2021~~ 31/12/2021	Discussions taking place with Finance Business Partner to progress recruitment.
		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~~ 31/12/2021	Health Board will be early pilot site providing an early offer for children and young people and their families, who otherwise would be referred for direct support to the NHS.

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
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	1st				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	2nd								
	MH&LD QSE Group overseeing patient outcomes	2nd								
	An update was requested by the Chair and provided for the August Quality, Safety, Assurance Committee.									

Date Risk Identified:	Sep-18	**Executive Director Owner:**	Shakeshaft, Alison	**Date of Review:**	Sep-21
Strategic Objective:	2. Working together to be the best we can be	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Nov-21

Risk ID:	**628**	**Principal Risk Description:**	There is a risk that patients in need of therapy services do not receive them in a timely period or do not receive the required level or intensity. This is caused by gaps or fragile staffing levels in the therapy service provision across acute, community and primary care settings from historical under-resourcing, exacerbated by recurrent savings targets, vacancies and recruitment/retention issues due to national shortages. There is the additional challenge that COVID-19 has placed upon workforce models due to increased complexity and acuity of patients presenting post lockdown having had treatments suspended and of not able to access timely care. This could lead to an impact/affect on patient outcomes, longer recovery times, increased length of stay, a reduction in performance against performance targets including 14 week waiting time, non-compliance with clinical guidance, and potential adverse impact on patient safety/harm.

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



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

Rationale for CURRENT Risk Score:

#Therapy service provision across acute, community and primary care continue to be challenging, as described in the cause section, but have improved following additional resourcing (Major Trauma, Nutrition, Rehabilitation, Lymphoedema, Dementia, MSK, Winter Funding) , Long COVID, workforce redesign and over recruitment of Band 5 graduates (Physiotherapy, OT, Podiatry & S&LT).

#Impact to service provision by COVID-19 pandemic and rehabilitation requirements have added an additional challenge to workforce models, but have also enabled the roll out at scale of digital and virtual consultations.

#Across therapy services, current demand is largely being met for new patient referrals, apart from those clinical areas where physical delivery of hands on treatment is impacted by the demands of physical distancing and IP&C requirements.
Post COVID Recovery modelling suggests additional demand to support patients displaying ongoing symptoms post 12 weeks Acute COVID infection, with complex rehabilitation needs.
Further work is underway to understand the potential additional demand for rehabilitation for those indirectly affected by the interruption of access to routine service provision.

Rationale for TARGET Risk Score:

The target risk score has been assessed as 12 as although priority areas have been agreed and progressed, the risk will not be completely addressed in the coming year. A sustainable therapy workforce solution aligned to the Health and Care Strategy has been agreed. The following high impact/workforce priority areas were prioritised within the Annual Plan for focus during 2021/22: older people (incorporating frailty and stroke); improving self-management (including pulmonary rehabilitation and diabetes); therapists as first point of contact in primary care (including musculoskeletal, older people and irritable bowel syndrome); Major Trauma Plan. An additional requirement will be the delivery of the COVID-19 Rehabilitation Framework, and work is underway to identify the impact of this locally. A sustainable solution is currently in place 14 week waiting time target, with additional support required for Occupational therapy and Podiatry as a result of IP&C requirements. Therapy services will continue to pursue practical, prudent and incremental workforce solutions to improve patient care, outcomes and experience, and to ensure sustainably funded models are identified through whole-system review and potential shifting of resource from elsewhere in the health and care system.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective,	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# Individual service risks identified and discussed at a range of fora; i.e. QSEAC, OQSESC, Performance Reviews and Therapy Forum. # Priority areas agreed in the 2021/22 Annual Plan, to increase capacity in key areas identified in plan. Additional Capacity created in MSK service, Long COVID, ESD # Locum staff utilised where appropriate, funded from within core budget (2 vacancies required to fund 1 Locum) # Short-term contracts/additional hours within budget used to cover maternity leave. # Training of support staff to safely deliver delegated tasks. # Over-recruitment of Newly Qualified Staff / B5 & B6 staff where appropriate and approved by the Clinical Director to mange foreseeable and predictable staffing level capacity gaps. # Local solutions include review of each vacant post to make them attractive, including skill mix review, early advertisements for new graduates. # Student streamlining of B5 graduates from June 2021 # Prioritisation of patients is undertaken through triage and risk assessment by therapy services. # Use of Digital Platforms to support agile working and remote access # Continued training of the Malcomess Care Aims Framework for MDT/Therapy Service. # Workforce plan being reviewed in light of emerging pressures	Inability to secure funding for all developments identified in 21/22 annual plan. Shortage in some clinical specialities of qualified and specialist staff nationally Rurality of HDdUHB has historically limited applications to some posts. Unplanned service development due to short term or opportunistic funding. Lack of cohesive approach to workforce planning across therapy services. Reactive deployment of Therapy workforce to support surge or COVID Pandemic response. Appropriate resources to support COVID recovery	Developing robust plans to evidence improved patient outcomes and experience through reprovision of resource from elsewhere in the health and care system aligned with strategic direction of the HB. This is a significant, long term piece of work, which will need to run alongside strategic development through the Health and Care Strategy. This will include skill mix review such as new HCSW and Advan	Reed, Lance	Completed	Plans under development. Funding already secured for developments in pulmonary rehab, dementia, lymphoedema and to support some increase in front door/acute therapy input including plans to address malnutrition. Continued operational and strategic engagement with DoTHS, DOO, HoS, CDs and GMs to address COVID-19 response and to service developments that would release resource and savings from the wider health and care system through increased therapy provision, including areas of pathway re-design. WG funding for Therapy Assistant Practitioner HCSW role to support workforce model changes.
		Ensure process for robust workforce planning is in place to inform HEIW in respect to future graduate numbers required by the UHB/Region, which are aligned to the Health and Care Strategy workforce plan.	Shakeshaft, Alison	Completed	Long-term piece of work informed by action above on an annual basis. Lead in time of 3 years to benefit from graduate programme. HEIW AHP Streamlining to commence 2021

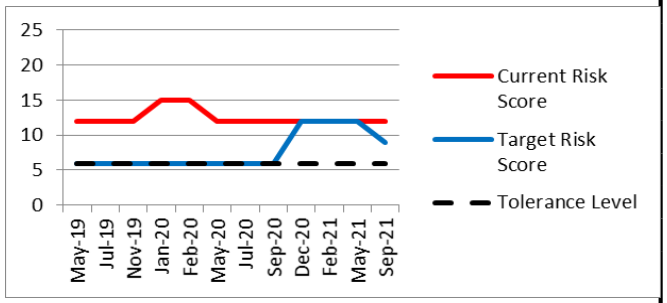
support COVID recovery	Pursue opportunities to attract local people into therapy careers in the HB, eg 'grow your own' schemes, apprenticeship programmes, development of career pathways from HCSW to graduate, development of local graduate training programme.	Reed, Lance	Completed	Commitment given to extend apprenticeship scheme to AHPs, agreed from 2020. Variety of HCSW training modules for level 3 and 4 developed and being implemented. HEIW review to commission local training provision for Physio & Occupational Therapy Undergraduate Training locally.
	Develop robust workforce plans that align to stroke, major trauma and neurology and COVID-19 rehabilitation service needs to maximise workforce opportunities.	Shakeshaft, Alison	~~31/03/2020~~ 31/03/2022	Plan being developed as part of Therapy 3 Year Plan 2021/23 to include extended and 7 day working.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
Maintenance of 14 week waiting times for therapy services. Clearance of backlog for pulmonary rehabilitation, with 100% achievement of 14 week maximum wait by Dec21. Improved compliance with minimum standards for stroke therapy care by Q2 2021/22 (Dec21). Improved staffing ratios for priority areas by Dec21. Recruitment & Retention monitoring	Management monitoring of breaches of 14 week waiting times	1st			Briefing on current position - QSEAC: Risk 628 - 06.10.2020 Briefing Paper on Therapy Staffing - HDCHC Services Planning Committee 14.12.20 Briefing on Therapy Staffing - HDCHC Services Planning Committee 16.02.21 Executive Team Briefing -					
	Exceptions to achieving 14 week waiting times reported via IPAR to PPPAC	2nd								
	Monitored nationally via SSNAP and monitored via Stroke Steering Group & RCP Annual Report with recommendations produced	2nd								
	External Peer Reviews, Delivery Unit Reviews & national audits, eg Diabetes paediatric audit - action plans developed	3rd								

Date Risk Identified:	Apr-17	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Sep-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Nov-21

Risk ID:	**129**	**Principal Risk Description:**	There is a risk disruption to business continuity of the Hywel Dda Out of Hours (OOH) Service. This is caused by a lack of available of labour supply as GPs near retirement age and pay rate differentials across Health Boards in Wales impact the UHB's ability to recruit in the mid-long term. In the short term, any lifting of COVID-19 restrictions (a lot of clinicians are currently taking holidays following Covid-19 lockdown pressures) as well as possible impacts on in-hours provision is likely to result in a fragile workforce position once again. In addition, some clinicians may preferentially work 111 First shifts, as they are potentially much lighter (already seen in SBU). This could lead to an impact/affect on a detrimental impact on patient experience and the unscheduled care pathway.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×3=15
Current Risk Score (L x I):	4×3=12
Target Risk Score (L x I):	3×3=9
26/11/2020 - Board 'Accept' Target Risk	
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
The COVID pandemic combined with the temporary overnight service changes has brought some respite to the service fragility, and this is reflected in the current risk score. Generally the rotas continue to be unstable, particularly at the weekends. Any further absence on out of hours provision is likely to rapidly result in further deterioration of the current position. As of September 2021 there has been no notable change/definite trend in the service fragility. Rotas continue to be fragile, particularly at weekends. The potential adverse affects of a third wave are currently being considered, combined with other seasonal pressures, including the potential affect of RSV.	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 salary 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. 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 requirements have been flagged as part of the IMTP. 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 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 used to develop plans to re-open bases and provide better care, therefore the effect of the recruitment could be diluted through the expansion of the service.

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**
# 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. # Workforce support from 111 programme team in addressing OOH fragilities available if required. # 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	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. At present the staffing remains challenging, as we have lost the previous stability in the stable rota in Carmarthen. There are shortfalls in Pembrokeshire and Ceredigion that are affecting service provision throughout the 7 day operating period. Long term sickness has improved for one clinician but offset by medical retirement of another. 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	Ensure Transforming Clinical Services Programme incorporates a long term, viable plan for OOH.	Rees, Gareth	~~30/09/2020~~ 31/12/2021	Sept 2021- Still awaiting decision/direction on integration into TCS, as well as considering the impact of the ongoing COVID pandemic.
		Review the rationalisation of overnight temporary service change.	Richards, David	~~31/05/2021~~ ~~30/09/2021~~ 31/12/2021	All operational staff are aware that this review is now underway as of Feb21. The review is being designed and will look at patient demand and experience, and service risks. As of May21 this is being actively reviewed with the Director of Operations. The consultations will now take place into Jun21 with outcomes to be reported to the relevant UHB Committees in Sep21. Jul21- A patient and staff survey to be released and SDM to write paper to Director of Operations on service change. Currently working with Workforce colleagues to develop a true multidisciplinary team.
		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	~~31/08/2021~~ ~~30/09/2021~~ 31/12/2021	Admin team are currently building and inputting all services details. RotaMaster will then be tested before going live. As of Jul21 RotaMaster is still being built. Training sessions will become available once RotaMaster is in place and hopeful this will be completed by Dec21.

	formalised workforce plan and redesign is still required - reflected in IMTP submission. In relation to service demand, activity has 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, complicated by the inability to see red flow patients in an Out of Hours setting (option available for red flow patients is nearing	Implement Locum Hub Wales.	Richards, David	Completed	Completed- Locum Hub Wales is 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	~~30/06/2021~~ 31/12/2021	Interviews taking place w/b 19/07/2021 for 5 GPs. Some of these GPs are finishing training, but will be recruited for referred enrolment. Further recruitment advert will be considered following these interviews.

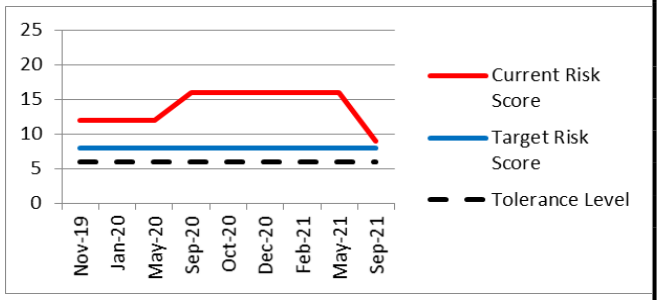
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed / Further action necessary to address the gaps	By Who	By When	Progress
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	1st			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	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	1st								
	Monitoring of performance against 111 standards	1st								
	Issues raised at fortnightly meeting with Primary Care Deputy Medical Director and Associate Medical Director	1st								

Monthly report to Joint Operations Group (WAST, 111 team & 111 Health Boards)	2nd			ET- Risk to OOH business continuity - Sep19 ET- OOH resilience - Nov19 & Jan20 BPPAC Quarterly monitoring Nov19 BPPAC - update on the
QSEAC monitoring	2nd			
Issues raised, and performance Matrix reviewed, at National OOH forum (bi-monthly, attended by WG)	3rd			
WG Peer Review Oct 19	3rd			

Date Risk Identified:	Jun-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Sep-21
Strategic Objective:	Delivery of the Quarter 3/4 Operating Plan	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Nov-21

Risk ID:	**750**	**Principal Risk Description:**	There is a risk unavoidable delays in the treatment of patients in Emergency Department (ED) at WGH, with the added potential of having to close the service. This is caused by a lack of substantive middles grade and high reliance on agency locum cover, which is not always available. This could lead to an impact/affect on patient care through prolonged stays in ED and delays in transferring to specialty, delays in diagnosis and treatment, poorer outcomes, and increased ambulance off load delays. Further impacts include inability to run a full rota and a decreased level of supervision of junior doctors, as well as deterioration in Tier 1 performance for 4 hours waiting time in A&E, and increased pressure on WGH financial position through use of agency at an enhanced time. If the service was to close, it would mean that Withybush would have no senior medical doctor or any senior Doctor on site to attend any emergencies or Met calls for the whole of hospital over night.

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×4=20
Current Risk Score (L x I):	3×3=9
Target Risk Score (L x I):	2×4=8
Tolerable Risk:	6



Does this risk link to any Directorate (operational) risks?	229
Trend:	

Rationale for CURRENT Risk Score:	**Rationale for TARGET Risk Score:**
WGH should have 7 middle grade doctors to fill rota. The rota remains under constant review and management as the department are fully reliant on temporary staff. The risk has therefore increased to 16 based on 3 substantive & 1 long term zero hours doctors being in place. Unfortunately, only 3 of these doctors work a full rota, including nights. This places additional pressure on the system. July: interviews taken place, one job offered waiting acceptance. post back out to advert. Aug: At present we have been able to drop this risk to High due to being able to fill posts with agency, but at a higher rate. Without agency we still have 4 WTE vacancies. Job plan is in progress.	It is anticipated that the completion of the recruitment process of 3 middle grade posts will provide some stability to the department. The contingency plan, which is currently under development, will ensure that robust procedures are in place in the event that the middle grade rota cannot be filled.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	**Gaps in CONTROLS**			
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective,	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Daily review of team strengths by rota co-ordinators and service manager unscheduled care. Issues identified escalated to GM and SDM. Recruitment program on-going to fill gaps and recruit into vacant posts. Medacs agency filling whenever possible with long term locums. Continuous monitoring of the team strengths to ensure consultant and senior support and supervision. Links with other Health Board sites (HDUHB & SBUHB) to outline current pressures and any opportunities to cross cover and to assess overall medical staffing position across HDUHB Weekly Urgent Response Group review rotas for the next six months. 1 x long term locum in place (2 left July 2020). Escalation procedures in place. March 2020 Middle grade rota merged with medical rota to strengthen workforce across 2 Emergency Departments. July 2020 - rotas have now separated as number of inpatients have increased and general medical teams have a larger inpatient & medical take to support.	Contingency plan for when middle grade shift is uncovered. Inability to recruit middle grade doctors at WGH.	Develop contingency plan to respond to incidences when middle grade rotas cannot be filled in WGH ED.	Cole-Williams, Janice	~~30/09/2019~~ 07/11/2020	Draft procedure under review. Plan A drafted and circulated. Unable to provide ED with ad hoc paediatric middle grade or consultant cover when ED middle grade position is uncovered. Therefore, Plan B currently being drafted.
		Complete the recruitment of 4 middle grade doctors.	Cole-Williams, Janice	~~31/12/2019~~ ~~07/11/2020~~ 13/05/2021	1 Post out to advert. Others offered but candidates are overseas. delays in transporting to the UK due to the Coronavirus pandemic and related travel restrictions.

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