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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	08 February 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

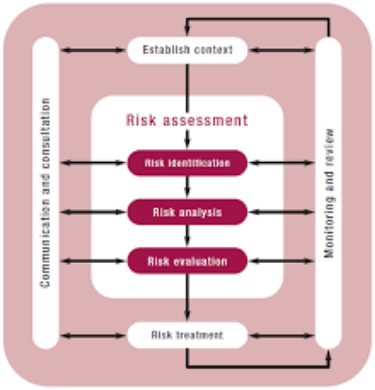
ADRODDIAD SCAA
SBAR REPORT

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 5 risks currently aligned to QSEC (out of the 16 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 (October 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	5	
New / escalated risks	1	*See note 1*
De-escalated/Closed risks	2	*See note 2*
Increase in risk score ↑	0	
Reduction in risk score ↓	0	
No change in risk score →	4	*See note 3*

Note 1 – New Risks
Since the previous report, there has been 1 new risk has been added to the CRR and aligned to QSEC.

Risk	**Lead Director**	**New/ Escalated**	**Date**	**Reason**
Risk 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	New	05/01/2022	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, and is scheduled to be completed by May22.

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

Risk Ref & Title	Lead Director	Closed/ De-escalated	Date	Reason
Risk 628 - Fragility of therapy provision across acute, community and primary care services	Director of Therapies and Health Sciences	De-escalated	13/10/2021	The Executive Team agreed to de-escalate this risk as deficits in all staffing groups is captured in the wider workforce corporate risk and the position within therapies is no worse than any other clinical group. The remaining outstanding action in respect of developing robust workforce plans is incorporated within the wider workforce corporate risk, and longer term within the workforce principal risk.
Risk 750 - Lack of substantive middle grade doctors affecting Emergency Department services in WGH, with the risk of service closure	Director of Operations	De-escalated	06/10/21	The Executive Team agreed to de-escalate this risk to Directorate level as the situation in WGH is no worse than any other site at present. The Director of Operations is to explore whether a new corporate risk in respect of medical staff in Emergency Departments across the HB is required.

Note 3 - 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**	08/11/21	The Executive Risk Group will be asked to close this at their meeting on 2 February and approve a more specific risk in relation to the NSTEMI pathway. This risk was reviewed following the Operational Risk Review meetings led by the Director of

					Nursing, Quality and Patient Experience and the Director of Operations.
Risk 684 - Lack of agreed replacement programme for radiology equipment across UHB	Director of Operations	**5x4=20**	**5x4=20**	23/12/21	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**	21/01/22	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**	11/01/2022	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.

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

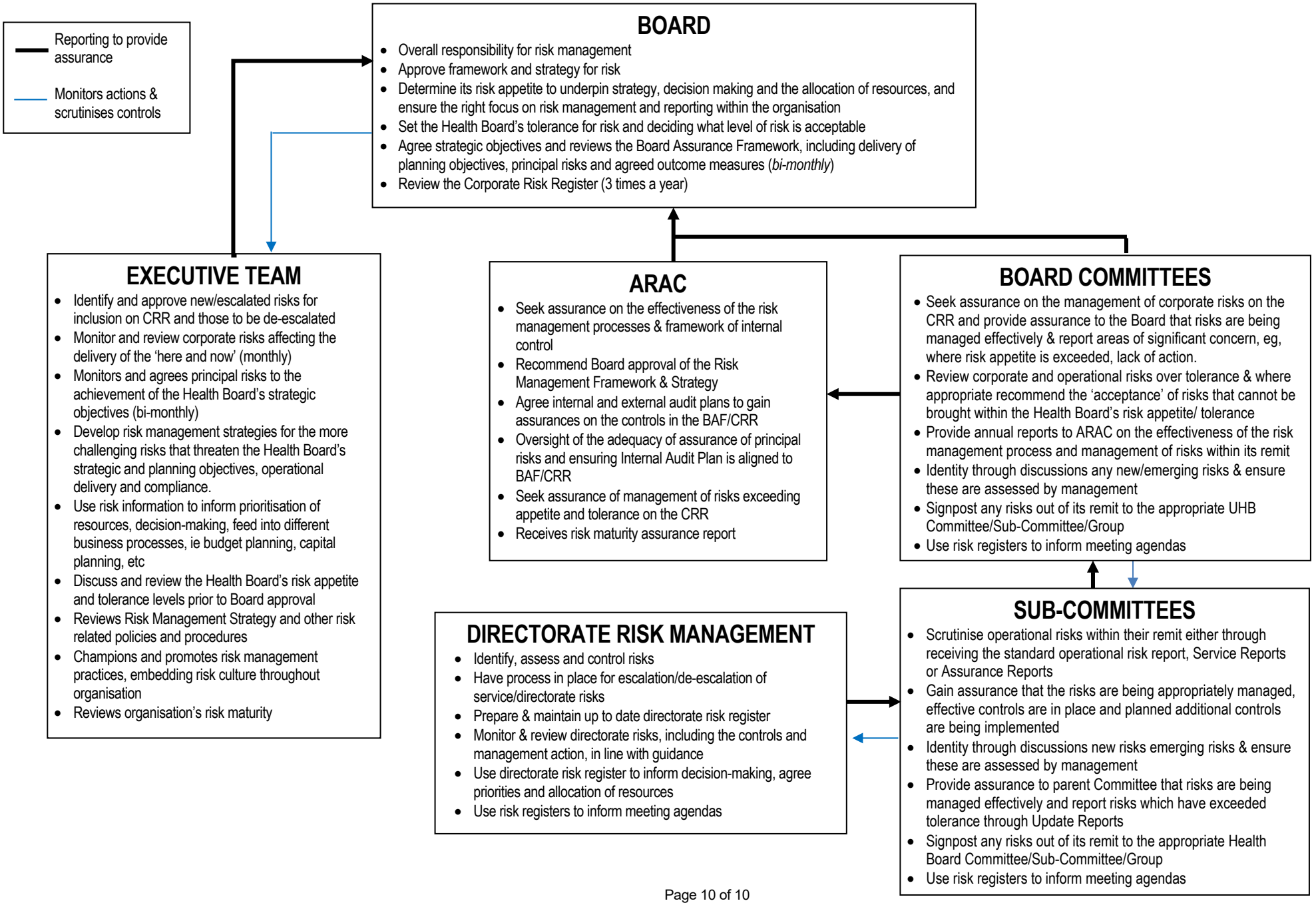
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	9. All HDdUHB Well-being Objectives apply

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 Jan-22	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	5x4=20	**5×4=20**	→	**3×4=12**	
117	Delays in transfers to tertiary centres for urgent cardiac investigations, treatment and surgery	Carruthers, Andrew	Safety - Patient, Staff or Public	6	4x5=20	**4×5=20**	→	**2×5=10**	
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	4x4=16	**4×4=16**	→	**3×4=12**	
129	Ability to deliver an Urgent Primary Care Out of Hours Service for Hywel Dda patients	Carruthers, Andrew	Service/Business interruption/disruption	6	4x3=12	**4×3=12**	→	**3×3=9** Accepted	
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, Phil	Adverse publicity/reputation	8	N/A	**3x4=12**	New	**2x4=8**	

Assurance Key:

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

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

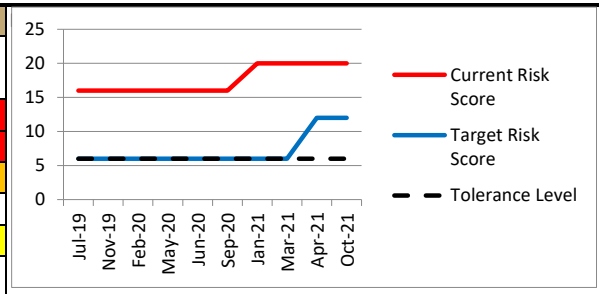
NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you

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

Date Risk Identified:	Jan-19	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Dec-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Jan-22

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



Rationale for CURRENT Risk Score:

The UHB's stock of imaging equipment routinely breaks down causing disruption to diagnostic imaging services across all sites which has a significant impact on the UHB's ability to meet its RTT target and impact to patients can include delays in diagnosis and treatment. Presently equipment downtime 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).

Rationale for TARGET Risk Score:

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, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**

# Service maintenance contracts in place and regularly reviewed to ensure value for money is maintained. # The difficult to source spares can be obtained through bespoke manufacture but this invariably results in inherent delays in returning equipment to service. # Regular quality assurance checks (eg daily checks). # Use of other equipment/transfer of patients across UHB during times of breakdown. # Ability to change working arrangements following breakdowns to minimise impact to patients. # Site business continuity plans in place. # Disaster recovery plan in place. # 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. # 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 Head of Radiology has confirmed that all relevant funding has been sourced, with ongoing work to install equipment / updates to be made alongside the Estates time. Action complete with regards to funding.
		Monthly project meeting to discuss commissioning of agreed equipment with estates, planning and manufacturers.	Roberts-Davies, Gail	~~31/12/2020~~ ~~30/08/2021~~ ~~31/03/2022~~ 31/03/2024	The replacement schedule currently is to replace CT at WGH with a plan to replace a number of ultrasound systems and Image Intensifiers across the four hospital sites. There has been further funding agreed to replace 2 CT scanners, 3 DR radiography systems and 2 fluoroscopy systems across the Health Board by the end of the 2023/24 financial year.

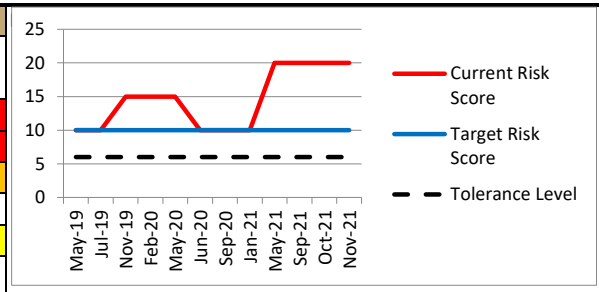
ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level			Identified Gaps in Assurance:	How are the 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	Monthly reports on equipment downtime and overtime costs	1st			Radiology Equipment SBAR - Executive Team - Mar19 Further	Lack of process of formal post breakdown review.				
	IPAR report overseen by PPPAC and Board bi-monthly	2nd								

overtime costs to nil by Mar22.	Internal Review of Radiology Service Report (Reasonable Rating	3rd			updates CEIMT Feb20 Further updates CEIMT Sep20				
	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:**	Nov-21
Strategic Objective:	N/A - Operational Risk	**Lead Committee:**	Quality, Safety and Experience Assurance Committee	**Date of Next Review:**	Dec-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.
Does this risk link to any Directorate (operational) risks?			

Risk Rating:(Likelihood x Impact)	
Domain:	Safety - Patient, Staff or Public
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	2×5=10
Tolerable Risk:	6
Trend:	⟷



Rationale for CURRENT 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.

Rationale for TARGET Risk Score:

The target score was reduced to 10 in March 2019 on account of the anticipated benefits of the Regional N-STEMI 'Treat & Repat' arrangement. The service initiated in January 2019 saw a reduction in transfer wait from an average of 10.7 to 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, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**

# All patients are risk-scored by cardiac team at SBUHB on receipt of patient referral from HDUHB 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 during 2020 due to COVID pressures. Development of local CTCA is a key priority within the ARCH Cardiology Programme in 2021/22. Indicative investment for CTCA highlighted in IMTP - detailed business case in development and scheduled for completion in December 2021 in support of IMTP.
		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 Aug '21. 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	Historic Pacing SBAR approved by Executive Team in Sep '19 supporting repatriation of Pacing (LTA) from SBUHB - this plan to phase repatriation from Spring 2020 was suspended by COVID throughout 2020. Development of local Pacing is a key priority within the ARCH Cardiology Programme in 2021/22. Indicative investment for Pacing highlighted in IMTP - 2019 SBAR currently being updated and scheduled for completion in December 2021 in support of IMTP.

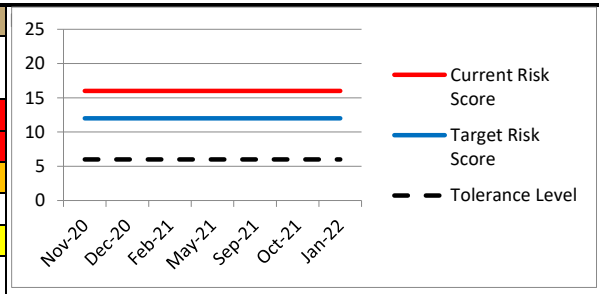
			Re-establish HDUHB ACS/N-STEMI Treat & Repatriate Pathway	Smith, Paul	~~01/07/2021~~ 30/12/2021	Development of Regional ACS pathway is a key priority within both the Cardiology Pathway Transformation Project (2021/22) and the ARCH Cardiology Programme. Indicative investment for restoration of Treat & Repatriate facility/service highlighted in IMTP - detailed business case in development and scheduled for completion in December 2021 in support of IMTP.
			Review ACS/NSTEMI Pathway and longer term plans/requirements to achieve NICE NG185 ACS recommendations.	Smith, Paul	31/12/2021	Development of Regional ACS pathway is a key priority within both the Cardiology Pathway Transformation Project (2021/22) and the ARCH Cardiology Programme. Cardiology Pathway Transformation Project (2021/22) currently mapping / re-mapping current pathway and developing gap analysis in support of NICE NG185 ACS compliance. Indicative investment for future pathway re-design highlighted in IMTP - detailed business case in development and scheduled for completion in December 2021 in support of IMTP.
			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	Development of Regional ACS pathway is a key priority within both the Cardiology Pathway Transformation Project (2021/22) and the ARCH Cardiology Programme. Consideration of priority/necessity/viability of developing HDUHB PCI service currently on-going within ARCH Steering Group / ARCH ACS Project group.
ASSURANCE MAP		**Control RAG**	**Latest Papers**	**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	(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
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 quarterly basis	1st								
	IPAR Performance Report to SDOPC & Board	2nd								
	Monthly oversight by WG	3rd								

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

Risk ID:	**1032**	**Principal Risk Description:**	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 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. Difficulty in recruiting suitably qualified staff and increasing demand. 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	

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:	⟷



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, 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 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. 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	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 ongoing, virtual assessment offered but uptake not good for ASD client group.	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~~ 31/03/2022	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, including corporate teams/Local Authority use of hubs. This has been made more difficult due to the withdrawal of Bro Cerwyn due to extensive unforeseen building damage.

not materialise		Head of Service to operationalise	Carroll, Mrs Liz	~~31/12/2020~~ 31/03/2022	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. Service specific template letters are being developed and initial conversations held with Informatics colleagues to progress which are still taking place alongside the development of QR codes and public facing webpages.
		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	Work underway across all services who have waiting times, be they intervention or assessment.
		Identify funding for Interim Clinical Psychologist lead post to assist with the waiting lists and service development.	Carroll, Mrs Liz	~~31/03/2021~~ 31/03/2022	Appointment has been made and waiting for new staff member to take up post.
		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~~ 31/03/2022	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. Awaiting an update on this work.
		Dedicated Psychologist for Autistic Spectrum Disorders commencing a fixed term appointment from July 2021 with a specific focus around demand and capacity.	Lodwick, Angela	Completed	Psychologist in post and commenced assessments with focus of reducing waiting lists
		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.	Amner, Karen	31/12/2022	New action.

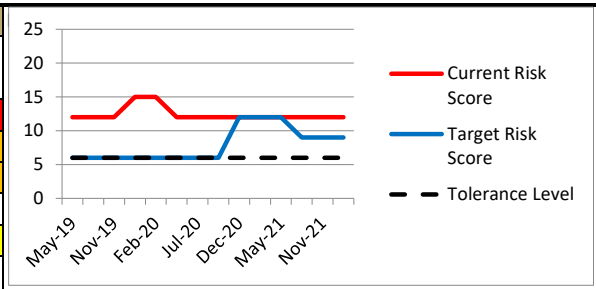
	Directorate to rationalise working from home/agile working in order to maximise the potential office / clinical space	Carroll, Mrs Liz	31/03/2022	Due to Omicrom variant greater numbers of staff have been working from home. An increase in DNA rates were experienced during this time. Directorate is awaiting delivery of additional IT kit to support home/agile 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
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			Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC (Oct21)	System to improve analysis of patient experience	There are outcome measure in place within Psychological Therapies following	Carroll, Mrs Liz	Completed	Directorate have been asked to participate in Health Board wide Task & Finish group. The Directorate
	Monthly MH&LD Business Planning and Performance Group overseeing	2nd								
	MH&LD QSE Group overseeing patient outcomes	2nd								
	Update - Risk 1032: Mental Health and Learning Disabilities Waiting Lists - QSEC	2nd								
	An update was requested by the Chair and provided for the August Quality, Safety, Assurance Committee.									

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

Risk ID:	**129**	**Principal Risk Description:**	There is a risk of the inability 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 across Health Boards in Wales impact the UHB's ability to recruit in the mid-long term. In the short term, seasonal illnesses, continued COVID19 pressures, and upcoming Christmas holiday period could further compromise the ability to fill shifts. This, combined with possible impacts on in-hours provision, will result in a deteriorating workforce position. In addition, some clinicians may preferentially work 111 First shifts, as they are potentially much lighter (already seen in SBU). Seasonal illnesses, continued COVID19 pressures, and usual winter pressures continue. 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 with in a timely manner.
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 Sep21 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, or we do not have evidence that the controls are working)	**How and when the Gap in control be addressed** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
# GP's rotas across the 3 counties are now managed centrally via the administration team based in Haverfordwest # Dedicated GP Advice sessions in place at times of high demand (mostly weekends). # Remote working telephone advice clinicians secured where required. # Additional remote working capacity has been secured to assist clinicians who may be shielding/ isolating to continue to support operational demand. # 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	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 affect	Ensure Transforming Clinical Services Programme incorporates a long term, viable plan for OOH.	Rees, Gareth	~~30/09/2020~~ ~~31/12/2021~~ 31/12/2022	As of January 2020 the development of a detailed redesign plan is underway but the timescale has yet to be identified. Feb 2020- this work is continuing to progress and work on medium term resolution has now commenced. Sept 2021- Still awaiting decision/direction on integration into TCS, as well as considering the impact of the ongoing Covid pandemic. Same situation in Jan 2022.

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 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.	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 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 completion). The focus on delivery of care via the telephone advice method is the significant factor in stabilising the risk at this time (70-80% of consultations is now dealt with on the phone)- but 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	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. Jan 22 - to continue with the temporary arrangements due to ongoing rota situation.
		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 30/04/2022	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. Jan 22 - little progress due to Christmas and New Year period. Training sessions being set up, some of which have been undertaken, with the aim to complete and using RotaMaster by the March 2022.

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~~ 30/06/2022	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. Jan 22 - recruited 8 (6WTE), but one has deferred, and others awaiting to start, and also staff on long term sick. Anticipated completion date for the action of June 2022.
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. Jan 22 - discussions on going as to the structure of the model.
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. Jan 22 - discussions on going as to the structure of the model.

		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	Jan 22 - options on other possible facilities or programmes identified after a successful roll out in other services. Follow up work to be undertaken on these.

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 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 BPPAC - OOH service design Feb20 QSEC - OOH Paper 5th	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								
	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			October 2021					

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

Risk ID:	**1337**	**Principal Risk Description:**	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:	*New risk*

No trend information available.

Rationale for CURRENT 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, and will now be completed by May22.

Rationale for TARGET Risk Score:

A sustainable TB service is required to support the ongoing outbreak management and ensure that all contacts are identified, screened and treated as appropriate. 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**
1 x permanent TB specialist nurse Limited paediatric provision (6 months funding) PHW Health Protection support supporting outbreak and contacting Paediatric cases who previously not attended All contacts have been contacted at least once. Treatment plans put in place where required	Not having a sustainable TB service in place which will be exacerbated by a lack of consultant provision from Apr22 Additional TB specialist nurse to support outbreak Ability to identify everyone as a contact from TB outbreak from different sources	Implementation of sustainable TB Service plan submitted as part of IMTP 2022/25 Development of TB Database to enable cross-referencing of contacts	Kloer, Dr Philip Tracey, Anthony	31/03/2022 31/03/2022	Submission to be considered as part 2022-25 IMTP process. A system has been developed however further work is required to enable is cross-reference contacts.

Provision to do BCGs Temporary phlebotomy provision in place A Project team will be established to support the review panel, led by a Project Manager and include administrative support, Communications and Information and Communications Technology.	High DNA rate from contacts	Develop a communications strategy through the TB Joint Oversight Group	Evans, John	31/05/2022	Communications Officer to develop strategy to support the publication of the final report in May22.

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
	TB operational group operational response chaired by LPHD	1st			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	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.
	Outbreak Control Team oversee the management of TB outbreak chaired PHW	2nd								
	Internal review presented to an In-Committee Board meeting in Nov19	2nd								
	TB Operational Task & Finish Group facilitating the external review	2nd								
	TB Joint Oversight Group chaired by Medical Directors of UHB and PHW	2nd								

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

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

RISK ASSESSMENT - FREQUENCY OF REVIEW

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