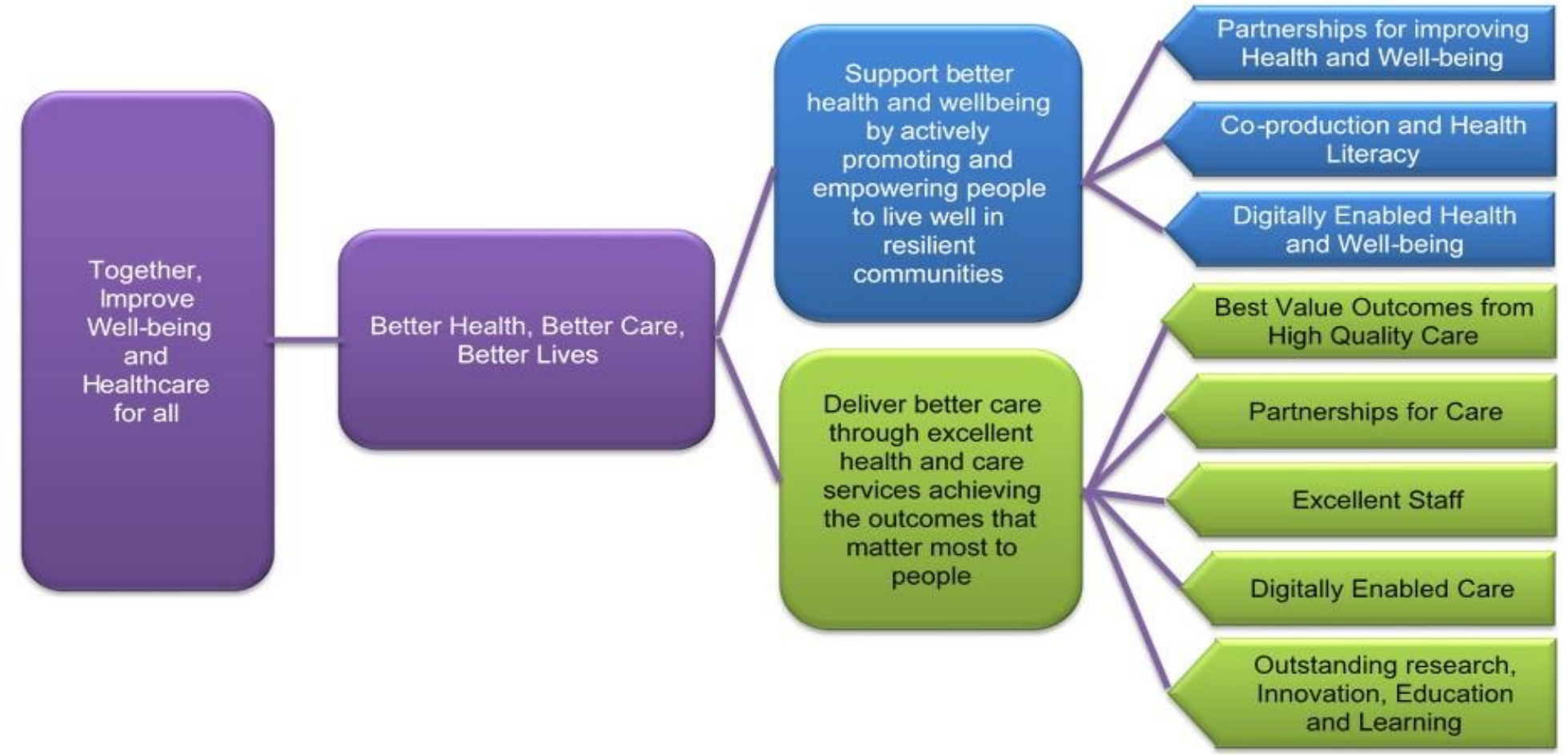
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

# HEALTH BOARD RISK REGISTER
# APRIL 2021


**Aligning Risk with Swansea Bay University Health Board (SBUHB) Strategy**

The Swansea Bay University Health Board (SBUHB) strategy is outlined in the figure below and all risks identified for inclusion on the Health Board Risk Register are mapped to our enabling objectives.



**HEALTH BOARD RISK REGISTER**
**DASHBOARD OF ASSESSED RISKS – April 2021**

| Impact/Consequences | | | | | | |
|---|---|---|---|---|---|---|
| | **5** | | | **53:** Compliance with Welsh Language Standards | **39:** IMTP Statutory Responsibility<br>**41:** Fire Safety Regulation Compliance<br>**60:** Cyber Security<br>**68:** Pandemic Framework (proposed to be closed)<br>**70:** Data Centre outages<br>**69:** Adolescents being admitted to Adult MH wards | **16:** Access to Planned Care<br>**50:** Access to Cancer Services<br>**64:** H&S Infrastructure<br>**66:** Access to Cancer Services - SACT<br>**67:** Access to Cancer Services - Radiotherapy |
| | **4** | | | **13:** Environment of Health Board Premises<br>**37:** Operational and strategic decisions are not data informed Reduced from 16<br>**52**: Engagement & Impact Assessment Requirements<br>**54:** No Deal Brexit Reduced from 15 | **01:** Access to Unscheduled Care Service<br>**27:** Sustainable Clinical Services for Digital Transformation<br>**36:** Electronic Patient Record Increased from 12<br>**43:** DOLS Authorisation and Compliance with Legislation<br>**48:** Child & Adolescence Mental Health Services<br>**57:** Non-compliance with Home Office Controlled Drug Licensing requirements<br>**61:** Paediatric Dental GA Service – Parkway<br>**49:** TAVI Service (Reduced from 25) | **03:** Workforce Recruitment of Medical and Dental Staff<br>**04:** Infection Control<br>**15:** Population Health Improvement (proposed to be closed)<br>**51:** Compliance with Nurse Staffing Levels (Wales) Act 2016<br>**58:** Ophthalmology Clinic Capacity (proposed to be closed)<br>**63:** Screening for Fetal Growth Assessment in line with Gap-Grow (G&G)<br>**65:** CTG Monitoring in Labour Wards<br>**73:** There is potential for a residual cost base increase post COVID-19 as a result of changes to service delivery models and ways of working. |
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| **C X L** | | **1** | **2** | **3** | **4** | **5** |
| | | Likelihood | | | | |

## Risk Register Dashboard

| Strategic Objective | Risk Reference | Description of risk identified | Initial Score | Current Score | Trend | Controls | Last Reviewed | Scrutiny Committee |
|---|---|---|---|---|---|---|---|---|
| **Best Value Outcomes from High Quality Care** | 1 (738) | **Access to Unscheduled Care Service** Failure to comply with Tier 1 target for Unscheduled Care could impact on patient and family experience of care. | 20 | 16 | ➔ | 🡻 | April 2021 | Performance and Finance Committee |
| | 4 (739) | **Infection Control** Failure to achieve infection control targets set by Welsh Government could impact on patient and family experience of care. | 20 | 20 | ➔ | ➔ | April 2021 | Quality and Safety Committee |
| | 13 (841) | **Environment of HB Premises** Failure to meet statutory health and safety requirements. | 16 | 12 | ➔ | 🡻 | April 2021 | Health and Safety Committee |
| | 16 (840) | **Access to Planned Care** Failure to achieve compliance with waiting times, there is a risk that patients may come to harm. Also, financial risk not achieving targets. | 16 | 25 | ➔ | 🡹 | April 2021 | Performance and Finance Committee |
| | 37 (1217) | **Information Led Decisions** Operational and strategic decisions are not data informed. **Reduced from 16** | 12 | 12 | ➔ | 🡻 | April 2021 | Audit Committee |
| | 39 (1297) | **Approved IMTP – Statutory Compliance** If the Health Board does not have an approved IMTP signed off by Welsh Government, primarily due to the inability to align performance and financial plans it will remain in escalation status, currently "targeted intervention". | 16 | 20 | ➔ | 🡹 | April 2021 | Performance and Finance Committee |

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| 41<br>(1567) | **Fire Safety Compliance**<br>Fire Safety notice received from the Fire Authority – MH&LD Unit. Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance.re safety regulations. | 15 | 20 | → | ↑ | April 2021 | Health and Safety Committee |
| 43<br>(1514) | **DoLS**<br>If the Health Board is unable to complete timely completion of DoLS Authorisation then the Health Board will be in breach of legislation and claims may be received in this respect. | 16 | 16 | → | → | April 2021 | Quality and Safety Committee |
| 48<br>(1563) | **CAMHS**<br>Failure to sustain Child and Adolescent Mental Health Services (CAHMS). | 16 | 16 | → | → | April 2021 | Performance and Finance Committee |
| 49<br>(922) | **Trans-catheter Aortic Valve Implementation (TAVI)**<br>Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI) | 25 | 16 | → | ↓ | April 2021 | Quality and Safety Committee |
| 50<br>(1761) | **Access to Cancer Services**<br>Failure to sustain services as currently configured to meet cancer targets could impact on patient and family experience of care. | 20 | 25 | → | ↑ | April 2021 | Performance and Finance Committee |
| 57<br>(1799) | **Controlled Drugs**<br>Non-compliance with Home Office Controlled Drug Licensing requirements. | 20 | 16 | → | ↓ | April 2021 | Audit Committee |

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| | 63 (1605) | **Screening for Fetal Growth Assessment in line with Gap-Grow** Due to the scanning capacity there are significant challenges in achieving this standard. | 12 | 20 | ➔ | ↑ | April 2021 | Quality and Safety Committee |
| | 64 (2159) | **Health and Safety Infrastructure** Insufficient resource and capacity of the health, safety and fire function to maintain legislative and regulatory compliance. | 20 | 25 | ➔ | ↑ | April 2021 | Health and Safety Committee |
| | 66 (1834) | **Access to Cancer Services** Delays in access to SACT treatment in Chemotherapy Day Unit | 25 | 25 | ➔ | ➔ | April 2021 | Quality and Safety Committee |
| | 67 (89) | **Risk target breaches – Radiotherapy** Clinical risk – Target breeches of radical radiotherapy treatment | 16 | 25 | ➔ | ↑ | April 2021 | Quality and Safety Committee |
| | 69 (1418) | **Safeguarding** Adolescents being admitted to adult MH wards | 20 | 20 | ➔ | ↑ | April 2021 | Quality & Safety Committee |
| | 73 (2450) | **Finance** There is a potential for a residual cost base increase post COVID-19 as a result of changes to service delivery models and ways of working. | 20 | 20 | ➔ | ➔ | April 2021 | Performance and Finance Committee |
| **Excellent Staff** | 3 (843) | **Workforce Recruitment** Failure to recruit medical & dental staff | 20 | 20 | ➔ | ➔ | April 2021 | Workforce and OD Committee |
| | 51 (1759) | **Nurse Staffing (Wales) Act** Risk of Non Compliance with the Nurse Staffing (Wales) Act | 16 | 20 | ↑ | ↓ | April 2021 | Workforce and OD Committee |

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| **Digitally Enabled Care** | 27 (1035) | **Sustained Clinical Services** Inability to deliver sustainable clinical services due to lack of digital transformation. | 16 | 16 | ➔ | ➔ | April 2021 | Audit Committee |
| | 36 (1043) | **Storage of Paper Records** Failure to provide adequate storage facilities for paper records then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if there is poor records management in some wards. **Increased from 12** | 20 | 16 | ➔ | ↑ | April 2021 | Audit Committee |
| | 60 (2003) | **Cyber Security – High level risk** The level of cyber security incidents is at an unprecedented level and health is a known target. | 20 | 20 | ➔ | ➔ | April 2021 | Audit Committee |
| | 65 (329) | **CTG Monitoring on Labour Wards** Risk associated with misinterpreting abnormal CTG readings in delivery rooms. | 16 | 20 | ➔ | ↑ | April 2021 | Quality & Safety Committee |
| | 70 (2245) | **National Data Centre Outages** The failure of national systems causes severe disruption across NHS Wales, affecting Primary and secondary care services. | 20 | 20 | ➔ | ➔ | April 2021 | Audit Committee |

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| **Partnerships for Improving Health and Wellbeing** | 15<br>(737) | **Population Health Targets**<br>Failure to achieve population health improvement targets leading to an increase in preventable disease amongst the population resulting in increased morbidity impacting on operational and financial pressures. | 15 | 20 | ➔ | ↑ | April 2021 | Quality and Safety Committee |
| | 58<br>(146) | **Ophthalmology - Excellent Patient Outcomes**<br>There is a failure to provide adequate clinic capacity to support follow-up patients within the Ophthalmology specialty. | 12 | 20 | ➔ | ↑ | April 2021 | Quality and Safety Committee |
| | 61<br>(1587) | **Paediatric Dental GA Service – Parkway**<br>Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morriston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies. | 15 | 16 | ➔ | ↑ | April 2021 | Quality and Safety Committee |
| | 68<br>(2299) | **Pandemic Framework**<br>Risk of declared pandemic due to Coronavirus Infectious Disease outbreak 2020. | 20 | 20 | ➔ | ↓ | April 2021 | Quality and Safety Committee |
| **Partnerships for Care** | 52<br>(1763) | **Statutory Compliance**<br>The Health Board does not have sufficient resource in place to undertake engagement & impact assess in line with Statutory Duties | 16 | 12 | ➔ | ↓ | April 2021 | Performance & Finance Committee |

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| | 53<br>(1762) | **Welsh Language Standards**<br>Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board. | 15 | 15 | ➔ | ➔ | April 2021 | Health Board (Welsh Language Group) |
| | 54<br>(1724) | **Brexit**<br>Failure to maintain services as a result of the potential no deal Brexit<br>**Reduced from 15** | 20 | 12 | ➔ | 🡻 | April 2021 | Health Board (Emergency Preparedness Resilience and Response Group) |

## Risk Schedules

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| **Datix ID Number: 738**<br>**Health & Care Standard: 5.1 Timely Care** | **HBR Ref Number: 1**<br>**Target Date: 31st March 2022** |
| **Objective**: Best Value Outcomes from High Quality Care | **Director Lead:** Rab McEwan, Chief Operating Officer<br>**Assuring Committee:** Performance and Finance Committee |
| **Risk:** If we fail to comply with Tier 1 target – **Access to Unscheduled Care** then this will have an impact on patient and family experience. Challenges with capacity /staffing across the Health and Social care sectors. | **Date last reviewed:** April 2021 |
| **Risk Rating** (consequence x likelihood):<br>Initial: 4 x 5 = 20<br>Current: 4 x 4 = 16<br>Target: 3 x 4 =12 | **Rationale for current score:**<br>Due to current measures related to COVID 19 including the cancellation of all non-urgent activity, Emergency Department and MIU attendance have reduced by nearly 50%, red call performance is at 65% and 4hr handover for the last 3 weeks has been in excess of 75%. Both Morriston and Singleton have predominantly been at risk level 1 for the past 2 months. It is recognised that this is not likely to be maintained as we go into the winter months and therefore remains a high risk. |
| **Level of Control** = 50% | **Rationale for target score:** |
| **Date added to the HB risk register** 26.01.16 | The service delivery units have been implementing models of care that reflect National priorities and there is evidence that these are starting to impact positively on patient flow, length of stay and demand management. Workforce capacity issues continue to be challenging in some key specialty areas. |


| Controls (What are we currently doing about the risk?) | Mitigating actions (What more should we do?) | | |
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| | **Action** | **Lead** | **Deadline** |
| • Programme management arrangements are in place to improve Unscheduled Care performance.<br>• Daily Health Board wide conference calls/ escalation process in place.<br>• Regular reporting to Executive Team, Executive Board and Health Board/Quality and Safety Committee.<br>• Increased reporting as a result of escalation to targeted intervention status.<br>• Targeted unscheduled care investment to support changes to front door service models/ workforce redesign/ patient flow.<br>• Weekly unscheduled care meeting implemented, led by COO and attended by Service Directors<br>• Development of new Acute Medical Services Model focused on increasing the provision of ambulatory care.<br>• Development of a Phone First for ED model in conjunction with 111 to reduce demand. | Implementation of Phone First for ED as one the initiatives set out in the National Unscheduled Care Programme – six goals. | Chief Operating Officer | 31st October 2021 |
| | Phased implementation of the Acute Medical Services Redesign. Business case for ambulatory care element of service redesign submitted WG. | Chief Operating Officer | 31st October 2021 |

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| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>• Executive monitoring/support to achieve improvement plans on a weekly basis. | **Gaps in assurance**<br>**(What additional assurances should we seek?)**<br>The need to deliver sustained service. |

| Current Risk Rating<br>4 x 4 = 16 | Additional Comments |
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| **Datix ID Number: 843**<br>**Health & Care Standard: Staff & Resources 7.1 Workforce** | **HBR Ref Number: 3**<br>**Target Date: 31st March 2022** |
| **Objective**: Excellent Staff | **Director Lead:** Kathryn Jones, Interim Director of Workforce and Operational Development<br>**Assuring Committee:** Workforce and OD Committee |
| **Risk:** Workforce recruitment of medical & dental staff | **Date last reviewed:** April 2021 |
| **Risk Rating** (consequence x likelihood):<br>Initial: 5 x 4 = 20<br>Current: 4 x 5 =20<br>Target: 4 x 3 = 12 | **Rationale for current score:**<br>National shortages of numbers in some areas can lead to:<br>• Unable to recruit sufficient numbers of trainees to fulfil rotas on all sites<br>• Unable to attract non training grades to complete rotas<br>• Unable to fill Consultant grade posts in some specialties with adverse effects on patient safety and industrial relations. Unable to recruit sufficient registered nursing staff. |
| **Level of Control** = 70% | **Rationale for target score:** |
| **Date added to the HB risk register**<br>April 2012 | This remains a challenge and is also a national problem. |


| Controls (What are we currently doing about the risk?) | Mitigating actions (What more should we do?) | | |
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| • Regular monitoring of recruitment position with reports to Executive Team and Board via Medical Director and Medical Workforce Board.<br>• Specialty based local workforce boards established to monitor and control specific issues. The new HB Workforce & OD Committee will seek assurance of medical workforce plans to maintain services.<br>• Engagement of the Deanery about recruitment position. | **Action** | **Lead** | **Deadline** |
| | Medical training initiatives pursued in a number of specialties to ease junior doctor recruitment | Interim Director W&OD. | 31st March 2022 |
| | The Medical Workforce Board continues to monitor recruitment and junior doctor's rotas. | Interim Director W&OD. | 31st March 2022 |
| | Continue to recruit internationally. | Interim Director W&OD. | 31st March 2022 |

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| **Assurances (How do we know if the things we are doing are having an impact?)**<br>• General situation monitored through W&OD Committee<br>• Communication with Deanery<br>• Recruitment campaigns<br>• Monitoring by Executive Teams and specialty based local workforce boards | **Gaps in assurance**<br>**(What additional assurances should we seek?)**<br>Locum cover<br>Adequate supply of doctors who can work in this country<br>Ability to flexibly deploy doctors in training. |
| **Current Risk Rating**<br>**4 x 5 = 20** | **Additional Comments**<br>Risk covers all hospitals and multiple specialties. Participated in BAPIO in November, appointed 25 doctors. Working with Medacs to replace long term locums e.g. in Haematology and Histopathology. Developing an Invest to Save Bid for international overseas recruitment for nursing to upscale the activity for 20/21. Recruitment remains a challenge but is also a national problem. The problem persists but the restriction on overseas travel is not the same as in the first phase. We are still recruiting staff from overseas but have had to provide hotel accommodation for them to quarantine for 14 days before they can commence work. Supply issues to the COVID areas however have been |

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| | mitigated by using doctors from other specialties where demand is currently low and we are looking to over establish locum posts in medicine, ITU and Anaesthetics. Some issues with the lack of NHS experience for many locums which means we have had to consider some off contract agencies.<br>International recruitment - In progress but this has been delayed due to Covid. New approaches from Spring 21 onwards. |

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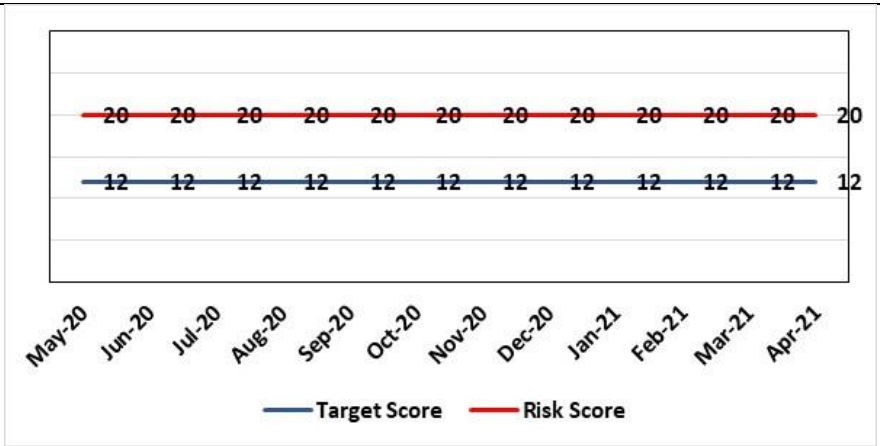
| **Datix ID Number: 739**<br>**Health & Care Standard: 2.4 Infection Prevention & Control & Decontamination** | **HBR Ref Number: 4**<br>**Target Date: 31st March 2022** |
| **Objective**: Best Value Outcomes from High Quality Care | **Director Lead:** Christine Williams, Interim Director of Nursing and Patient Experience<br>**Assuring Committee:** Quality and Safety Committee |
| **Risk:** Failure to achieve **infection control** targets set by Welsh Government, increase risk to patients and increased costs associated with length of stays. | **Date last reviewed:** April 2021 |
| **Risk Rating** (consequence x likelihood):<br>Initial: 4 x 5 = 20<br>Current: 4 x 5 = 20<br>Target: 4 x 3 =12 | **Rationale for current score:**<br>Currently under targeted intervention for rates of infection, achievement of targets are variable with monthly fluctuations. |
| **Level of Control** = 40% | **Rationale for target score:** |
| **Date added to the HB risk register** January 2016 | Once the infection control team is fully recruited to, ICNet is functioning to its full capability the infection control team will be able to support the clinical areas more and drive service improvements. In addition, a negative pressure isolation facility is being built into the new emergency department at Morriston hospital providing another facility to appropriately manage patients at the front door. Review and implementation of a robust clean of patient rooms following an infection will reduce the risk of cross infection. |




| Controls (What are we currently doing about the risk?) | Mitigating actions (What more should we do?) | | |
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| | **Action** | **Lead** | **Deadline** |
| • Regular monitoring on infection rates<br>• Policies, procedures and guidelines in place<br>• Regular reporting through internal processes<br>• ICNet information management system for infections is in place<br>• Infection control team support the clinical teams for issues relating to infection control<br>• A permanent infection control doctor has been recruited<br>• Recruitment is ongoing. Decontamination lead & assistant director of nursing in infection control appointed.<br>• Bug stop quality improvement programme<br>• Incident reporting | Ongoing infection control team involvement in site level estates projects to ensure appropriate isolation facilities are factored in from the outset | Senior Infection Control Matron | 1st May 2021 |

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| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>• Ongoing monitoring of infection control rates and feedback provided to delivery units<br>• Infection Control Committee monitors infection rates and identifies key actions to drive improvement | **Gaps in assurance**<br>**(What additional assurances should we seek?)**<br>ICNet provides information linked with PAS relating to patients who have been inpatients since the connection was made therefore additional manual records are maintained by the infection control team creating additional work and some duplication. |

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| • Sub groups to the infection control committee such as the decontamination group provide the assurances and operationally drive key areas of work.<br>• Clear assurance framework in place at Corporate level with Health Board Infection Prevention & Control Committee, Health Board C. Difficile Infection Improvement Group; Corporate Infection Prevention & Control Nursing Team; Water Safety Group; and Directly Managed Unit Infection Prevention & Control Groups.<br>• Incident reporting<br>• Root Cause Analysis to ensure monitoring and lessons continued to be learned from HCAI. | |
| **Current Risk Rating**<br>**5 x 4 = 20** | |

**Additional Comments**

It is challenging to attain improvements in reduction of targeted infections. However, there has been year-on-year improvement in the following key infections: Staph. aureus, E. coli, Klebsiella, and Pseudomonas aeruginosa bacteraemia cases. Of concern, there has been an approximate 75% year-on-year increase in C. difficle cases.
COVID has led to increased compliance with training for PPE. Increased ICN presence clinically supporting DUs with the increase in resource and a full 7 day ICN service.
29/01/21 - the rate of increase in C. difficile cases has slowed, from a 75% increase year-on-year in November, to an approximate 20% increase in January 2021. There has been an improvement in Staph. aureus, E-coli and Pseudomonas aeruginosa bacteraemia, but a worsening of position in relation to Klebsiella spp. bacteraemia.
Increased clinical presence of ICNs on wards, the extension of the service to include Primary Care and a 7 day service continues, DD
26.02.2021 - With Covid nosocomial transmissions reducing, a greater emphasis on the Tier 1 targets will be made. Some in depth scrutiny working with microbiology to commence for Klebsiella. LH
12/04/21 - Progress in relation to E. coli and Pseudomonas bacteraemia, however, failed to achieve Tier 1 targets for C. difficile, Staph. aureus and Klebsiella

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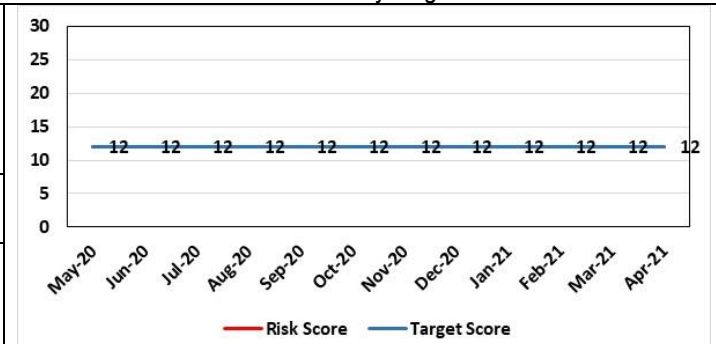
| **Datix ID Number: 841**<br>**Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety** | **HBR Ref Number: 13**<br>**Target Date: 31st March 2022** |
| **Objective**: Best Value Outcomes | **Director Lead:** Rab McEwan, Chief Operating Officer/Sian Harrop-Griffiths, Director of Strategy<br>**Assuring Committee**: Health and Safety Committee |
| **Risk: Health & Safety Compliance** – Environment of Premises. Risk relates to compliance in terms of appropriate accommodation in line with Health and Safety Regulations. | **Date last reviewed:** April 2021 |
| **Risk Rating**<br>(consequence x likelihood):<br>Initial: 4 x 4 = 16<br>Current: 4 x 3 =12<br>Target: 4 x 3 = 12 | **Rationale for current score:**<br>HSE issued ten improvement notices.<br>Lack of accommodation to meet statutory/health and safety requirements could have an adverse impact on citizens, staff, financial and operational performance. |
| **Level of Control**<br>= 90% | **Rationale for target score:** |
| **Date added to the HB risk register**<br>April 2012 | Risk assessments of premises. |




**Controls (What are we currently doing about the risk?)**

- Key areas where performance linked to health & safety/fire issues flagged through Health & Safety and Quality & Safety Committees and actions agreed to mitigate impacts.
- Issues raised through site meetings held regarding service changes for all 4 acute hospital sites.
- Primary Care developments required.

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Develop a strategy to improve primary & community services estate. | Service Group Director P&C | 31st May 2021 |
| Develop BJC's to improve the infrastructure of the 3 acute hospital sites (not including NPTH). | Assistant Director - Estates | 31st May 2021 |

**Assurances (How do we know if the things we are doing are having an impact?)**

The Cabinet Secretary for Health & Social Services set the initial pipeline of health and care centres to be delivered by 2020-21 and the following projects identified for the Health Board

- Penclawdd Health Centre - refurbishment/redevelopment proposal (£0.800m at 16-17 prices) – now completed
- Murton Community Clinic – refurbishment/redevelopment proposal (£0.400m at 16-17 prices) – now completed
- Swansea Wellness Centre – new build development (£10.000m at 16-17 prices) SOC submitted to WG. FBC under development for submission June 2021. Cost projection significantly higher that stated here but WG aware and are members of the Project Board.
- BJC Environmental Infrastructure replacement of Estates AHU plant and Morriston electrical Sub Station 6 all designed up and tendered through Design for Life procurement process.

**Gaps in assurance**
**(What additional assurances should we seek?)**

| Current Risk Rating<br>4 x 3 = 12 | Additional Comments<br>Planned interviews to take on board a SCP 1ST / 2ND Week of November 20. 3 months to undertake verification of our design by the SCP then submit to the WG for approval and funding |
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| **Datix ID Number: 737**<br>**Health & Care Standard: Staying Healthy 1.1 Health Promotion** | | **HBR Ref Number: 15**<br>**Target Date: 31st March 2022** |
| **Objective**: Partnerships for Improving Health and Wellbeing | | **Director Lead:** Keith Reid, Director of Public Health<br>**Assuring Committee:** Quality and Safety Committee |
| **Risk:** If we fail to achieve **population health improvement targets** leading to an increase in preventable disease amongst the population resulting in increased morbidity impacting on operational and financial pressures. | | **Date last reviewed:** April 2021 |
| **Risk Rating**<br>(consequence x likelihood):<br>Initial: 5 x 3 = 15<br>Current: 5 x 4 = 20<br>Target: 3 x 3 = 9 |  | **Rationale for current score:**<br>If we fail to prevent a serious outbreak by effectively achieving herd immunity in the population through immunisation and vaccination programmes, or to effectively manage an outbreak by disrupting the spread, this will result in serious harm to individual, maybe death, and pressure on health services, disruption to flow, business continuity and reputational damage to the health board and public health team. |
| **Level of Control**<br>= 60% | | **Rationale for target score:** |
| **Date added to the HB risk register**<br>26.01.16 | | Manage preventable disease. |

| Controls (What are we currently doing about the risk?) | Mitigating actions (What more should we do?) | | |
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| | **Action** | **Lead** | **Deadline** |
| • Public Health Strategy and work plan<br>• Internal Audit Management Plan<br>• Strategic Immunisation Group<br>• MMR Task & Finish group<br>• Childhood Imms Group;<br>• Primary Care Influenza Group<br>• Support from PHW Health Protection | Deliver immunisation awareness training for pre-school settings to promote key vaccination messages | Consultant Public Health Medicine | 31st March 2021 |
| | Contribute to the implementation of recommendations made in the "MMR Immunisation: process mapping of the child's journey" report. | Consultant Public Health Medicine | 31st March 2021 |
| | Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins | Consultant Public Health Medicine | 31st March 2021 |

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| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>• School imms target is over 70%, we are the 2nd highest in Wales. All other childhood imms targets below trajectory. | **Gaps in assurance**<br>**(What additional assurances should we seek?)**<br>The need to deliver sustained service. |
| **Current Risk Rating**<br>**5 x 4 = 20** | **Additional Comments**<br>Scrutiny by internal audit, raise awareness, encourage uptake, target population. Co-production work with the public.<br>The impact of COVID-19 has been to disrupt usual population health activities. This |

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| | disruption is ongoing.<br>Control measures have had a mixed impact on behaviours associated with health eg ability to undertake exercise has been negatively affected.<br>There will be a legacy of adverse psychological effects which will require community-based approaches to mitigate. This is likely to require a sustained response over several years.<br>COVID-19 has had a disproportionate impact on those with existing poor health or underlying risk factors and also impacted more severely on those areas of high deprivation. Overall inequities in health are likely to increase as a consequence.<br>The risk rating probably needs to be increased to 20 – likelihood is probably 5 and impact 4 – it will require the development of a mitigation strategy in response. |

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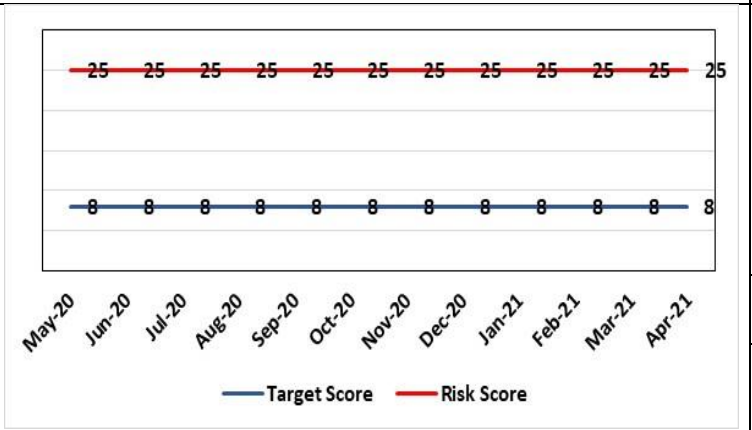
| **Datix ID Number: 840**<br>**Health & Care Standard: 5.1 Timely Care** | **HBR Ref Number: 16**<br>**Target Date: 31st March 2022** |
| **Objective**: Best Value Outcomes from High Quality Care | **Director Lead:** Rab McEwan, Chief Operating Officer<br>**Assuring Committee:** Performance and Finance Committee |
| **Risk:** Access and Planned Care. There is a risk of harm to patients if we fail to diagnose and treat them in a timely way. | **Date last reviewed:** April 2021 |
| **Risk Rating**<br>(consequence x likelihood):<br>Initial: 4 x 4 = 16<br>Current: 5 x 5 = 25<br>Target: 4 x 2 = 8 | **Rationale for current score:**<br>All non-urgent activity was cancelled due to response to the Covid-19 pandemic and has increased the backlog of planned care cases across the organisation. Whilst mitigating measures such as virtual clinics have been put in place new referrals are still being accepted which is adding to the outpatient backlog particularly in Ophthalmology and Orthopaedics. The significant reduction in theatre activity is obviously increasing the number of patients now breaching 36 and 52 week thresholds. |
| **Level of Control**<br>= 90% | **Rationale for target score:** |
| **Date added to the HB risk register**<br>January 2013 | There is scope to reduce the likelihood score to reduce the Risk to an acceptable level |




| **Controls (What are we currently doing about the risk?)** | **Mitigating actions (What more should we do?)** | | |
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| | **Action** | **Lead** | **Deadline** |
| • Post Covid 19 the focus is on minimising harm by ensuring that the patients with the high clinical priority are treatment first. The Health Board is following the Royal College of Surgeons guidance for all surgical procedures and patients on the waiting list have been categorised accordingly.<br>• There is a bi-weekly Recovery meeting for assurance on the recovery of our elective programme.<br>• The annual plan is based on specialty level capacity and demand models at specialty level that set out the baseline capacity and identify solutions to bridge the gap. Non-recurring pump – prime funding is available to support initial recovery measures. Monthly performance reviews track progress against delivery.<br>• A focused intervention is in train support to the 10 specialties with the longest waits. | Develop and implement a full range of '**treat while you wait'** interventions at specialty level to minimise harm. | Service Directors | 16th June 2021 |

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| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>• Weekly meetings in place to ensure patients with greatest clinical need are treated first. | **Gaps in assurance**<br>**(What additional assurances should we seek?)** |
| **Current Risk Rating**<br>**5 x 5 = 25** | **Additional Comments**<br>23.04.2021 – Action closed - Development of a whole system model for NPTH as a centre for Orthopaedic and Spinal services, to include the scoping of ambulant trauma options and capital requirements - Strategic Outline Case submitted to WG awaiting outcome. |

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| **Datix ID Number: 1035**<br>**Health & Care Standard: Effective Care 3.1 Clinically Effective Care** | **HBR Ref Number: 27**<br>**Target Date: 31st March 2022** |
| **Objective**: Digitally enabled care | **Director Lead:** Matt John, Director of Digital<br>**Assuring Committee:** Audit Committee |
| **Risk: Digital Transformation** Inability to deliver sustainable clinical services due to lack of Digital Transformation.<br>There are insufficient resources to:<br>• invest in the delivery of the ABMU Digital strategy,<br>• support the growth in utilisation of existing and new digital solutions<br>• replace existing technology infrastructure and the end of its useful life. | **Date last reviewed:** April 2021 |
| **Risk Rating** (consequence x likelihood):<br>Initial: 4 x 4 = 16<br>Current: 4 x 4 = 16<br>Target: 5 x 2 =10<br><br>**Level of Control** = 50%<br><br>**Date added to the HB risk register** 2012 |  |
| | **Rationale for current score:**<br>C – Reliance on digital ways of working has increased. Loss of IT service has a greater impact on ability to provide clinical care. Lack of investment in new digital solutions to make services more effective will mean clinical service provision will become unsustainable.<br>L- The Digital response to COVID has ensured that our people and essential services have continued to be provided during the pandemic. This response has meant the issuing of over 2,000 mobile devices and the escalation of a number of digital solutions that had previously flagged as Tier 2 in the IMTP planning process such as MS365 and attend anywhere. As a result of the support arrangements required to maintain sustainable digital services needs to be increased eg. Volume of calls a month to the IT helpdesk have increased by approximately 50%.<br>CTM have also started the process to start ceasing parts of the Digital Services SLA. AS flagged during the disaggregation process Digital services for SBUHB would not be sustainable if 28% of resources were transferred to CTM due to economies of scale etc. |
| | **Rationale for target score:**<br>C – Of failure will increase as the reliance and proliferation of the use of digital solutions increases.<br>L – Investment will mean the support mechanisms, rate of failure and ability to deliver solutions that meet the needs of users will improve sustainable digital services. There will however always be an inherent risk of failure of IT solutions. |

| **Controls (What are we currently doing about the risk?)** | **Mitigating actions (What more should we do?)** | | |
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| | **Action** | **Lead** | **Deadline** |
| • Digital strategy has been approved by the Health Board<br>• Capital priority group for the HB considers digital risks for replacement technology which is fed into the annual discretionary capital plan<br>• IBG process allows for investment requests in projects to be submitted to the HB for consideration and provides scrutiny to ensure Digital resources required are considered for all | Establish a 5 year financial plan for Digital including the risks of the termination of the CTM SLA.<br>(Timescales amended as this is an ongoing action) | Assistant Informatics Business Manager | 31st March 2022 |

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| projects<br>• Informatics prioritisation process has been introduced to ensure requests for digital solutions are considered in terms of alignment to the strategy objective, technical solutions and financial implications<br>• HB has invested £900k recurrently in the project staffing resources to facilitate the delivery of the Informatics Strategic Outline Plan<br>• Working closely with WG to identify funding streams to support investment in digital including the approval of the Informatics Strategic Outline Plan<br>• Digital Leadership Group has been introduced to provide the overarching governance to the delivery of the Digital Strategic Plan.<br>• Digital Services prioritisation process has been embedded in the ways of working so that resource implications of digital solutions are transparent and agreed prior to the initiation of projects.<br>• Business cases requiring digital services are evaluated to ensure they include appropriate implementation and support costs<br>• Digital services revenue have been submitted as part of the 21/22 annual plan process | | | |
| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>• Progress has been made in securing capital investment both internally and externally for new developments<br>• IBG and CPG processes are in place and ensuring highest technology replacement risks are being addressed<br>• There are 22 active projects in place and being delivered<br>• Digital enablement is a cornerstone of the organization strategy. Two of the strategies, 8 areas, of focus are digital enablement.<br>• WG have announced (Oct 19) £50m investment into Digital Transformation in 19/20. The HB are awaiting final confirmation of its allocation which is indicated to be £1,390k capital and £1,060k revenue. Whilst this is under what was requested it will be utilised against priority requirements for the HB. | **Gaps in assurance**<br>**(What additional assurances should we seek?)**<br>Lack of certainty over future funding streams makes planning and implementation difficult/less effective<br>Revenue model for support unclear given the financial pressures of the organisation. | | |
| **Current Risk Rating**<br>**4 x 4 = 16** | **Additional Comments**<br>The updated Strategy digital overview, priorities and maturity assessment was presented to January 2020 Health Board. –The Action has therefore been closed off 31/1/2020 within Datix and progress reported through to Audit Committee.<br>17.03.21: Action completed – Ensure informatics prioritisation process is embedded into the ways of working so that resource implications of digital solutions are transparent and agreed at outset of projects.<br>The Digital Leadership Group members were asked to prioritise their top three digital projects for 2021/22. | | |

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| | Revenue consequences of new initiatives have been planned at approval stage for HEPMA & Signal and included in the Annual Plan revenue requirements. Submitted two bids for HEPMA & TOMS for funding 2021/22.<br>28.04.21: Action closed - Ensure business cases requiring digital services include appropriate implementation and support costs. |

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| **Datix ID Number: 1043**<br>**Health & Care Standard: Effective Care 3.1 Clinically Effective Care** | **HBR Ref Number: 36**<br>**Target Date: 31st March 2022** |
| **Objective**: Digitally enabled care | **Director Lead:** Matt John, Director of Digital<br>**Assuring Committee:** Audit Committee |
| **Risk: Paper Record Storage:** Lack of a single electronic record means there is greater reliance on the provision of the paper record. If we fail to provide adequate storage facilities for paper records then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if there is poor records management in some wards. | **Date last reviewed:** April 2021 |
| **Risk Rating** (consequence x likelihood):<br>Initial: 4 x 5 = 20<br>Current: 4 x 4 = 16<br>Target: 3 x 3 =9 | **Rationale for current score:**<br>C - Inability to find records for patients could delay care/increase length of stay over 15 days. Could also mean patients receive incorrect treatment<br>L - we know this happens from incidents raised |
| **Level of Control** = 70% | **Rationale for target score:** |
| **Date added to the HB risk register**<br>June 2016 | C - Inability to find records for patients could delay care/increase length of stay over 15 days. Could also mean patients receive incorrect treatment we know this happens from incidents raised<br>L – The likelihood score for this risk has been increased from 3 to 4 bringing the overall score up to 16. This is due to the ongoing Blood Enquiry and issues regarding the decommissioning of sites that traditionally stored records such as Cefn Coed. |


| Controls (What are we currently doing about the risk?) | Mitigating actions (What more should we do?) | | |
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| | **Action** | **Lead** | **Deadline** |
| • Outpatient continuation Sheet has been rolled out and will form part of the plan to move Outpatients to paper light.<br>• MTED has been rolled out across Morriston and commenced in NPT<br>• Nursing Documentation (WNCR) piloted successfully in NPT<br>• Temporary retention and destruction plans are in place.<br>• Alternative storage arrangements are being identified and utilised where appropriate.<br>• Ward protocols and audits have been rolled out across sites.<br>• RFID project now approved. Implementation process has started and will change the way records are filed and release storage capacity.<br>• Roll out plan for WCP is in place and being enacted as outlined in the SOP<br>• All records must be documented and risk assessed in the Information Asset Register (IAR)<br>• Develop a case for improved storage solution both for paper and digitally.<br>• RFID Solution was implemented in November 2029 | Develop Business Case for improved storage solution for both paper and digital records. | Head of Health Records & Clinical Coding | 31st March 2022 |
| | Implementation of WNCR at NPTH | Interim Chief Information Officer | 19th April through to 11th June 2021 |
| | Complete convergence with WCP (replace ABMU Clinical Portal with Welsh Clinical Portal at all inpatient locations) | Interim Chief Information Officer | 29th October 2021 |

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| | Establish the legalities around the scanning and destruction of paper records in relation to the Blood Enquiry | Director of Digital | 31st May 2021 |

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| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>• RFID has been implemented for the acute record improving the management of records<br>• Health Records performance reports to be developed in line with RFID technology Attainment of the Tier 1 Health Board target for clinical coding completeness which relies on the timely availability and quality of the Paper record<br>• Monitoring complaints and incident reporting Gaps in Assurance Investment required supporting the delivery and operational costs of the Digital Strategy. Reliance on NWIS for delivery of the solution for a fully electronic patient record. Impact of the infected Blood Enquiry on the health boards ability to destroy notes is increasing the pressure on storage capacity and negating some of the mitigating actions that are being put in place | **Gaps in assurance**<br>**(What additional assurances should we seek?)**<br>Investment required supporting the delivery and operational costs of the Digital strategy.<br>Reliance on NWIS for delivery of the solution for a fully electronic patient record<br>Impact of the Infected Blood Enquiry on the Health Boards ability to destroy notes. |
| **Current Risk Rating**<br>**4 x 4 = 16** | **Additional Comments**<br>Health Records Department will work with HB colleagues to develop a case for improved storage solution both for paper and digitally.<br><br>In terms of the development of a case for the improved storage solution for the acute paper record. This risk still continues even with the roll-out of RFID technology across the acute health record service and location based filing due to the embargo that continues to be in place as a result of the infected blood inquiry, in that no records can be destroyed. Within the Acute Health Records Service and across numerous Health board services that manage and store their records separately from the acute record thousands of records continue to be moved off site to a third party storage supplier called the Maltings at a significant cost to the Health Board due to a lack of capacity on-site to store the records.<br>Following the completion of implementation of E-Prescribing (WCP at Singleton Hospital) in June 2021, the proposal is to implement WCP across all remaining inpatient locations across SBU by the end of Q2 2021-22.<br>Implementation commences 19 April 2021 – project board to agree to scale up across NPTH two weeks after go live, in advance of further enhancements becoming available. Proposal likely to be to continue across NPTH, upgrade and then implement across Singleton Hospital this year.<br>17.03.21: Two Actions completed – Continue with the roll out of WCP and Continue with roll out of digitisation of health record with a focus on Outpatients and Nursing documentation |

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| | Timescales for completion of the Health Board storage work have slipped due to the impact of COVID and are now as follows:-<br>Scoping exercise completed 2021/22<br>Business Case for completion 21/22<br>Implementation - 22/23 Q2<br>19/04/2021: Implementation of WNCR commenced 19th April 2021 across 6 wards, due for completion 11th June 2021. |

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| **Datix ID Number: 1217**<br>**Health & Care Standard: Effective Care 3.1 Safer & Clinically Effective Care** | **HBR Ref Number: 37**<br>**Target Date: 31st March 2022** |
| **Objective**: Best Value Outcomes from Quality Care | **Director Lead:** Matt John, Director of Digital<br>**Assuring Committee:** Audit Committee |
| **Risk: Operational and strategic decisions are not data informed:-**<br>• Business intelligence and information already available is not utilized<br>• Users are unable to access the information they require to make decisions at the right time<br>• Gaps in information collection including patient outcome measures | **Date last reviewed:** April 2021 |
| **Risk Rating**<br>(consequence x likelihood):<br>Initial: 4 x 3 = 12<br>Current: 4 x 3 = 12<br>Target: 4 x 2 = 8 | **Rationale for current score:**<br>C – Opportunity cost of not acting on data could mean opportunities for improvement are missed, failures are not identified in a timely manner resulting in adverse national publicity and/or delays in care/increased length of stay.<br>L - Dashboard utilisation is lower than would be anticipated. Management Board have approved the investment for 4 BI partners to work with the SDGs to become more data driven. |
| **Level of Control**<br>= 70% | **Rationale for target score:** |
| **Date added to the HB risk register**<br>June 2016 | C- will remain the same or increase due to increased reliance in information<br>L- Investment in BI will lead to more information be available and used. The higher the use of information at operational level will lead to better quality data. |


| Controls (What are we currently doing about the risk?) | Mitigating actions (What more should we do?) | | |
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| | **Action** | **Lead** | **Deadline** |
| • BI partner role to be funded and introduced to support the SDG's to become more data driven.<br>• COVID19 Dashboards Developed and are being used to inform the decision making process at Gold<br>• Business Intelligence Strategy developed but not presented to Board due to COVID19<br>• The Health Board has continued to invest in the provision of interactive dashboards with the addition of the Power BI Business Intelligence software and infrastructure to support it.<br>• 33 dashboards in place including Cancer, Patient Flow, Outpatients, Mortality, Clinical Variation, Primary & Community Care Delivery Unit Dashboard and Ward Dashboard<br>• Safety Huddle implemented in Morriston is improving data quality and improving operational working<br>• Business Intelligent Information Manager appointed, who will take the lead for creating a Business Intelligence Strategy and Implementation Plan<br>• Investment and revised ways of working introduced within the coding department have achieved coding targets and data quality<br>• Flexible operational management of Coding Teams on a daily basis to cope with demand. Training programme in place for new coders. | Investment and implementation of system to record patient outcome measures | Assist Information Business Manager | 24th September 2021 |
| | Produce BI strategy implementation plan outlining investment requirements in capacity and capability | Assist Information Business Manager | 30th June 2021 |
| | Produce BI strategy implementation plan outlining investment requirements in capacity and capability push back from June | Assist Information Business Manager | 30th September 2021 |

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| • Short term funding secured at year end to support mtg tier 1 targets, does not resolve ongoing issues<br>• Information Dept. working with service leads in Planning and Finance to develop meaningful indicators also utilising dashboards to present information in a user friendly way<br>• New technologies being reviewed for advanced analytics and integration into a new Health Board analytics platform.<br>• Ensuring that the Health Board has representation on national groups such as the newly formed Advanced Analytics Group (AAG), all Wales Business Intelligence and Data Warehousing Group and Welsh Modelling Collaborative. | | | |
| **Assurances (How do we know if the things we are doing are having an impact?)**<br>More evidence based and proactive decisions being made.<br>Dashboard technology; assist in developing indicators / triangulating information to identify issues | **Gaps in assurance (What additional assurances should we seek?)**<br>Culture of the organisation needs to change to focus on information and Business intelligence for operational rather than reporting purposes.<br>Capability of operational staff to utilise the tools and capacity to act on the intelligence provided. | | |
| **Current Risk Rating**<br>**4 x 3 = 12** | **Additional Comments**<br>19.04.21 – Action closed - Produce Business Intelligence Strategy and get signed off by the Board<br>28.04.21 - Management Board have approved the investment for 4 BI partners to work with the SDGs to become more data driven. The risk likelihood score has therefore been reduced from 4 to bringing the overall risk score down to 12 | | |

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| **Datix ID Number: 1297**<br>**Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety** | **HBR Ref Number: 39**<br>**Target Date: 31st March 2022** |
| **Objective**: Demonstrating Value and Sustainability<br>Risk in Brief: If the Health Board fails to have an approvable IMTP for 2018/19 then we will lose public confidence and breach legislation. | **Director Lead:** Sian Harrop-Griffiths, Director of Strategy<br>**Assuring Committee**: Performance and Finance Committee / Strategy, Planning and Commissioning Group Health Board |
| **Risk: Operational and strategic decisions are not data informed:-**<br>Health Board does not have an IMTP signed off by WG, primarily due to the inability to align performance and financial plans. WG also advised that the Health Board needed to have a clear strategic direction by developing an Organisational Strategy and refreshing our Clinical Services Plan. In September 2016, the Health Board was escalated to 'targeted intervention' and having an approved IMTP is a key factor in improving our WG monitoring status. | **Date last reviewed:** April 2021 |
| **Risk Rating**<br>(consequence x likelihood):<br>Initial: 4 x 4 = 16<br>Current: 5 x 4 = 20<br>Target: 4 x 2 = 8<br>**Level of Control**<br>= 70%<br>**Date added to the HB risk register**<br>July 2017 |  |
| | **Rationale for current score:**<br>Our Organisational Strategy was approved by the Board in November 2018<br>This Annual Plan includes a balanced financial plan.<br>We have agreed with Welsh Government that we will continue our detailed planning and submit an approvable IMTP when ready.<br>We have continued the work from January onwards on our detailed plans to submit an approvable IMTP when ready.<br>Quarterly and half year plans submitted for 2020/21.<br>WG have required all Health Boards and Trusts in Wales to submit annual plans for 2021/22 due to COVID pandemic and uncertainty of planning requirements. |
| | **Rationale for target score:**<br>If the IMTP is approved it is likely our targeted intervention status will be improved when next reviewed and the risk can be closed. |

**Controls (What are we currently doing about the risk?)**

- Organisational Strategy approved by the Board in November 2018
- Clinical Services Plan approved by the Board in January 2019
- Annual Plan submitted to Board In Committee and approved in March for submission to Welsh Government
- The Transformation Programme to deliver the Organisational Strategy and CSP including programme approach was established in April 2019 but put on hold due to COVID 19. Revised arrangements currently being finalised
- Continuous planning through our CSP Programme and IMTP process will work up detailed plans to develop an integrated three year plan in line with the national timescales.
- The Health Board will develop a Service and Financial Recovery Plan to support its sustainability and provide the foundation to deliver an agreed IMTP for 2022/23.
- The new Operating Model and Finance PMO will contribute to delivery of the financial plan.
- National IMTP Processes suspended in March due to the Covid-19 outbreak – and remain suspended
- Welsh Government written statement published on the 7 October 2020 advising that SBUHB been

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
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| Development of draft Annual Plan within 3 year context considered By board In Committee in Mar21 and submitted to WG | Director of Strategy, Director of Finance & Director of Workforce & OD. | 30th June 2021 |
| Plan to be finalised during Q1 of 2021/22 for submission to Board and to WG. | Director of Strategy | 30th June 2021 |

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| de-escalated from targeted intervention status to 'enhanced monitoring' status. | | | |
| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>IMTP Executive Steering Group in place for development of the integrated medium term plan. Integrated Planning Group in place to co-ordinate Transformation and planning activities and approaches<br>Performance and Finance Plans are be assured by the P&F Committee before presentation to Board<br>Through monthly IMTP briefings, TI meetings and bi-annual JET meeting with WG – planning approach and emerging plans discussed and WG fully supportive of the direction of travel. | **Gaps in assurance (What additional assurances should we seek?)**<br>EIA in development for PFC assurance<br>QIAs in development for joint PFC/Q&S assurance | | |
| **Current Risk Rating**<br>**4 x 5 = 20** | **Additional Comments**<br>14.04.21 Update – Need to note that P&F only looks at finance and performance, not the whole IMTP approval – that sits with Board. The W&OD Committee eg reviews the workforce plan, Q&S Committee the Q&S elements.<br>The HB submitted a draft Annual Plan to WG in March 2021 as a record of progress with our planning. | | |

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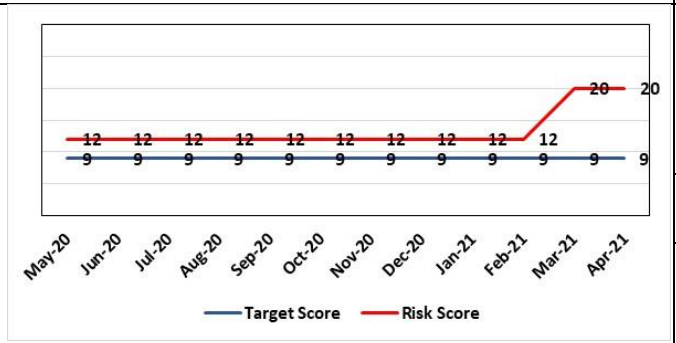
| **Datix ID Number: 1567**<br>**Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety** | **HBR Ref Number: 41**<br>**Target Date: 31st March 2022** |
| **Objective**: Best Value Outcomes | **Director Lead:** Christine Williams, Interim Director of Nursing and Patient Experience<br>**Assuring Committee:** Health and Safety Committee |
| **Risk: Fire Regulation Compliance** – one improvement notice received relating to MH&LD Unit. Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations. | **Date last reviewed:** April 2021 |
| **Risk Rating**<br>(consequence x likelihood):<br>Initial: 5 x 3 = 15<br>Current: 5 x 4 = 20<br>Target: 3 x 3 = 9<br><br>**Level of Control**<br>= 50%<br><br>**Date added to the HB risk register**<br>31/05/2018 |  | **Rationale for current score:**<br>Improvement notice in relation to MH&LD Unit.<br>Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations.<br>General compliance with fire regulations and WHTM/WHBN requirements<br><br>**Rationale for target score:**<br><br>Target Score should be lower |

| **Controls (What are we currently doing about the risk?)** | **Mitigating actions (What more should we do?)** | | |
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| • Fire risk assessments.<br>• Evacuation plans (vertical and horizontal).<br>• Fire safety training.<br>• Professional advice sought on compliance of panels.<br>• East flank panels removed<br>• Business case being developed for south panel removal and updating. | **Action** | **Lead** | **Deadline** |
| | Change in fire evacuation plans and alarm and detection cause and effect | Head of Health & Safety | 3rd May 2021 |
| | Replacing the existing cladding and insulation with alternative specifications and inserting 30 minute fire cavity barriers where appropriate | Service Improvement Manager | 14th May 2021 |

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| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>• Monitoring through the H&S committee to receive assurance and or identify gaps for key compliance and adherence to applicable legislation.<br>• NWSSP internal audits<br>• Site visits/tours to identify compliance and gaps in compliances.<br>• Completion of FRA's within targeted schedule | **Gaps in assurance**<br>**(What additional assurances should we seek?)**<br>Unclear if additional resources will be available |
| **Current Risk Rating**<br>**5 x 4 = 20** | **Additional Comments**<br>Professional assessment of panel compliance being taken forward with NWSSP-SES, building control and WG colleagues. W/c 26/8/19 Cladding being removed from East and West end of main block. Escape route on west end redirected with approval of Fire and Rescue Service. Removal of flank cladding completed at end of 2019. Business case being developed for removal of cladding on south side of building. Review of numbers of fire wardens completed by |

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| | Unit and new wardens being trained.<br><br>Update 25.02.21: Regular meetings with contractor and Singleton site on planning for the forthcoming works of cladding removal and replacement on the front elevation. Scaffolding works to commence on 03.03.21, with actual works scheduled to commence in April 2021. Site walk arounds have been undertaken to agree site compounds and fire escape routes. Regular meetings scheduled to ensure appropriate levels of communications are in place and continue. HB will be linking with Mid and West Wales Fire and Rescue Services to ensure they are aware of the phases of work and progress.<br>11.03.21: Given the current works programme for the removal of the cladding (2.5years), there will be high levels of risk to manage locally given current resources corporately to actively support this. Additional resources are being requested on a permanent basis, with temporary arrangements in place to address overdue risk assessments. The HB will continue to work with MWWF to ensure they are kept up to date. |

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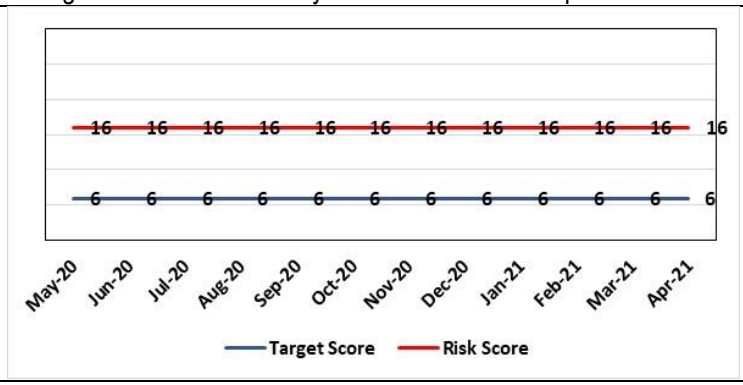
| **Datix ID Number: 1514**<br>**Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety** | **HBR Ref Number: 43**<br>**Target Date: 31st March 2022** |
| **Objective**: Best Value Outcomes from High Quality Care | **Director Lead:** Christine Williams, Interim Director of Nursing & Patient Experience<br>**Assuring Committee:** Quality and Safety Committee |
| **Risk:** If the Health Board is unable to complete timely completion of DoLS Authorisation then the Health Board will be in breach of legislation and claims may be received in this respect. | **Date last reviewed:** April 2021 |
| **Risk Rating** (consequence x likelihood):<br>Initial: 4 x 4 = 16<br>Current: 4 x 4 = 16<br>Target: 3 x 2 = 6 | **Rationale for current score:**<br>Although processes have been planned or implemented, the impact is yet to be measured over a longer term, and the challenges of managing a large backlog of breaches. |
| **Level of Control** = 40% | **Rationale for target score:**<br>Consequences of DoLS breaches for the Health Board will not change. With controls in place, over time likelihood should decrease. |
| **Date added to the HB risk register**<br>July 2017 | |




**Controls (What are we currently doing about the risk?)**

- Supervisory body signatories in place
- BIA rota now implemented but limited uptake due to inability to release staff
- 2 x substantive BIA posts and additional admin post in place
- DoLS database updated and DoLS dashboard devised to enable more accurate monitoring and reporting
- Regular reporting to Mental Health and Legislative Committee (MHLC)(Nov 20)
- QIA completed for re-introduction of DoLS BIAs attending Ward as part of Reset and Recovery April 2021
- QIA reviewed and service stood down in light of increased COVID incidence Oct 2020, service recommenced April 2021
- Managing and supporting all referrals remotely
- New legislation changes expected in April 2022 which will require a different service model, business case to meet existing and future requirements will be progressed March 21.

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Delivery of DOLS Action plan reviewed monthly (change coding above also) | Director Primary & Community | Monthly Review |
| DoLS dashboard in place, monitoring applications and breaches via dedicated BIAs and Admin. | UND Primary and Community | Monthly Review |
| Report to Mental Health and Legislative Committee advising cessation of DoLS assessors visiting wards to minimise spread of COVID. Expertise, advice and support available to wards via substantive BIAs | UND Primary and Community | Monthly Review |
| Business case for revised service model | UND Primary and Community | 31st July 2021 |

**Assurances**
**(How do we know if the things we are doing are having an impact?)**

- Regular scrutiny at Safeguarding Committee and by DoLS Internal Audit; monitoring via DoLS Dashboard this will provide real-time accurate data.
- Update report to MHLC, impact of COVID and focus on urgent cases via virtual process and plan to progress business case by year end.

**Gaps in assurance**
**(What additional assurances should we seek?)**

**Current Risk Rating**

**Additional Comments**

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| **4 x 4 = 16** | All actions attributable to safeguarding completed and Internal Audit aware.<br>DoLS and MCA Training provided to doctors and managers by Solicitor from Legal & Risk Services in January and February 2021. |

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| **Datix ID Number: 1563**<br>**Health & Care Standard: Safe Care 5.1 Access** | **HBR Ref Number: 48**<br>**Target Date: 31st March 2022** |
| **Objective**: Best Value Outcomes from High Quality Care | **Director Lead:** Sian Harrop-Griffiths, Director of Strategy<br>**Assuring Committee:** Performance and Finance Committee, Health Board |
| **Risk:** Failure to sustain Child and Adolescent Mental Health Services | **Date last reviewed:** April 2021 |
| **Risk Rating** (consequence x likelihood):<br>Initial: 4 x 4 = 16<br>Current: 4 x 4 = 16<br>Target: 4 x 2 = 8<br>**Level of Control** = 50%<br>**Date added to HB the risk register** 31/05/2018 |  |
| | **Rationale for current score:**<br>The specialist CAMHS Network is delivered by Cwm Taf University Health Board on behalf of ABMU. |
| | **Rationale for target score:** New service model and improved performance |

**Controls (What are we currently doing about the risk?)**

- Performance Scrutiny - is undertaken at monthly commissioning meetings between Swansea Bay & Cwm Taf Morgannwg University Health Boards. Improved governance -ensures that issues and concerns are discussed by all interested parties including local authorities to support the network identify local solutions.
- New Service Model agreed and being established by Summer 2019 which should give further stability to service.

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Additional investment expected - from Welsh Government is supporting the delivery of Waiting List Initiative clinics to support the position. | CAMHS network | 30th September 2021 |
| The Network is seeking to recruit agency staff to fill existing and upcoming vacancies to ensure that core capacity is maximised. | CAMHS network | 30th September 2021 |

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| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)** | **Gaps in assurance**<br>**(What additional assurances should we seek?)** |
| **Current Risk Rating**<br>**4 x 4 = 16** | **Additional Comments**<br>A new pathway for CAMHS patients is currently being developed which provides advice on the appropriate actions for dealing with these children and young people and will reduce the need to hold them in the Emergency Department at Morriston.<br>01.04.21 – Action update – Additional demands as a result of Covid expected and will need additional investment either from MH development monies or from direct Welsh Government funding. |

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| **Datix ID Number: 922**<br>**Health & Care Standard: Effective Care 3.1 Clinically Effective Care** | **HBR Ref Number: 49**<br>**Target Date: 31st July 2021** |
| **Objective**: Best Value Outcomes from High Quality Care | **Director Lead:** Richard Evans, Medical Director<br>**Assuring Committee:** Quality and Safety Committee |
| **Risk:** Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI) | **Date last reviewed:** April 2021 |
| **Risk Rating** (consequence x likelihood):<br>Initial: 5 x 5 = 25<br>Current: 4 x 4 = 16<br>Target: 3 x 4 = 12<br><br>**Level of Control** = 50%<br><br>**Date added to the HB risk register**<br>July 2016 |  | **Rationale for current score:**<br>• External review undertaken by Royal College of Physicians which will likely indicate that patients have come to serious harm as a result of excessive waits.<br>• Remains significant reputational risk to the Health Board<br><br>**Rationale for target score:**<br>External review by the Royal College of Physicians will provide a view on improvement required immediately and for sustainability. |

| **Controls (What are we currently doing about the risk?)** | **Mitigating actions (What more should we do?)** | | |
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| | **Action** | **Lead** | **Deadline** |
| • TAVI Recovery Plan implemented and backlog has been cleared.<br>• Plan is supported with Executive oversight at fortnightly TAVI has been prioritised in next year's WHSSC ICP for 2020/21.<br>• Royal College of Physicians have provided reports on the service and action plans have been developed and implemented | Continued oversight of outcomes by the Executive Medical Director, reporting to Quality and Safety committee regularly | Executive Medical Director | 31st July 2021 |

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| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>Reduction in waiting times for TAVI.<br>Executive Medical Director Oversight of improvement plans.<br>Development of Quality and Safety Dashboard. Oversight and scrutiny by Quality and Safety Committee | **Gaps in assurance**<br>**(What additional assurances should we seek?)** |
| **Current Risk Rating**<br>**4 x 4 = 16** | **Additional Comments**<br>WHSSC informed the Health Board of its decision to de-escalate the TAVI service from its current Stage 3 to Stage 2 of the WHSSC Escalation process, having recognised that the service has delivered a significant improvement in the overall quality of the TAVI programme including the reduction in waiting times despite the pandemic.<br>RCP 2nd report received which is positive. Clearly defined pathways now established, TAVIs being undertaken twice weekly. Managed by 2 independent TAVI nurses. Only 1 or 2 patients now waiting >25 weeks with reasons for this.<br>27.04.21 update: Improvements to service being embedded sustainably. Action plans in response to RCP report now complete, pending second cohort review. |

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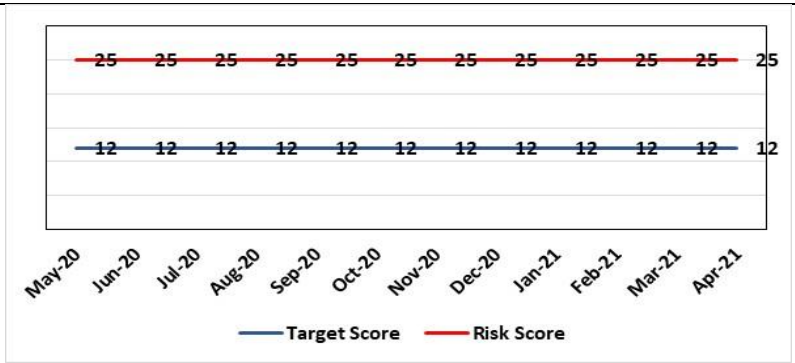
| **Datix ID Number: 1761**<br>**Health & Care Standard: Timely Care 5.1 Access** | **HBR Ref Number: 50**<br>**Target Date: 31st March 2022** |
| **Objective**: Best Value Outcomes from High Quality Care | **Director Lead**: Rab McEwan, Chief Operating Officer<br>**Assuring Committee:** Performance and Finance Committee |
| **Risk:** Access to Cancer Services – There is a risk of harm to patients with cancer due to delayed presentation, referral, diagnosis or treatment. | **Date last reviewed:** April 2021 |
| **Risk Rating**<br>(consequence x likelihood):<br>Initial: 4 x 5 = 20<br>Current: 5 x 5 = 25<br>Target: 4 x 3 = 12<br><br>**Level of Control**<br>= 70%<br><br>**Date added to the HB risk register**<br>April 2014 |  | **Rationale for current score:**<br>There has been a reduction in presentation and referrals for cancer. The cancer backlog has increased and treatment times have got longer due to Covid-19 related reductions in surgical capacity.<br><br>**Rationale for target score:**<br><br>Target score reflects the challenge this area of work present the Board and where small numbers of patients impact on the potential to breach target |

**Controls (What are we currently doing about the risk?)**

- Tight management processes to manage each individual case on the unscheduled care (USC) Pathway.
- Initiatives to protect surgical capacity to support USC pathways have been put in place in RGH and PCH to protect core activity.
- Additional investment in MDT consideration, with 5 cancer trackers appointed in April 2021.
- Prioritised pathway in place to fast track USC patients.
- Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies.
- Weekly cancer performance meetings are held at both Singleton and Morriston Delivery Units.
- The tumour sites of concern are in development. One of the areas is Lower GI where clinic capacity has increased by 4 times in April.
- Endoscopy contract has been extended.

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Phased and sustainable solution for the required uplift in endoscopy capacity that will be key to supporting both the Urgent Suspected Cancer backlog and future cancer diagnostic demand on Endoscopy Services. Harm review process to be implemented. | Service Group Manager | 1st November 2021 |
| To explore the possibility of offering SBAR RT for high risk lung cancer patients in SWWCC | Service Manager Surgical Services | 30th June 2021 |

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| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>General improvement (sustained) trajectory. Need to continue improvement actions and close monitoring. Early diagnosis pathway launched and impact being closely monitored. | **Gaps in assurance**<br>**(What additional assurances should we seek?)**<br>Clear current funding gap. |
| **Current Risk Rating**<br>**5 x 5 = 25** | **Additional Comments**<br>The need to deliver sustained performance.<br>Whilst every effort is being made to maintain cancer treatment, surgical cancer activity in particular is being impacted upon by both the reduction in elective theatre capacity and availability in critical care beds due to the COVID-19 outbreak.<br>Covid screening is in place for all patients starting their 1st cycle of SACT and for |

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| | all Lung RT patients.<br>Action - Establishment of mobile unit to carry out PET/CT scans for Swansea and South West Wales patients. – Completed<br>Action - Continue to expand our Surgery capacity to allow our complex cancer surgeries to deal with any backlog of patients – Completed<br>01.03.21: Action Completed – Introduce COVID testing for Oncology and Haematology |

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| **Datix ID Number: 1759**<br>**Health & Care Standard: Staff & Resources 7.1 Workforce** | **HBR Ref Number: 51**<br>**Target Date: 31st March 2022** |
| **Objective**: Excellent Staff | **Director Lead:** Christine Williams, Interim Director of Nursing<br>**Assuring Committee:** Workforce and OD Committee |
| **Risk:** Non Compliance with Nurse Staffing Levels Act (2016) | **Date last reviewed:** April 2021 |
| **Risk Rating** (consequence x likelihood):<br>Initial: 4 x 4 = 16<br>Current: 5 x 5 = 25<br>Target: 4 x 2 = 8<br><br>**Level of Control** = 80%<br><br>**Date added to the HB risk register**<br>November 2018 |  |
| | **Rationale for current score:**<br>• Increased risk as a result of reduction in staff availability as a result of staff isolation/sickness - Covid-19. Frequently below minimum staffing number requirements.<br>• Risk escalated to 25 due to the escalating concerns around COVID-19 and requirement around surge plans, including wards being re-purposed and opening and commissioning of new wards. |
| | **Rationale for target score:**<br>• The Health Board is ensuring we have the structures and processes in place to provide reassurance under the Act and are allocating resources accordingly.<br>• Health Boards are duty bound to take all reasonable steps to maintain nurse staffing levels. |

**Controls (What are we currently doing about the risk?)**

The Health board has put the following controls in place:

**Additional Controls re-instated in October 2020 include:**

- Workforce Plans have been developed by Unit Nurse Directors & Each Delivery Group to agree staffing in light of escalation to surge & super surge due to COVID-19, with consideration of all reasonable steps
- A Nurse Staffing & Workforce meeting has been set up chaired by the Interim Director of Nursing & Patient Experience. Weekly meetings initially re-instated & have now increased to 3 times weekly with the potential to be increased to daily. The meetings will include a discussion around staffing hotspots, all reasonable steps associated with nurse staffing, deployment of staff, repurposed wards and surge plan, roster scrutiny
- Corporate Nursing Staffing 7 day a week rota reintroduced.
- Health Board wide overview of commissioning of new wards.
- Review of Education Hub & training needs in line with COVID plan.

**Additional Control's introduced in March include:**

- Daily Silver Nurse staffing Cell meetings chaired by Executive Director of Nursing & Patient Experience to discuss hot spots and the staff available across the Health Board.
- Nurse Bank fully utilised and part of the nurse staffing meetings, Unit Nurse Directors can now sanction non contract agency without Executive approval to maintain a safe service.
- Corporate Nursing 7 day rota introduced.

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Daily Staffing Tool has been agreed across the Delivery Groups to maintain a consistent approach. | Director of Nursing & Patient Experience | 31st May 2021 |
| The Ward Sister / Charge Nurse and Senior Nurse should continuously assess the situation and keep the designated person formally appraised. | Director of Nursing & Patient Experience | 17th May 2021<br>Monthly ongoing |
| The Board should ensure a system is in place that allows the recording, review and reporting of every occasion when the number of nurses deployed varies from the planned roster. *(Progress being made, last paper went to Board in November 2019. Paper accepted by the Board)* | Director of Nursing & Patient Experience | 30th June 2021 |
| The responsibility for decisions relating to the maintenance of the nurse staffing level rests with the Health Board should be based on evidence provided by and the professional opinions of the Executive Directors with the portfolios of Nursing, Finance, Workforce, | Director of Nursing & Patient Experience | 31st May 2021 |

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| • Database set up to record wards that have been repurposed as novel wards (COVID-19)<br>• Set up COVID-19 Corporate Training and Education Hub which outlines a clear plan for training and education<br>• Approved Registered Staff who have retired from the Nursing Midwifery Council Register in the last three years have been contacted with a view to return to practice and into the Health Board workforce.<br>• Delivery Units have appropriately deployed of ward nurses to key areas. And also administration staff utilised to release nurses into providing care.<br>• Student nurses have returned to clinical practice which has been supported corporately.<br>**Existing Controls**<br>• Confirmed the designated person<br>• Represented the All-Wales Nurse Staffing Group and its sub groups<br>• Contributed with the work undertaken at an all-Wales level on Acuity levels of care.<br>• Undertaken a formal review across all acute Service Delivery Units for calculating and reporting nurse staffing requirements to ensure a Health Board wide consistent approach is adopted.<br>• Presented a Health Board position status paper to both Board & Executive team outlining the preparedness for the Nurse Staffing Act (Wales).<br>• Conducted a review of workforce planning procedures, for 2018 to 2021, which includes; Health Board recruitment events, retention, workforce planning & redesign, training and development.<br>• Developed a monthly Health Board Multidisciplinary Nurse Staffing Act Task & Finish Group, chaired by the Interim Deputy Director of Nursing & Patient Experience, which reports to Nursing and Midwifery Board and Workforce & Organisational Development Committee.<br>• Provided acuity feedback sessions to all Service Delivery Units included in the June audit.<br>• Formally launched the Nurse Staffing (Wales) Act Guidance.<br>• Raised the issue regarding Information Technology barriers around the capture of data required for the Act on an All- Wales and Health Board basis.<br>• Circulated the Welsh Levels of Care and Operational Handbook to Service Delivery Unit Leads.<br>• Confirmed the 32 acute medical & surgical clinical areas that fall within the Act. These areas have been agreed using the criteria set out in the Operational Handbook.<br>• A Rigorous data approval process has been put in place to ensure accuracy of the 6 monthly acuity data prior to sign off. There has also been a number of workshops organised across the organisation to ensure a consistent approach to data collection and there is national work on solutions for electronic capture of acuity data.<br>• The NSA Steering group continues to meet on a monthly basis.<br>• Risks are presented at each meeting<br>• Scrutiny panels are held for each SDU following the submission of acuity templates.<br>• Impact assessment work is being undertaken to prepare for further roll out of the Act. | and Operations.<br>Risk register to be reviewed monthly to ensure compliance | Director of Nursing & Patient Experience | 31st May 2021<br>Monthly ongoing |
| **Assurances (How do we know if the things we are doing are having an impact?)** | **Gaps in assurance**<br>**(What additional assurances should we seek?)** | | |

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| • Ongoing robust recruitment and retention plans in place to reduce vacancies in key clinical areas, which is in line with the Health Board recruitment plan.<br>• Accurate reporting of Acuity data and governance around sign off.<br>• Implement mobile devises to be used within adult acute medical and surgical wards included within the Act in readiness for the June Adult Acuity Audit.<br>• Agreed establishments to funded.<br>• Implementation of E-Rostering to enable accurate reporting of Compliance<br>• Implement all Wales Templates, which are visible and signed within the agreed 32 ward areas, informing patients of planned roster.<br>• At least Yearly Board reports outlining compliance and any key risks. August 2019 update In line with the Boundary changes there are now 29 reportable wards which excludes POW. E-rostering has been rolled out in Singleton and Morriston is in the process of being rolled out. Scrutiny panels are in place. Following the investment already provided to the funded establishments. The overall risks have reduced as outlined above. The quality and accuracy of the Acuity data has improved. | |
| **Current Risk Rating**<br>**5 x 4 = 20** | |

**Additional Comments**

<u>February 2021 update</u>
Corporate Risk currently at 25 to reduce to score of 20.
Discussed in Nurse Staffing Act Meeting 5.2.21 formally agreed to reduce the score from 25 to 20 based on evidence provided from Delivery Groups Risk Assessments report improved staffing levels decreased Covid pressures.

Daily staffing tool is being completed to provide an overview of the staffing situation in each Delivery Group this supports the decision making process with deployment of staff daily.
9th April 2021 in NSA steering group the Service Groups, Mental Health & Learning Disabilities and Primary & Community reported risk registers ranging from 12 - 16. There remains pressure points on the acute sites and high nursing vacancies, therefore will remain at 20 and review in the May NSA Steering group.

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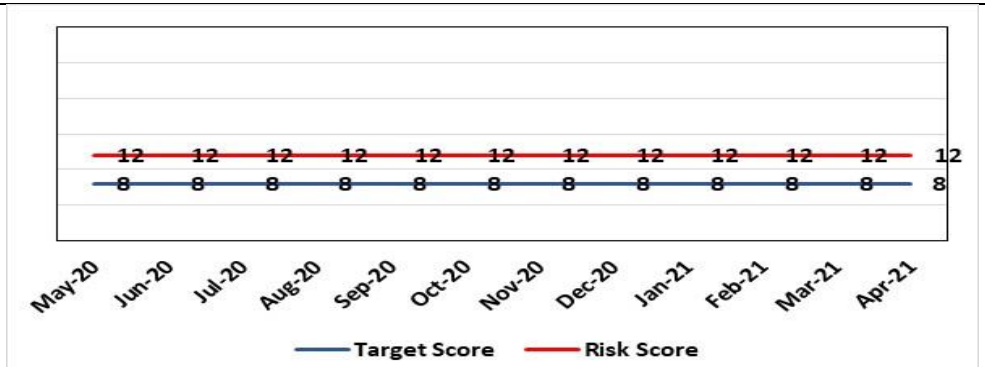
| **Datix ID Number: 1763**<br>**Health & Care Standard: Staff & Resources 7.1 Workforce** | **HBR Ref Number: 52**<br>**Target Date: 31st March 2022** |
| **Objective**: Partnerships for Care – Effective Governance | **Director Lead:** Sian Harrop-Griffiths, Director of Strategy<br>**Assuring Committee:** Performance and Finance Committee |
| **Risk:** The Health Board does not have sufficient resource in place to undertake engagement & impact assessment in line with strategic service change | **Date last reviewed:** April 2021 |
| **Risk Rating** (consequence x likelihood):<br>Initial: 4 x 4 = 16<br>Current: 4 x 3 = 12<br>Target: 4 x 2 = 8 | **Rationale for current score:**<br>• Current lack of sustainable funding source to secure capacity |
| **Level of Control** = 50% | **Rationale for target score:**<br>• All of these areas need to have adequate resourcing and robust processes / policies in place for the organisation to make robust plans, engage public confidence and meet our statutory and public duties. |
| **Date added to the HB risk register**<br>November 2018 | |




**Controls (What are we currently doing about the risk?)**

- Engagement – a temporary post was created for a Head of Engagement for 6 months. The impact of this post was evaluated and will be used to inform the structures change (Operating model). In the meantime the Band 5 has been backfilled to support engagement activities. Robust processes are, however, in place as agreed with the CHC and based on best practice guidance.
- Impact Assessment - A JD has been drafted. The post has now been put forward as part of the CSP support package but funding not secured. As part of restructuring plan to develop Business Partners for Delivery Groups a requirement has been included to support the development of EIAs. Provided this is funded this will bridge this gap.
- Commissioning - two temporary posts are in place until the end of 2019/20 to support the disaggregation programme relating to Bridgend. Will be considered by the Joint Executive Group as part of the resource assessment for the ongoing legacy of the Bridgend transfer.
- Planning - 2 temporary unfunded posts in place (Partnerships Manager and Older peoples Programme Manager). Executive Team agreed to fund these, as well as appoint an Acute Care Planning Manager. Core department resources have been aligned to the needs of the CSP and a range of additional posts have been put forward in the resource assessment for the Transformation Portfolio.
- Robust policies and processes to be in place for Impact Assessment going forward.
- Temporary 8a funding finished. Instead funding of additional Band 4 and difference between Band 5 and 6. However unable to appoint Band 4 until April 2021. (Engagement)
- Band 4 post appointed January 2021 after delays due to Covid. Acting Band 6 to be made substantive by end March 2021. (Engagement)

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Conclude work on Exec Equalities portfolios | Interim Assistant Director of Strategy | 31st August 2021 |
| Appoint to agreed Planning posts | Interim Assistant Director of Strategy | 30th June 2021 |
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| **Assurances (How do we know if the things we are doing are having an impact?)**<br>Temporary additional resource in place for CSP (part of requirements). Now agreed by the Executive Team. Equality Impact specialist advice and support to be considered as part of Exec portfolios for equality review. | **Gaps in assurance**<br>**(What additional assurances should we seek?)**<br>Permanent additional resources not yet available |
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| **Current Risk Rating**<br>**4 x 3 = 12** | **Additional Comments**<br>As at 23.12.20 there has been no progress to create a IIA post. Need to appoint additional planning staff to support USC, planned care, thoracics, partnerships, TTP and project support. Funding agreed for most posts or externally sourced. Pursuing HR process to get roles agreed and in place.<br>31.03.21 – Action completed – Agreement of dedicated resource to support Engagement activity – through structure reviews |

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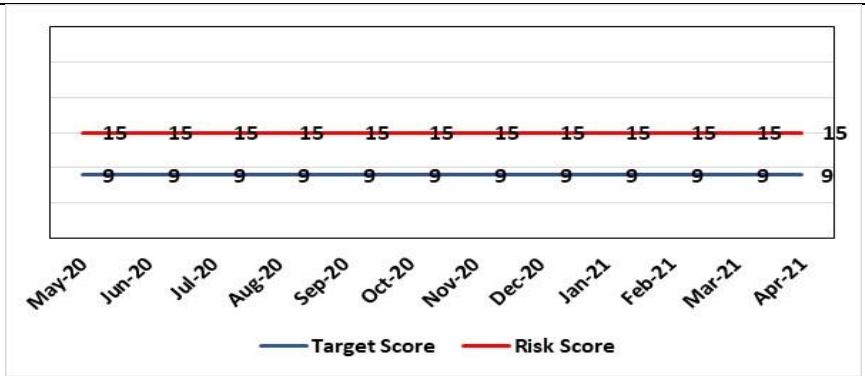
| **Datix ID Number: 1762**<br>**Health & Care Standard: Staff & Resources 7.1 Workforce** | **HBR Ref Number: 53**<br>**Target Date: 31st March 2022** |
| **Objective**: Partnerships for Care | **Director Lead**: Pam Wenger**,** Director of Corporate Governance<br>**Assuring Committee:** Health Board (Welsh Language Group) |
| **Risk:** Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board. | **Date last reviewed:** April 2021 |
| **Risk Rating**<br>(consequence x likelihood):<br>Initial: 5 x 3 = 15<br>Current: 5 x 3 = 15<br>Target: 3 x 3 = 15 | **Rationale for current score:**<br>As a consequence of an internal assessment of the Standards and their impact on the UHB, it is recognised that the Health Board will not be fully compliant with all applicable Standards.<br>This position has been confirmed/verified via an independent baseline assessment. |
| **Level of Control**<br>= 60% | **Rationale for target score:**<br>Working through its related improvement plan the likelihood of noncompliance will reduce as awareness and staff training in response to the Standards, is raised. |
| **Date added to the HB risk register**<br>November 2018 | |




| Controls (What are we currently doing about the risk?) | Mitigating actions (What more should we do?) | | |
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| | **Action** | **Lead** | **Deadline** |
| • An independent baseline assessment of the Health Board's position against the Standards has now been undertaken. This is in addition to the Health Board's own self-assessment.<br>• Work to implement the recommendations contained within the above baseline assessment has commenced.<br>• An online staff Welsh Language Skills Survey has been launched.<br>• A new Welsh Language Officer (WLO) has now been appointed, taking up her post in September 2020.<br>• Close constructive working relationships are in place with the Welsh Language Commissioner's Office<br>• Strong networks are in place amongst Welsh Language Officers across NHS Wales to inform learning and development of responses to the Standards.<br>• Proactive communication and marketing activity is being undertaken across the Health Board to raise awareness of Welsh language compliance, customer service standards and training opportunities.<br>• Working with NHS Wales Shared Services (NWSSP) to achieve compliance for workforce and recruitment standards. | Review and update the Welsh Language Standards Action Plan to reflect the findings of the independent baseline assessment | Head of Compliance | 30th June 2021 |
| | Following the appointment of the WLO, reinstate quarterly meetings of the Welsh Language Delivery Group. | Head of Compliance | 30th June 2021 |
| | Ensure the Board is fully sighted on the UHB's position through regular reporting to the Health Board. Update reports issued to the Executive Team and Board. | Head of Compliance | 30th June 2021 |
| | Recruitment of Welsh Language Officer | Head of Compliance | 30th June 2021 |

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| **Assurances (How do we know if the things we are doing are having an impact?)**<br>1. Compliance with Statutory requirements outlined in Welsh Language Act and related Standards.<br>2. Meetings with the Welsh Language Commissioner.<br>3. Self-Assessment against the requirements of More Than Just Words.<br>4. Production of an Annual Report. | **Gaps in assurance**<br>**(What additional assurances should we seek?)**<br>Meetings of the Welsh Language Standards Delivery Group, which is charged with 'overseeing compliance with the Welsh Language Standards and reporting on such to the Executive Board and the Board' need to be reinstated once the Welsh Language Officer has taken up her post. |
| **Current Risk Rating** | **Additional Comments** |

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| **5 x 3 = 15** | The self-assessment and independent baseline assessment has confirmed that the Health Board is not able to fully comply with all the Standards at this time and that the Health Board will need to take a risk management approach to the delivery of the standards. Ongoing gap in the team following the retirement of the Welsh Language Officer in December 2019. A new Welsh Language Officer has been appointed and will be taking up her post imminently.<br>A new Welsh Language Officer (WLO) has now been appointed, taking up her post in September 2020. Since appointment, the WLO's focus has been on:<br>• The review and update of the Welsh Language Standards Action Plan to reflect the findings of the independent baseline assessment<br>• The production of a self-assessment against the requirements of More Than Just Words<br>• The Annual Report<br>The WLO has also met with the Executive Medical Director, who chairs the WLSDG, with a view to re-commencing meetings in January 2021.<br>The resignation of the Welsh Language Officer in December 2020 has adversely impacted upon our ability to progress mitigating actions, notably the reinstatement of the Welsh Language Delivery Group meetings. These actions will now be progressed following the recruitment of the new Welsh Language Officer. |

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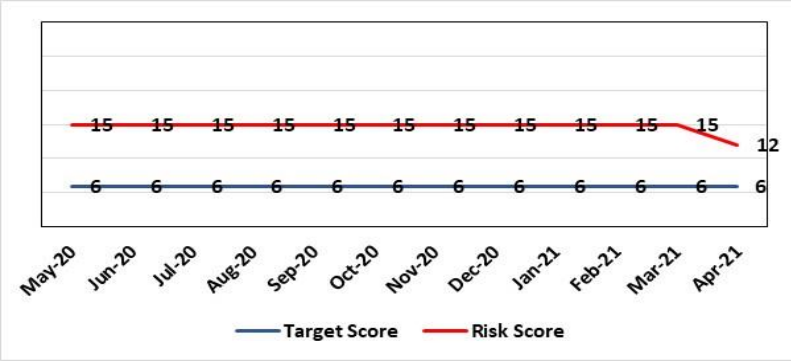
| **Datix ID Number: 1724**<br>**Health & Care Standard: Safe Care 2.1 Managing Risk & Health & Safety** | | **HBR Ref Number: 54**<br>**Target Date: 1st January 2022** |
| **Objective**: Partnerships for Care | | **Director Lead:** Sian Harrop-Griffiths, Director of Strategy<br>**Assuring Committee:** Health Board (Emergency Preparedness Resilience and Response Group) |
| **Risk:** Failure to maintain services as a result of the potential no deal Brexit | | **Date last reviewed:** April 2021 |
| **Risk Rating**<br>(consequence x likelihood):<br>Initial: 4 x 5 = 20<br>Current: 3 x 4 = 12<br>Target: 3 x 2 = 6 |  | **Rationale for current score:**<br>The initial risk assessment is based on the fact that significant work needs to take place to understand the risks in terms of the Health Board's ability to maintain services as business as usual. This has been undertaken, but given that there remain some unknowns in terms of future agreements as some are being reviewed during the summer of 2021, the current risk rating has reduced but remains in place. |
| **Level of Control**<br>= 70% | | **Rationale for target score:**<br>By undertaking the actions highlighted it is anticipated that the arrangements put in place will ensure business as usual even if some future trade agreements pose some risks to some services and business continuity plans have been updated to include the required mitigations. |
| **Date added to the HB risk register**<br>November 2018 | | |

**Controls (What are we currently doing about the risk?)**

- Emergency Preparedness resilience and response, (EPRR) work programme in relation to the 6 statutory duties is monitored via the EPRR Strategy Group; this includes emergency planning, risk assessment, collaboration, sharing of information, warning and informing and business continuity.
- The Health Board continues to respond to the C-19 pandemic and has been in response since 31.01.21. In addition, there have been a number of concurrencies that the Health Board has responded to; emphasising the need for a continued cycle of emergency planning, to be emergency prepared and consequently to improve resilience. There is an EPRR risk register as well as a Brexit specific risk register.
- All services have completed a full risk assessment and have identified high risks related to Brexit on the risk register, and there is also a strategic risk log. Services noting high risks have a separate Risk, Action Issues, Decisions, (RAID) log in place. Engagement in health national groups continues to monitor this.
- Welsh Government continues to work with NWSSP procurement and commissioned a review of devices and consumables supply chain in Wales to complement the work already completed at UK level. There is national oversight of Procurement specifically for Brexit.
- Welsh Government has put in place national communication and co-ordination arrangements,

That remain including:

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
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| To review and rehearse promptly the existing business continuity and resilience/contingency arrangements, and to do so working with your local and regional partners, including through your local resilience forums.<br>Plans were exercised during 2018 for a no deal Brexit. Continued planning remained in place and a constant review of risk assessments. In addition, the Health Board has invoked its business continuity arrangements a few times whilst responding to the pandemic and the most was in relation to disruption to supplies of blood science products. The learning from this incident is being taken forward to ensure critical stocks and supplies of just in time products is more robust. | Head of Emergency Preparedness, Resilience & Response | (Monthly meetings resumed in September 2020) 1st June 2021 Meetings during September to November 2020 were more frequent but continue to be monthly and currently focusing on Brexit. |

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| ○ A Brexit Ministerial Stakeholder Advisory Forum made up of senior leaders from across the sector, and led by the Cabinet Secretary for Health and Social Services and the Minister for Children, Older People and Social Care;<br>○ An EU Transition Leadership Group, chaired by WG focusing on ensuring operational readiness arrangements for both health and social services in Wales (terms of reference attached);<br>○ Regular meetings of NHS emergency planners, chaired by Welsh Government, as part of established resilience arrangements;<br>○ A 4 Nations public health group addressing public health associated risks and health security concerns, and a joint Welsh Government – Public Health Wales working group considering specific Welsh issues;<br>○ Working in partnership with the Welsh NHS Confederation to ensure ongoing flexible and effective communication and engagement between us and other stakeholders in the health and care system; and Regular updates on Brexit to the monthly NHS Wales Executive Board meetings.<br>○ Command and control requirements; however, the ECCW for Brexit has now stood down.<br>○ Work programme monitored via EPRR Strategy Group<br>○ All services have updated business continuity plans to reflect Brexit issues and C-19 issues<br>○ Continued engagement in health national groups<br>○ Continued engagement and oversight with the South Wales Local Resilience Forum. The Strategic Coordination group is in place for C-19 and also receives updates in relation to Brexit. There is also a separate oversight group. | | | |
| **Assurances (How do we know if the things we are doing are having an impact?)**<br>• Work programme in place and monitored via EPRR Strategy Group<br>• All services have up to date business continuity plans<br>• Robust risk management system in place<br>• Preparedness and response assurance procedure specifically for Brexit<br>• Horizon scanning process in place for issues that may arise later during 2021 | **Gaps in assurance (What additional assurances should we seek?)**<br>To understand from the review what arrangements need to be in place to minimise the risks in relation to continued issues related to Brexit. The robust risk assessment and RAID log provision allows for careful observation of issues and contingencies to mitigate the risks. | | |
| **Current Risk Rating**<br>**3 x 4 = 12** | **Additional Comments**<br>There is an obligation to maintain critical services and business as usual in an emergency and this includes issues arising due to Brexit and consequently there is the potential for disruption in commercial and public services and therefore supplies, services, transport, fuel, border issues, EU national issues, immigration, critical infrastructure, energy, data flaws and command resilience etc.<br>All EPRR and Brexit meetings were postponed temporarily due to the Covid-19 pandemic but resumed during September 2020. Prior to this Services re-commenced a review of the risk assessments and updating of business continuity plans; this remains a continuum.<br>Action – Revision of business continuity plans to take account of Covid-19 - Completed 23.11.20<br>29.04.21 update - The monitoring of Brexit related risks is overseen by the EPRR Strategy Group and there is a specific Brexit risk log and register. C-19 Gold has oversight of the risks also as there are some synergies with regard to the C-19 | | |

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| | response. Where there are risks scored 16 and above, there is a separate Risk, Action, Issues, Decision log in place by that service. All Business Continuity plans and necessary mitigations have been identified and services have provided assurance in EPRR Strategy Group. |

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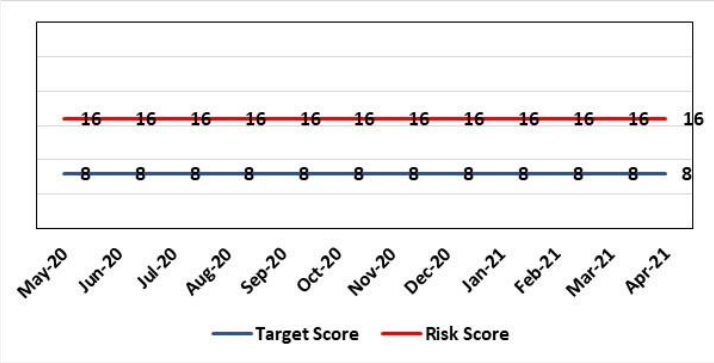
| **Datix ID Number: 1799**<br>**Health & Care Standard: Controlled Drug 2.6 Medicines Management** | **HBR Ref Number: 57**<br>**Target Date: 31st December 2021** |
| **Objective**: Best Value Outcomes of High Quality Care | **Director Lead**: Richard Evans, Executive Medical Director<br>**Assuring Committee**: Audit Committee |
| **Risk:** Non-compliance with Home Office Controlled Drug Licensing requirements. The Health Board has limited assurance regarding whether or not it is compliant with Home Office Controlled Drug Licensing requirements at the present time, nor does it currently have processes in place to ensure any future service change complies. | **Date last reviewed:** April 2021 |
| **Risk Rating** (consequence x likelihood):<br>Initial: 5 x 4 = 20<br>Current: 4 x 4 = 16<br>Target: 4 x 2 = 8 | **Rationale for current score:**<br>Risk: That the Health Board is operating in breach of the law by managing controlled drugs without an appropriate Home Office Controlled Drug License. Legal advice provided to the Health Board has indicated that failure to comply with the Home Office Controlled Drug licensing requirements could result in criminal and civil action, both against responsible individuals and the Health Board as a public body. The Health Board ratified a policy to determine requirements for Home Office Licenses (written following independent legal advice) in August 2020 however the content of the policy differs from Home Office advice received to date – the Health Board are awaiting response from the Home Office having shared a copy of this policy and have asked for a meeting to discuss differences in opinion. As such then, the risk of non-compliance with Home Office direction and associated consequences still stand.<br>Risk: That the Health Board is maintaining unnecessary Home Office Controlled Drug Licenses. Each Home Office Controlled Drug license costs around £3k plus additional administrative set-up and maintenance costs. Health Board wide scrutiny is required to ensure no unnecessary licenses are held (one such example has recently been discovered). |
| **Level of Control** = 40% | **Rationale for target score:** |
| **Date added to the HB risk register** January 2019 | Following either the Home Office agreeing with the content of the Health Board 'Policy to determine the requirement for Home Office Controlled Drug Licenses,' or a position of compromise being agreed there will be a training session held with all Service Groups supported at Executive level. |




| Controls (What are we currently doing about the risk?) | Mitigating actions (What more should we do?) | | |
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| | **Action** | **Lead** | **Deadline** |
| Director of Corporate Governance, has formally written to the Home Office to share a copy of the Health Board's, 'Policy to determine the requirement for Home Office Controlled Drug Licenses,' and to ask for a meeting at their earliest convenience to discuss difference of opinion regarding number and nature of licenses required. In response to difficulties sourcing Controlled Drugs from the pharmaceutical wholesale system for HMP Swansea due to uncertainty around whether a Home Office CD license is required at this site, the Health Board have decided to apply for such a license. This decision, whilst not in line with Health Board policy, does follow Home Office direction and is anticipated will result in resumption of normal supply of CDs to HMP Swansea. | Upon agreement of policy with the Home office: HB to develop and implement a control system to ensure compliance with HO license requirements (now and in the future). | Clinical Director Pharmacy | 1st September 2021 |
| | Upon agreement of policy with the Home office: HB to undertake a baseline assessment of current CD management in the HB in line with the new HB policy on requirements for HO Controlled Drug licenses | Clinical Director Pharmacy | 1st September 2021 |

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| Additionally, the Controlled Drug Accountable Officer is currently working with Service Group Triumvirates to strengthen Controlled Drug Governance. This will provide an opportunity to expedite some of the actions outlined in this register entry.<br>. | Apply for a Home Office Controlled Drug License for HMP Swansea | CD Lead, Primary Care & Therapies Service Group | 1st September 2021 |
| | HB to discuss and agree a policy position on the requirements for Home Office Controlled Drug Licenses with the Home Office. (Currently awaiting a reply in response to the Health Board's invitation to meet.) | Clinical Director Pharmacy | 1st September 2021 |
| | HB to undertake a baseline assessment of HO CD licenses currently held by the HB | Clinical Director Pharmacy | 1st September 2021 |
| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>• To date the HB has written a policy to determine the requirements for Home Office Controlled Drug Licenses. The principles contained within the policy are referred to when issues are raised in order to provide consistency in arrangements. | **Gaps in assurance**<br>**(What additional assurances should we seek?)**<br>The Health Board will develop a license compliance register, this is expected to be maintained by the Corporate Governance Team thus ensuring there is sufficient segregation of duty. | | |
| **Current Risk Rating**<br>**4 x 4 = 16** | **Additional Comments**<br>Director of Corporate Governance wrote to the Home Office to share the Health Board policy for determining requirements for Home Office CD Licenses and to ask for a meeting to discuss difference of opinion on the 15th December 2020.<br>The decision that the Health Board should apply for a Home Office CD license for HMP Swansea was taken on the 27th January 2021. The Controlled Drug Accountable Officer requested that Primary Care & Therapies Service Group applied for this license on behalf of the Health Board on the 28th January 2021.<br>It is proposed that it would be more prudent to undertake actions 1 and 2 following agreement between the Health Board and the Home Office regarding policy position on number and nature of CD licenses required.<br>Action four will be addressed as part of the strengthening of CD governance currently being undertaken by Service Groups in conjunction with the Controlled Drug Accountable Officer. | | |

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| **Datix ID Number: 146**<br>**Health & Care Standard: Effective Care 3.1 Clinically Effective Care** | **HBR Ref Number: 58**<br>**Target Date: 31st March 2022** |
| **Objective**: Excellent Patient Outcomes | **Director Lead**: Rab McEwan, Chief Operating Officer<br>**Assuring Committee**: Quality and Safety Committee |
| **Risk:** There is a failure to provide adequate clinic capacity to support follow-up patients within the **Ophthalmology** specialty.<br>The consequence of this failure is a delay in patients with chronic eye conditions accessing ongoing secondary care monitoring of diagnosed conditions with the potential risk of permanently impairing eyesight. | **Date last reviewed:** April 2021 |
| **Risk Rating** (consequence x likelihood):<br>Initial: 4 x 3 = 12<br>Current: 4 x 5 = 20<br>Target: 4 x 1 = 4<br><br>**Level of Control** = 40%<br><br>**Date added to the HB risk register**<br>December 2014 |  | **Rationale for current score:**<br>Sustainable plans underway - short term measures in process of being implemented. Serious incidents being reported to WG. Gold Command exec-led oversight established November 2018. Risk rating increased to 25 January 2019 as instructed by Gold Command. LJ advised change risk score to 16, 03/04/2019 as Probable x Major. Risk rating increased to 20 in July 2020 due to Covid-19 pandemic.<br><br>**Rationale for target score:** |

| **Controls (What are we currently doing about the risk?)** | **Mitigating actions (What more should we do?)** | | |
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| • All patients are categorised by condition in order to quantify issue. Second glaucoma consultant appointed November 2018.<br>• Additional accommodation secured to increase capacity; implementation plan under development. Welsh government funding secured for 2019/20 to employ additional activity and deliver some services in a community setting. Virtual clinics established.<br>• Service Manager for Ophthalmology providing regular updates via Planned Care Programme. | **Action** | **Lead** | **Deadline** |
| | An overall Sustainability Plan to be delivered (Gold command process in place) | Service Group Manager Surgical Specialties | 31st March 2021 (Monthly ongoing) |

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| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>• A Welsh Government pilot programme was implemented in June 2014. The purpose of the HES project is to use clinic capacity to assess, review and treat patients within clinical priority rather than prioritising new patients based on their waiting time. A Project Management Lead was in post to deliver on the HES objectives. | **Gaps in assurance**<br>**(What additional assurances should we seek?)**<br>Extended waiting times for patients requiring routine clinical intervention, but these are still listed as per RTT guidance. |
| **Current Risk Rating**<br>**4 x 5 = 20** | **Additional Comments**<br>Additional Glaucoma practitioner (temporary for 12 months) commenced in post 11/06/2018. 2nd Glaucoma Consultant started 05/11/2018. Advert for substantive consultant as part of regional development with Hywel Dda to be placed in November |

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| | Accommodation in Corridor 3 reconfigured 08/02/2019. Further work needed on accommodation and additional rooms required. Ongoing discussions continue with Singleton Unit so that space can be created to house a co-located Ophthalmology Department Middle grade doctor to commence in post April 2019.<br>Monthly tracker of glaucoma backlog patients indicates reduction of over 800 patients to end of January 2019.<br>Diabetic Retinopathy Virtual Review clinics are to be increased via a WG funded successful bid.<br>Reviewed by AD& PT Sustainable plans are under way and are on target against follow up trajectory backlog. 20/21 sustainable plans are currently being drafted. Risk score reviewed to maintain at 20.<br>Although routine outpatient's appointment are not being undertaken due to COVID-19 those patients at high risk i.e. wet AMD are still being seen and receiving treatment and those patients in other high risk specialties such as glaucoma are being reviewed virtually and if deemed necessary attending for urgent appointments.<br>Since the advent of the Covid-19 outbreak only the following essential Eye services have been maintained during Covid 19.<br>• AMD treatments<br>• Retina services<br>• Rapid Access Eye clinic (RACE - Eye Casualty)<br>As a consequence, the progress made through the previous eye care initiatives has been reversed.<br>During the pandemic the following has been achieved:<br>• Paediatric – 2 consultants have started with a post Covid timetable covering Hywel Dda sessions under SLA contract.<br>• Diabetic Retina – Band 4 Coordinator appointed from interview 19th June 2020.<br>• Glaucoma – Strawberry Place ODTC clinics to resume for 3 months from July 2020 while we look for alterative accommodation, which has now been secure in NPT Resource Centre.<br>Some clinically urgent Cataract operations have been undertaken through May and June 2020.<br>The progress made in reducing follow up patients has been reversed due to significant reduction in capacity during pandemic. Revised action plans to recover the position have been developed but are reliant on post Covid activity levels being restored.<br>14.04.21 - Additional glaucoma clinic capacity now available in Wellbeing Centre, Swansea University, but overall capacity is still below pre-COVID levels due to social distancing requirements and the theatre capacity only being allocated to Priority 2 patients.<br>Gold Command process in place to regularly review recovery plans.<br>Work ongoing with Hywel Dda HB on regional solutions. |

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| **Datix ID Number: 2003**<br>**Health & Care Standard: Effective Care 3.1 Clinically Effective Care** | **HBR Ref Number: 60**<br>**Target Date: 31st March 2022** |
| **Objective**: **Digitally Enabled Care** | **Director Lead:** Matt John, Director of Digital<br>**Assuring Committee:** Audit Committee |
| **Risk: Cyber Security - high level risk**<br>The level of cyber security incidents is at an unprecedented level and health is a known target.<br>The health board has increased digital services (users, devices and systems) and therefore the impact of a cyber-security attack is much higher than in previous years.<br>The introduction of the Network and Information Systems Directive (NISD) in May 2018 means that large fines can be issued to organisations that are not compliant with the Directive.<br>A report from the department of health following the Wannacry incident in May 2017 stated that attack cost the NHS (England) £92m as 19,000 appointments were cancelled and this was before the NISD came into effect.<br>The largest risk to the organisation is on user awareness and unsupported software (old versions which are no longer patched for security vulnerabilities) and devices not managed by the ICT department e.g. medical devices. | **Date last reviewed:** April 2021 |
| **Risk Rating**<br>(consequence x likelihood):<br>Initial: 5 x 4 = 20<br>Current: 5 x 4 = 20<br>Target: 5 x 3 = 15 | **Rationale for current score: C and L**<br>The level of cyber security incidents is at an unprecedented level and health is a known target.<br>The health board has increased digital services (users, devices and systems) and therefore the impact of a cybersecurity attack is much higher than in previous years. |
| **Level of Control** | **Rationale for target score:** |
| **Date added to the HB risk register**<br>July 2019 | C- Will remain the same or increase due to increased reliance in information<br>L- The overall likelihood score would decrease to 3 if mandatory Cyber Security training is achieved and implemented across the Health Board |


| Controls (What are we currently doing about the risk?) | Mitigating actions (What more should we do?) | | |
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| | **Action** | **Lead** | **Deadline** |
| • Cyber Security Manager and supporting roles now in place.<br>• The national security tools will highlight vulnerabilities and provide warnings when potential attacks are occurring. Swansea Bay will adopt these tools in financial year 2019/20.<br>• The NHS in Wales is protected by a firewall by NHS Wales Informatics Service (NWIS).<br>• Swansea Bay UHB has advanced firewall protection to protect the network from potential cyber- attacks.<br>• All emails coming into NHS Wales are scanned using the national email filter. Whilst malicious emails come into the health board on a daily basis, the number are vastly reduced using the email filter and NWIS issue warnings to users affected when the contents are discovered (same day). Users are warned to delete emails and if opened, contact ICT service desk for investigation. | Adopt mandatory Cyber training across SBUHB, or identify alternative options. | Cyber Security Manager | 1st August 2021 |
| | Undertake Cyber Assessment as part of annual NIS compliance work with Cyber Resilience Unit in DHCW | Cyber Security Manager | 1st August 2021 |

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| • A patching regime has been in place around 18 months which ensures desktops, laptops and servers are protected against any known security vulnerabilities. Anti-virus is in place to protect against known viruses with intelligent scanning on potential viruses not yet discovered.<br>• Access to the internet is controlled through a smart filtering solution which restricts access to potentially vulnerable content.<br>• Work is ongoing in order to replace out of date systems, this is a huge task given the number of clinical and administrative systems in place across the health board. The creation of the service management board will help in terms of getting stakeholder agreement and engagement. Capital funding has also been available to address this.<br>• A Cyber Security training module has been developed and available in the Electronic Staff Record training to ensure staff are fully aware of the risk of cyber security and are vigilant in recognising malicious activity e.g. malicious email. This needs to be adopted as mandatory training.<br>• Scam email specific testing, training and awareness undertaken by SBU Cyber Security Team across all staff using Metaphish tool purchased until March 2022. Phishing emails and staff awareness is one of our biggest cyber risks. | | | |
| **Assurances (How do we know if the things we are doing are having an impact?)**<br>Submissions of the Cyber Assessment Framework response to the Cyber Resilience Unit (onto Welsh Gov) as part of NIS compliance will identify recommendations and actions to undertake as part of an annual assessment and continuous improvement cycle. | **Gaps in assurance (What additional assurances should we seek?)** | | |
| **Current Risk Rating**<br>**5 x 4 = 20** | **Additional Comments**<br>Band 8a Cyber Security Manager appointed October 2019.<br>Microsoft patching is compliant.<br>NISD CAF completed and submitted to OSSMB.<br>2 Band (6) Cyber Security staff have now been appointed and are due to commence shortly. (completed)<br>National Security Tool - SIEM Systems integrated, currently working on the final interfaces.<br>NESSUS still awaiting National timescales for NWIS for rollout.<br>Meetings in progress to make Cyber Security Training mandatory across the Health Board.<br>Papers on progress on Cyber Security have been sent to the Senior Leadership Team, Audit committee and Health Board meetings and were well received in each of those. The progress on the establishment of a dedicated Cyber Security team and adoption of local and national cyber tools to improve cyber defences and establish proactive monitoring was noted.<br>The risk score of 20 remains as the largest risk to Cyber Security are the staff that access computer systems such as inadvertently clicking on a | | |

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| | malicious link in a Phishing email.<br>The Senior Leadership Team agreed, in principle, for Cyber Security Training to be made mandatory. A further paper for approval, describing the implications for the workforce, will be submitted to a future SLT meeting.<br>National Security Tool -SIEM Systems integrated currently working on final interfaces. NESSUS still awaiting national timescales from NWIS for rollout.<br>Following from the previous update, Cyber Team now use the Security Information and Event Management system (SIEM) daily to provide a dashboard for security monitoring to ensure visibility of potential cyber threats.<br>Training for Cyber staff on operational use of the SIEM is was due in March 2020, but was delayed as a result of COVID and is now scheduled for October. SIEM training has now been completed.<br>Action timescale amended as this is an ongoing requirement.<br>Action closed – Raise awareness of Cyber Security across the whole Health Board through training and awareness tools and communications. |

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| **Datix ID Number: 1587**<br>**Health & Care Standard: 3.1 Safe and Clinically Effective Care** | **HBR Ref Number: 61**<br>**Target Date: 31st March 2022** |
| **Objective**: Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morriston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies. | **Director Lead:** Rab McEwan, Chief Operating Officer<br>**Assuring Committee:** Quality and Safety Committee/Strategy Planning and Commissioning Committee |
| **Risk:** Paediatric dental GA/Sedation services provided under contract from Parkway Clinic, Swansea. Medical Safety risk GAs performed on children outside of an acute hospital setting. | **Date last reviewed:** April 2021 |

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| **Risk Rating** (consequence x likelihood):<br>Initial: 5 x 3 = 15<br>Current: 4 x 4 = 16<br>Target: 4 x 2 = 8 |  | **Rationale for current score:**<br>There is no immediate access to crash team/ICU facilities in in Parkway Clinic – the client group are undergoing G/A/sedation. Paediatric GA/Sedation services provided under contract from Parkway Clinic, Swansea continue due to lack of capacity for these patients to be accommodated in Secondary Care |
| **Level of Control** = 60% | | **Rationale for target score:** |
| **Date added to the HB risk register** 4th July 2018 | | Relocation of the paediatric GA service [provided by Parkway Clinic] to a hospital site being treated as a priority |

| **Controls (What are we currently doing about the risk?)** | **Mitigating actions (What more should we do?)** | | |
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| | **Action** | **Lead** | **Deadline** |
| • Consultant Anaesthetist present for every General Anaesthetic clinic.<br>• Assurance Documentation supplied by Parkway Clinic including confirmation of arrangements in place with WAST and Morriston Hospital for transfer and treatment of patients<br>• New care pathway implemented - no direct referrals to provider for GA.<br>• Multi-drug sedation ceased from Sep 2018 in line with WHC 2018 009<br>• Revised SLA/Service Specification<br>• HIW Inspection Visit Documentation provided to HB<br>• All extended GA cases require approval from paediatric specialist prior to treatment | | | |
| | Transfer of services from Parkway. | Interim Head of Primary Care | 31st May 2021 |

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| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>• RMC collate referral and treatment outcome data for review by Paediatric Specialist<br>• Regular clinical meeting arranged with Parkway to discuss individual cases/concerns<br>• Regular clinical/ management meeting for CDS/primary care management team to discuss service pathway /concerns/issues arising<br>• Roll out of new pathway to encompass urgent referrals | **Gaps in assurance**<br>**(What additional assurances should we seek?)**<br>ToR for the task and finish group should continue to include consideration of the pressures on the POW special care dental GA list and this service is considered alongside any plans for the Parkway contract. |
| **Current Risk Rating**<br>**4 X 4 = 16** | **Additional Comments**<br>Task & Finish Group continue to progress transfer of service to Morriston. Action moved to May 2021 due to Covid pressures. However, PWC have now |

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| | given the Health Board notice that they wish to terminate the contract at the end of January 2021. Transfer of this service to Morriston is not feasible by the end of January and given the limitations on staffing and theatre capacity is not achievable by May 2021 therefore T&F Group are looking at the other options available to deliver the service which, includes extending the contract with PWC through to March 2022 or transferring the service the NPTH. A paper setting the options will be presented the Senior Leadership on 18 November 2020.<br>Risk remains - for review in November following meeting with Senior Leadership on 18th November 2020.<br>Task and Finish Group re-established first meeting on 1st December to progress transfer to Morriston Hospital by 31st May 2021.<br>The limited theatre capacity available due to Covid restrictions has resulted in an extension of the contract with Parkway until June 2022 being negotiated. |

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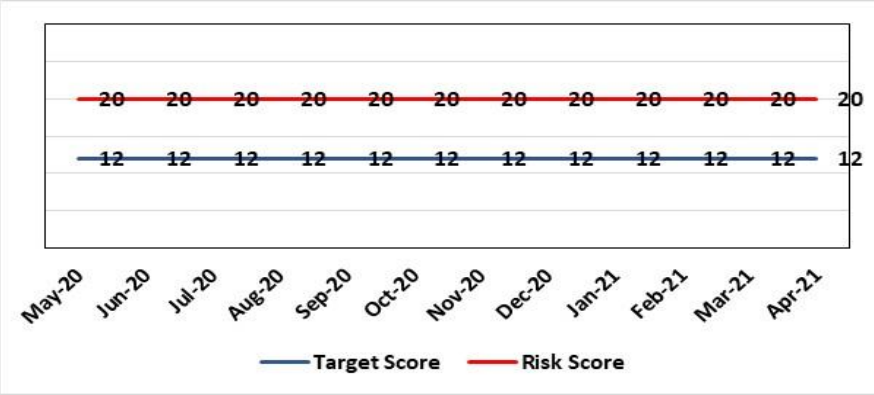
| **Datix ID Number: 1605**<br>**Health & Care Standard: 3.1 Safe and Clinically Effective Care** | **HBR Ref Number: 63**<br>**Target Date: 31st March 2022** |
| **Objective**: Screening for Fetal Growth Assessment in line with Gap-Grow (G&G) | **Director Lead**: Christine Williams, Interim Director of Nursing and Patient Experience<br>**Assuring Committee:** Quality and Safety Committee |
| **Risk:** There is evidence a growth restricted/small for gestational age fetus (SGA), has an increased risk of intra-uterine death before or during the intrapartum period. Identification and appropriate management for SGA in pregnancy should lead to improved outcomes. GAP & Grow standards were implemented to contribute to the reduction of stillbirth rates in wales. Obstetric USS scan appointments are at capacity leading to delays in obtaining required appointments. In addition, the guidance from Gap & Grow is for women requiring serial scanning with a risk factor for a growth restricted baby must have 3 weekly scans from 28 to 40 week gestation. Due to the scanning capacity there are significant challenges in achieving this standard. | **Date last reviewed:** April 2021 |
| **Risk Rating** (consequence x likelihood):<br>Initial: 4 x 3 = 12<br>Current: 4 x 5 = 20<br>Target: 3 x 4 = 12<br>**Level of Control** = 60%<br>**Date added to the HB risk register**<br>1st August 2019 |  | **Rationale for current score:**<br>CSFM's leading on audit reviewing records of all women where SGA not identified in antenatal period. Scanning capacity under increasing pressure.<br>Meeting arranged with radiology management to discuss introduction of midwife sonographer third trimester scanning. Staff to be informed to submit Datix incident where scan not available in line with standards.<br><br>**Rationale for target score:**<br><br>Compliance with Gap & Grow requirements. |

| **Controls (What are we currently doing about the risk?)** | **Mitigating actions (What more should we do?)** | | |
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| | **Action** | **Lead** | **Deadline** |
| All staff have received training on Gap & Grow and detection of small for gestational babies. Obstetric scanning capacity across the HB is being reviewed and compliance with criteria for scanning is being monitored. Ultrasound are assisting with finding capacity wherever possible in order to meet standards for screening and complying with Gap & grow recommendations. | Adherence to Gap/Grow Standards | Deputy Head of Midwifery | 31st December 2021 |

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| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>Audit of compliance with guidance being undertaken, detection rates of babies born below the 10th centile is being monitored via datix and audited by the service. Ultrasound are assisting with finding capacity wherever possible in order to meet standards for screening and complying with Gap & grow recommendations. | **Gaps in assurance**<br>**(What additional assurances should we seek?)** |
| **Current Risk Rating**<br>**4 X 5 = 20** | **Additional Comments**<br>Recruitment for a fixed term 2 year role for a sonographer trainer will commence February 2021.<br>Training currently being provided by appropriately trained obstetrician |

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| | the two trainee midwife sonographers are making good progress in their university course and practical skills training.<br>An ultrasound machine has been purchased from capital funds and will be installed by 31/03/2021 for midwife sonographer service use.<br>relocation of some gynaecology clinics will free up space for a dedicated room in the antenatal clinic environment.<br>04.05.21 – Update - Trainer role currently on trac (2 year fixed term)<br>2 current trainee sonographers progressing well through training.<br>Ensure SBAR for recruitment for two further trainee sonographers is completed and presented to NPTSSG group for approval. |

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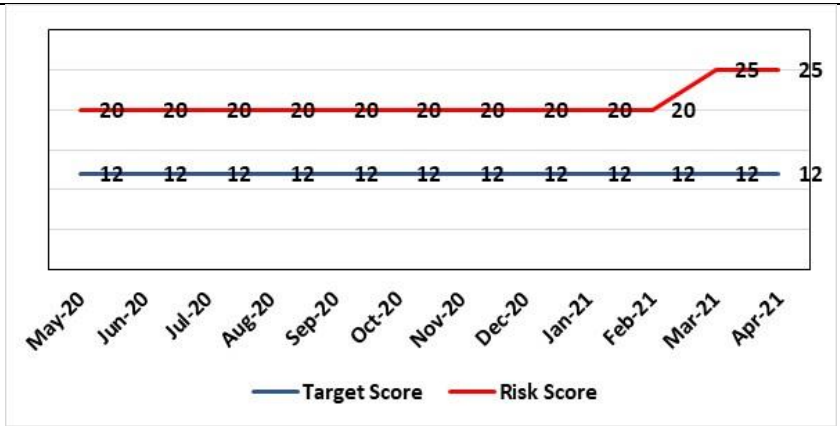
| **Datix ID Number: 2159**<br>**Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety** | | **HBR Ref Number: 64**<br>**Target Date: 31st March 2022** |
| **Objective**: Best Value Outcomes | | **Director Lead:** Christine Williams, Interim Director of Nursing and Patient Experience<br>**Assuring Committee:** Health and Safety Committee |
| **Risk:** Insufficient resource and capacity of the Health, safety and fire function within SBUHB to maintain legislative and regulatory compliance for the workforce and for the sites across SBUHB.<br>. | | **Date last reviewed:** April 2021 |
| **Risk Rating**<br>(consequence x likelihood):<br>Initial: 5 x 4 = 20<br>Current: 5 x 5 = 25<br>Target: 4 x 3 = 12 |  | **Rationale for current score:**<br>The Health Board are in receipt of 10 Health & Safety Executive (HSE) improvement notices concerning health and safety management, violence and aggression and manual handling, limited assurance internal audit reports for water safety management and COSHH, and a fire enforcement notice for one of our sites. Fire risk assessment frequencies are not being kept up to date. Statutory/mandatory training provision and recording will not be sustainable. Unable to support units sufficiently for H&S, case management (V&A), fire and training or to conduct audits/inspections. Potential for litigation, with implications of financial and reputational consequences for not meeting legislative requirements. |
| **Level of Control**<br>= 70% | | **Rationale for target score:**<br>Compliance with the notices and to have sufficient resources to implement a sustainable health and safety provision to support the legal requirements of the Health Board |
| **Date added to the HB risk register**<br>September 2019 | | Additional resources and updated/refreshed/new systems will enable the Health Board to demonstrate that suitable resources are in place to undertake the roles and responsibilities of the department, and to undertake suitable and sufficient training, provide corporate overview/audit to ensure practices are being employed in the workplace. Risk assessments are being undertaken within required frequencies and periodic audits are taking place to support the various units and departments. |

| **Controls (What are we currently doing about the risk?)** | **Mitigating actions (What more should we do?)** | | |
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| | **Action** | **Lead** | **Deadline** |
| • HSE Improvement working group set up to address the HSE recommendations and meets fortnightly to monitor the improvement action plan.<br>• Interim posts of Assistant Director of Health and Safety and Interim Head of Compliance employed on secondment to support strengthening and developing the H&S function<br>• Health and Safety Operational Group meets quarterly and reports to the Health and Safety Committee<br>• Water safety management action plan in place<br>• COSHH procedure reviewed and updated | Health and safety department structure to be reviewed and produce proposals, business case | Assistant Director of H&S | 31st May 2021 |
| | Health and safety structure review to be presented to the H&S Committee | Assistant Director of H&S | 31st May 2021 |

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| • Fire risk assessments are being undertaken at priority sites (patient areas) to address recommendations of the MAWWFRS<br>• Fire training in place and fire wardens in place | | | |
| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>• Monitoring through the H&S committee to receive assurance and or identify gaps for key compliance and adherence to applicable legislation.<br>• HSE focus group monitor compliance against the 10 improvement notices and report to the H&S operational group and H&S committee.<br>• Site visits/tours to identify compliance and gaps in compliances. | **Gaps in assurance**<br>**(What additional assurances should we seek?)** | | |
| **Current Risk Rating**<br>**5 X 5 = 25** | **Additional Comments**<br>The re-inspections took place w/c 16 September 2019, visiting NPTH on 16th, Singleton & Morriston Hospital on 17th, Tonna Hospital and NPTH on 18th and NPTH on 20th. All visits went well overall with a number seven of the ten notices closed and three extended to 6th December 2019. A further visit was arranged for 5th December (Theatres at Singleton) where it was confirmed that two more notices were complied with and the other one extended to 31 January 2020. Confirmation via email was received on 7th February that all improvement notices have been complied with.<br>Business case to be written by 31st October 2020.<br>Re-structure review to be presented to H&S committee during 3rd quarter 2020/21.<br>Long term plans to be developed to understand the Health and Safety resource requirements for the Health Board.<br>The restructure is to be reviewed and business case written by 31st October 2020.<br>Due to the pandemic (COVID-19) progress has been minimal and will review when operationally possible, this could be delayed until October/November 2020. Initial review undertaken and an early draft is currently having costs drawn up for the draft options to be submitted to Execs. COVID-19 has had an impact of the progression of this and will be presented on Q4.<br>Due to the pandemic (COVID-19) progress has been minimal and will review when operationally possible, this could be delayed until March 2021.<br>24.02.21 - Long term plans to be developed to understand the health and safety resource requirements for SBUHB.<br>09.03.21 – COVID-19 has enforced a pause In a number of areas, with limited access to building to undertake works i.e. compartmentation surveys. Given the reduction in COVID-19 cases it is envisaged that Mid and West Wales Fire & Rescue Service along with other enforcement agencies will restart their audit/inspection programmes. Given that M&WWFRS have already carried out inspection in Hywel Dda over the last 12-24 months and received site wide enforcement notices for Withybush Hospital; Glangwili Hospital and | | |

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| | Compartmentation and fire doors at St Caradogs Hospital, there are also enforcement notices issued by South Wales Fire & Rescue Service for CTMUHB and ABUHB. When SBUHB are inspected by M&WWFRS it is highly likely that similar issues will be identified and enforcement notices issued. There is also the potential if the HSE inspect that improvement notices may be issued due to the current level of resources within the health & safety team.<br>Temporary additional resources are in place from March 2021 and a plan in place to reduce the number of overdue fire risk assessments.<br>The increase is based on the current resource position and that there are a number of fire risk assessments overdue and as this RR risk is more about Singleton and the cladding works commencing in April this will add to the risk level score. I also don't believe the original rating was a true reflection and thought this had been replaced by the overall H&S HBRR 64 that has recently been increased to 25 following discussions with CW, CW and DG. |

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| **Datix ID Number: 329**<br>**Health & Care Standard: 3.1 Safe and Clinically Effective Care** | **HBR Ref Number: 65**<br>**Target Date: 31st March 2022** |
| **Objective**: Digitally enabled Care | **Director Lead**: Christine Williams, Interim Director of Nursing and Patient Experience<br>**Assuring Committee:** Quality & Safety Committee |
| **Risk:** Risk associated with misinterpreting abnormal cardiotocography readings in the delivery room. A central monitoring station would enable multi-disciplinary viewing and discussion of the readings to take place, and reduce the risk of a concerning CTG trace going unidentified. Provisionally scored C4 (irrecoverable injury) x L3= 12. The central monitoring system has a facility to archive the CTG recordings: currently these tracings are only available as a paper copy, which can be lost from the maternity records. There is also a concern that the paper tracings fade over time which makes defending claims very difficult. | **Date last reviewed:** April 2021<br>**Rationale for current score:**<br>Meeting with K2, IT, finance, procurement and midwifery team on 30/09/2019. System viewed and IT needs identified. Final costing to be assessed prior to resubmission to IBG in Oct or November 2019. |
| **Risk Rating** (consequence x likelihood):<br>Initial: 4 x 4 = 16<br>Current: 4 x 5 = 20<br>Target: 4 x 2 = 8<br>**Level of Control** = 50%<br>**Date added to the HB risk register** 31st December 2011 |  |
| | **Rationale for target score:** |

| Controls (What are we currently doing about the risk?) | Mitigating actions (What more should we do?) | | |
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| | **Action** | **Lead** | **Deadline** |
| Current controls include all staff undertaking RCOG CTG training and competency assessment. Protocol in place for an hourly "fresh eyes" on 'intrapartum CTG's' and jump call procedures. CTG prompting stickers have been implemented to correctly categorise CTG recordings. Central monitoring is also expected to strengthen the HB's position in defending claims. K2 fetal monitoring system has been identified as the best option for a central monitoring system. | Business case prepared for Central monitoring system to store CTG recordings of fetal heart rate in electronic format. | Deputy Head of Midwifery | 31st December 2021 |
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| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>All Wales Fetal Surveillance Standards for 6hrs Fetal Surveillance Training per year | **Gaps in assurance**<br>**(What additional assurances should we seek?)** |
| **Current Risk Rating**<br>**4 X 5 = 20** | **Additional Comments**<br>Submission to IGB in January 2019. CTG envelopes placed in every set of records for safe storage of CTG. Business case completed by maternity service and multi-professional team. Remaining issue outstanding is the financial detail from IT. To ensure submission of case in January 2020<br>Initial capital funding has been agreed. Meeting held with delivery unit finance director, head of IT and procurement to agree if tendering process required. Paper |

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| | submitted to describe what specifications are required. Decision awaited from procurement lead if tendering process is required.<br>Tenders have been received, Narrowed down to one suitable provider.<br>Procurement are continuing with the process.<br>Chosen provider for central monitoring system agreed.<br>The chosen monitoring system will include a computerised analysis algorithm as recommended by HIW.<br>Funding for central monitoring approved for 2021/22<br>Meeting to be arranged with provider and key stakeholders in SBU to commence the project toward installation and training.<br>04.05.21 – Update - Awaiting final sign off for purchase of central monitoring. Walk around planned for 12th May 2021 for estates and I.T to cost up the infrastructure aspect of the bid. |

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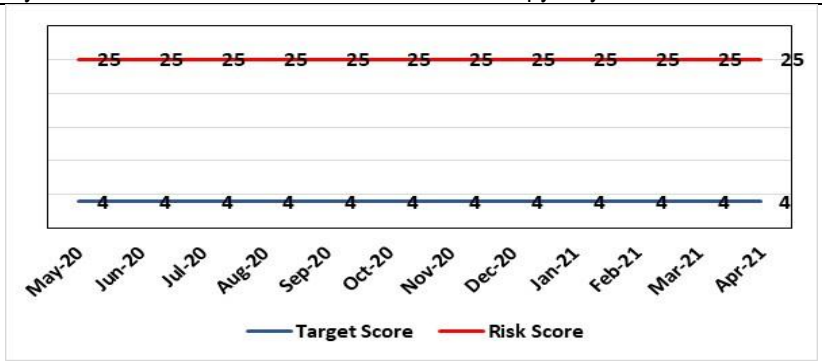
| **Datix ID Number: 1834**<br>**Health & Care Standard: 5.1 Timely Care** | **HBR Ref Number: 66**<br>**Target Date: 31st March 2022** |
| **Objective**: Best values outcomes from high quality care | **Director Lead**: Richard Evans, Executive Medical Director<br>**Assuring Committee:** Quality and Safety Committee |
| **Risk:** Unacceptable delays in access to SACT treatment in Chemotherapy Day Unit | **Date last reviewed:** April 2021 |
| **Risk Rating** (consequence x likelihood):<br>Initial: 5 x 5 = 25<br>Current: 5 x 5 = 25<br>Target: 2 x 2 = 4<br>**Level of Control** =<br>**Date added to the HB risk register** 30/11/2019 |  |
| | **Rationale for current score:** Increased risk to 25 as waiting times starting to re-increase for Long chair regimes, discussed at oncology business meeting. |
| | **Rationale for target score:** |

| Controls (What are we currently doing about the risk?) | Mitigating actions (What more should we do?) | | |
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| Review of CDU by improvement science practitioner<br>Increase nursing staff x 1 at risk, to ensure all nurses are working appropriately.<br>Review of scheduling by staff to ensure all chairs used appropriately.<br>Options appraisal to be completed for SSDU senior management team by service group | **Action** | **Lead** | **Deadline** |
| | Expansion of home care delivery and additional chair capacity - SACT group | Service Manager Surgical Services | 28th May 2021 |

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| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>Extra nurse in place reliant on agency. Senior team meeting to review findings of service review paper. Additional funding agreed to support increase in nurse establish to appropriately run the unit during their main opening hours | **Gaps in assurance**<br>**(What additional assurances should we seek?)** |
| **Current Risk Rating**<br>**5 X 5 = 25** | **Additional Comments**<br>Continuing to working with GE/B Braun around modelling work around gap. There some issues with report from GE. However work has identified 2 areas of work:<br>1. Infrastructure for expansion of home care delivery for low risk drugs- Joint paper between pharmacy and cancer team under development.<br>2. Scoping up option of 7 additional chairs initially (exact number TBC) in NPTH.<br>27.04.21 update - Loss of 3 Chairs (due to IPC controls for COVID) has impacted on capacity. Currently running alternate Saturdays in CDU to mitigate loss. Current wait time for SACT >21 days for the majority of patients.<br>Business case to enhance HomeCare capacity for delivery of chemotherapy at home being considered w/c 26th April. Scheme is cost-saving. If approved and when recruited to, risk score will reduce to 16. |

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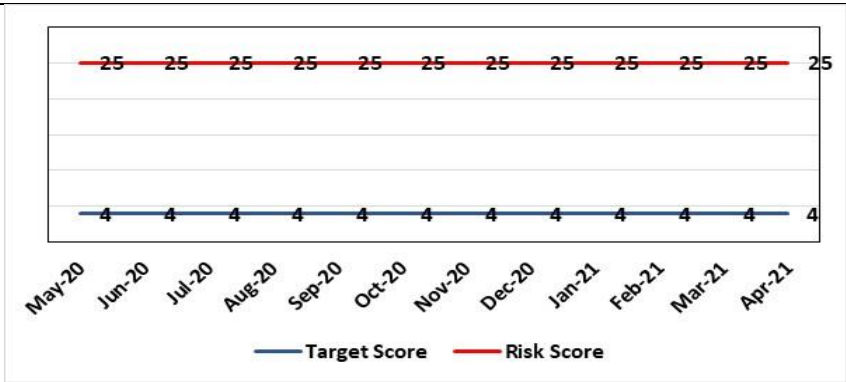
| **Datix ID Number: 89**<br>**Health & Care Standard: 5.1 Timely Care** | **HBR Ref Number: 67**<br>**Target Date: 31st March 2022** |
| **Objective**: Best values outcomes from high quality care | **Director Lead**: Richard Evans, Executive Medical Director<br>**Assuring Committee:** Quality and Safety Committee |
| **Risk:** Clinical risk-target breeches in the provision of radical radiotherapy treatment. Due to capacity and demand issues the department is experiencing target breaches in the provision of radical radiotherapy treatment to patients. | **Date last reviewed:** April 2021 |
| **Risk Rating** (consequence x likelihood):<br>Initial: 4 x 4 = 16<br>Current: 5 x 5 = 25<br>Target: 2 x 2 = 4<br>**Level of Control** =<br>**Date added to the HB risk register** 30/11/2019 |  | **Rationale for current score:**<br>Waiting times deteriorating for elective delays patients, particularly prostates discussed in Oncology business meeting.<br><br>**Rationale for target score:** |

| Controls (What are we currently doing about the risk?) | Mitigating actions (What more should we do?) | | |
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| Requests for treatment and treatment dates monitored by senior management team. | **Action** | **Lead** | **Deadline** |
| | Additional RT capacity plan | Service Manager Cancer Services | 30th April 2021 |

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| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>Performance and activity data is being monitored and monthly data shared with radiotherapy management meeting and cancer board. It is also now included in scorecard. | **Gaps in assurance**<br>**(What additional assurances should we seek?)** |
| **Current Risk Rating**<br>**5 X 5 = 25** | **Additional Comments**<br>Number of projects around hypo fractionation treatments have been developed and are being developed. Breast hypo fractionation has been agreed and additional resources were given in Qtr 3-4 to support this. Recruitment to posts is just been finalised. Work for hypo fractionation in prostate in partnership with Urology teams in SBU and HD is in development stage and is included as priority in annual plan. Clinical fellow to support hypo fractionation development work in pancreas has also been supported on fixed term basis and is due to commence in April/May 21. Case for Lung Hypo fractionation has also been developed and is with WHSSC for consideration. Without investment unless we see drop in demand risk will not be reduced.<br>27.04.21 Update - Risk remains 25 due to limited CT and LINAC capacity. Wait time for RT >28 days for the majority of patients. |

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| | Exploration of further opportunities to (a) increase hyperfractionation for other diseases (b) opportunity to outsource.<br>New CT due to be operational mid-May 2021. If on schedule and additional capacity (hyperfractionation and outsourcing) is confirmed, risk should reduce to 16. |

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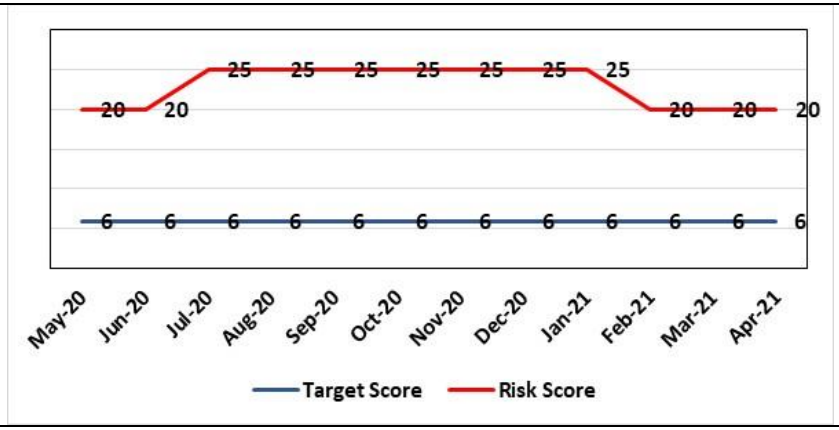
| **Datix ID Number: 2299**<br>**Health & Care Standard: 2.4 Infection Prevention and Control (IPC) and Decontamination** | **HBR Ref Number: 68**<br>**Target Date: 31st March 2022** |
| **Objective**: Best Value Outcomes from High Quality Care<br><br>**Risk:** Risk of declared pandemic due to Coronavirus Infectious Disease outbreak 2020 leading to disruption to Health Board activities. | **Director Lead**: Keith Reid, Executive Medical Director<br>**Assuring Committee:** Quality and Safety Committee<br>**Date last reviewed:** April 2021 |
| **Risk Rating** (consequence x likelihood):<br>Initial: 4 x 5 = 20<br>Current: 5 x 4 = 20<br>Target: 3 x 2 = 6<br><br>**Level of Control** =<br><br>**Date added to the HB risk register**<br>27/02/2020 |  | **Rationale for current score:**<br><br>Separate risk register capturing the specific Covid-19 risks which the Health Board are managing with high risks relating to:<br>• COVID Equipment – inc PPE<br>• COVID Workforce<br>• COVID Medicines<br>• COVID Capacity<br><br>**Rationale for target score:** |

| **Controls (What are we currently doing about the risk?)** | **Mitigating actions (What more should we do?)** | | |
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| | **Action** | **Lead** | **Deadline** |
| • HB Response now in place.<br>• Command and Control structure stood up.<br>• Non-COVID19 activity curtailed.<br>• Staff exclusions and testing in place.<br>• PPE guidance in place.<br>• Engagement with all Wales planning and delivery functions.<br>• Field hospitals developed and commissioned.<br>• Primary Care models adapted to current situation.<br>• Work with local authorities on maintaining care sector.<br>• Acting in concert with Local Resilience Forum to manage wider community risks. | Pandemic Plans invoked | Director of Public Health Wales | Monthly<br>Ongoing |

| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)** | **Gaps in assurance**<br>**(What additional assurances should we seek?)** |
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| • Community testing arrangements are active - Early detection.<br>• PPE training and procurement centrally co-ordinated.<br>• Command and control structures are monitoring effectiveness of corporate response.<br>• Engagement with All wales co-ordinating groups - alignment of local and national responses.<br>• Activation of local resilience forum arrangements. | Visibility and scrutiny of local plans at Executive/Board level. |

| Current Risk Rating<br>5 X 4 = 20 | **Additional Comments**<br>Mitigation as follows to identify and reduce risks of spread of infection:<br>Pandemic plans invoked<br>Command, Control and Coordination arrangements in place with Strategic, Tactical and bronze Groups in place to ensure Health Board wide engagement and instigate required planning including:<br>• Patient flow pathway scenarios for unwell patients and well patients that may self-present in both acute and Primary and Community Care<br>• Appropriate PPE kit and training<br>• Appropriate support service pathways for cleaning, decontamination, waste and linen management<br>• Multi-agency engagement<br>• Community Testing arrangements<br>• Workforce review<br>• Identified isolation facilities.<br><br>Pandemic was declared. Health Board stood up 3CF structures and response on 31 January 2020. System wide response in place. Lockdown established 23rd March. Current levels of demand are containable within existing capacity. Expectations that initial peak of infections has been managed within capacity.<br>08.03.21 – Current score reduced as per e-mail EMD |
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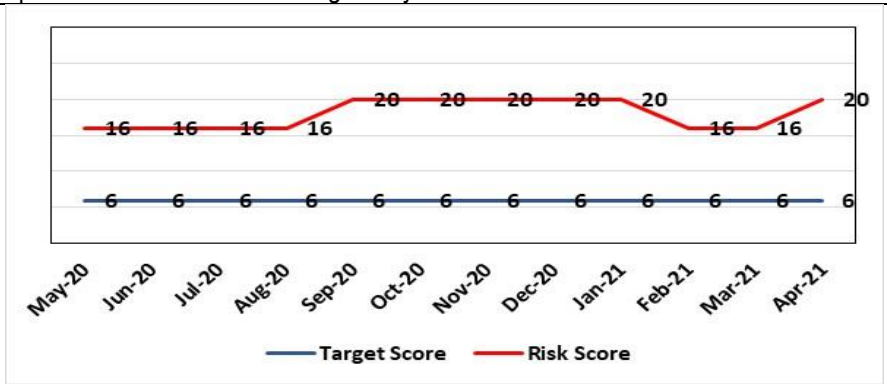
| **Datix ID Number: 1418**<br>**Health & Care Standard: 5.1 Timely Access** | **HBR Ref Number: 69**<br>**Target Date: 31st March 2022** |
| **Objective**: Best values outcomes from high quality care | **Director Lead**: Rab McEwan, Chief Operating Officer/Christine Williams, Interim Director of Nursing and Patient Experience<br>**Assuring Committee:** Performance and Finance Committee |
| **Risk:** Risk issues Related to **adolescent patients being admitted to Adult MH inpatient wards**- Inappropriate settings resulting in 'Safeguarding Issues' The WG has requested that HBs identify Secondary Care in -patient facilities for the care of adolescents- in Swansea Bay University Health Board Ward F NPT hospital is the dedicated receiving facility with one bed identified. | **Date last reviewed:** April 2021 |
| **Risk Rating** (consequence x likelihood):<br>Initial: 2 x 3 = 6<br>Current:5 x 4 = 20<br>Target: 2 x 3 = 4<br>**Level of Control** =<br>**Date added to the HB risk register**<br>27/02/2020 |  |
| | **Rationale for current score:**<br>Risk score increased to 20. |
| | **Rationale for target score:** |

| Controls (What are we currently doing about the risk?) | Mitigating actions (What more should we do?) | | |
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| | **Action** | **Lead** | **Deadline** |
| Safeguarding Training for Staff, Joint protocol with Cwm Taf LHB [CAMHS] currently subject to review, Local SBUHB policy on providing care to young people in this environment. This includes the requirement for all such patients on admission to be subject to Level 3 Safe and Supportive observations. | Review of Service by Swansea Bay Youth | Assistant Head of Operations MH | 30th April 2021 |
| | Learning event to be held facilitated by the Serious Incident Team to review a number of recommendations e.g. location of the crisis assessment. | Deputy Director of Nursing | 31st March 2021 |

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| **Assurances (How do we know if the things we are doing are having an impact?)**<br>Individual Rooms with ensuite facilities, joint working with CAMHS, monitoring of staff training, monitoring of admissions by the MH & LD DU Legislative Committee of the HB. | **Gaps in assurance**<br>**(What additional assurances should we seek?)** |
| **Current Risk Rating**<br>**4 X 4 = 16** | **Additional Comments**<br>Action Completed - Revised pathway and guidance for the management of CYP with emotional well- being issues presenting in the ED in Morriston has been developed in conjunction with CAMH service. A paper presented to and approved by Safeguarding Committee on 9th December 2020. Reduce to 16.<br>15.04.21 Update - The risk remains at 20, after discussion with the previous NPT locality manager (DN) and the new Mental Health Division manager (MJ). We are awaiting clarification around MHSIF funding, for CAMHS in particular. There will |

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| | be reportedly, just under £9.5m for CAMHS across Wales, £4m for ongoing schools pilot and £5.5m for Tier 4 services in CAMHS. Further update to follow once the NHSIF letter arrives with us, hopefully next week. |

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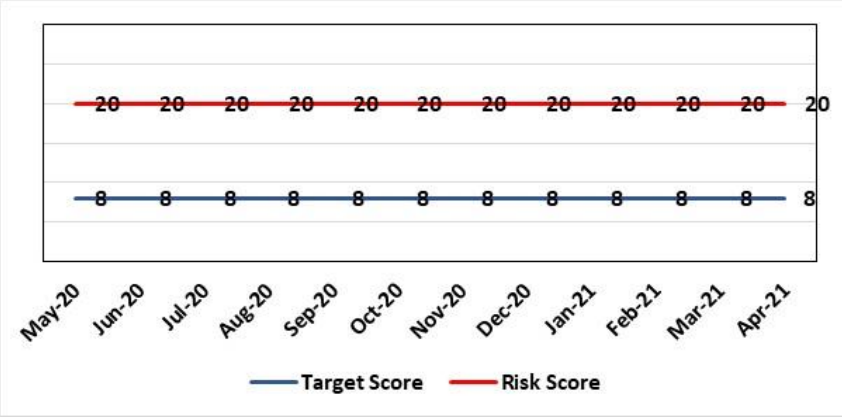
| **Datix ID Number: 2245**<br>**Health & Care Standard: 3.1 Clinically Effective Care** | **HBR Ref Number: 70**<br>**Target Date: 31st March 2022** |
| **Objective**: Digitally enabled care | **Director Lead**: Matt John, Director of Digital<br>**Assuring Committee:** Audit Committee |
| **Risk:** There is a risk of **national data centre outages** which disrupt health board services. The failure of national systems causes severe disruption across NHS Wales, affecting Primary and secondary care services. The delivery of national services including the management of systems, infrastructure and hosting services are the responsibility of NHS Wales Informatics Service (NWIS). | **Date last reviewed:** April 2021 |
| **Risk Rating** (consequence x likelihood):<br>Initial: 4 x 5 = 20<br>Current: 4 x 5 = 20<br>Target: 4 x 2 = 8<br>**Level of Control** =<br>**Date added to the HB risk register**<br>27/02/2020 |  |
| | **Rationale for current score:**<br>**C** -The number of outages in 2018 and impact across NHS Wales resulted in a review of NWIS services including the wider Informatics services in NHS Wales. In the June 2019 outage, some services took as long as 2 weeks to recover.<br>**L** -There have been a number of multi system outages over the last 2 years with a number of factors causing outages or resulting in extended outages. Therefore there is a likelihood of a recurrence in the future. |
| | **Rationale for target score:**<br>**C** – As reliance on digital solutions for the provision of clinical services grows the impact of outages will also grow. Whilst controls will be put in place to mitigate against the impact of outages this will be offset by the growth in the importance of digital solutions. As a result the consequence score will remain at 4.<br>**L** – The likelihood of national data center outages will never be fully eliminated. The current score of 5 is based on the fact there have been WLIMS outages over recent years. The implementation of the new National data center will reduce the likelihood of outages once complete and score will reduce to 2 |

**Controls (What are we currently doing about the risk?)**

- SBU Representation at SMB, IMB and NSMB
- Digital Services Representation at EPRR
- The national Infrastructure Management Board (IMB) and Service Management Board (SMB) are the boards that oversee Major Incidents, identify risks for national services and make recommendations to improve the availability of national services.
- These boards meet monthly to hold NWIS to account for delivery of services.
- Infrastructure major incident reviews are undertaken with selected board members and recommendations agreed in the board.
- The impact of outages is partly mitigated by the Business Continuity plans that are in place within the Service Delivery Units to allow operational services to continue during a data centre service outage.

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
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| Implementation of the new National data center byt DHCW – oversight of progress to be reported by Head of ICT Operations | Head of ICT Operations | 31st July 2021<br>Ongoing action |
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**Assurances**

**Gaps in assurance**

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| **(How do we know if the things we are doing are having an impact?)**<br>NWIS have a Programme of works to upgrade out of date equipment. The network upgrade Programme was completed this year at the NDC and BDC.<br>The final report on the BDC outage has been received and recommendations put in place to increase maintenance levels and monitoring. NWIS have produced an action plan which is agreed in the IMB and progress monitored. Any deviation from the action plan will be escalated to the SMB and if appropriate to the NHS Wales Informatics Management Board which is chaired by the Chief Executive Officer of NHS Wales and has Executive level board members. In addition, it is recommended that serious consideration should be given to identifying and funding an alternative Tier 3+ facility (in line with the NDC) to host these critical systems.<br>WLIMS 2016 upgrade is required to address some of the technical issues experienced on the existing version. This is planned for September 2020. A re- procurement of a new Pathology Laboratory Information Management system is in progress with timescales<br>An architecture review is underway to assess current services and make recommendations on future services (including hosting services). | **(What additional assurances should we seek?)** |
| **Current Risk Rating**<br>**4 X 5 = 20** | **Additional Comments**<br>Action completed 29.01.21: Representation at NWIS Directors Meetings<br>Progress Update 17/3/2021:<br>The main outages have been related to WLIMS infrastructure which consists of the main system and Citrix (used to access the application). Citrix hardware and software was updated in 2020 and the WLIMS upgraded followed with new hardware and WLIMS system upgraded to vL2016 in December 2020.<br>The Blaenavon Data Centre which was not considered fit for purpose as it was rated as tier 2 and not tier 3 as in the case on the commercial Newport Data Centre. The major outage in June 2019 due to an air conditioning failure resulted in replacement equipment being purchased and increased monitoring. Shared Resource Services (SRS) served notice that they would no longer be providing the hosting services from September 2021. NWIS subsequently procured a new data centre hosting facility – CloudCentres Data Centre (CDC) which is a tier 3 facility and have developed a plan to move all services from BDC to CDC by the end of July.<br>NWIS have also introduced more robust change management in order to reduce the likelihood of outages caused by human error.<br>Following the move to the new data centre, in which further outages could occur during the migration, the scoring of this risk will be re-assessed.<br>28.04.21 – Two Actions closed - Representation at SMB, IMB and NSMB. Representation on EPRR. |

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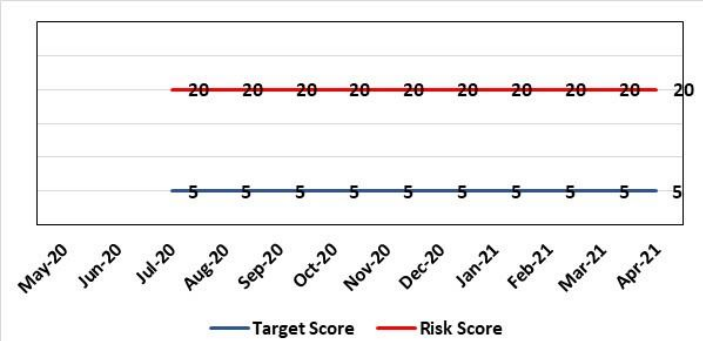
| **Datix ID Number: 2450**<br>**Health & Care Standard: 2.1.1 Managing Financial Risk** | | **HBR Ref Number: 73**<br>**Target Date: 31st March 2022** |
| **Objective**: Best Value Outcomes from High Quality Care<br>The Health Board underlying financial position may be detrimentally impacted by the COVID-19 pandemic. The COVID-19 pandemic has impacted on the Health Board ability to plan and execute the required level of recurrent savings delivery. There is a potential for a residual cost base increase post COVID-19 as a result of changes to service delivery models and ways of working. | | **Director Lead:** Darren Griffiths. Director of Finance (interim)<br>**Assuring Committee:** Performance and Finance Committee |
| **Risk:** | | **Date last reviewed: A**pril 2021 |
| **Risk Rating**<br>(consequence x likelihood):<br>Initial: 5 x 4 = 20<br>Current: 5 x 4 = 20<br>Target: 5 x 1 = 5 |  | **Rationale for current score:**<br>• There is a potential for a residual cost base increase post COVID-19 as a result of changes to service delivery models and ways of working - Risk Rated 20<br>• The residual cost base risk remains difficult to assess as the Health Board continues to respond to the impact of the pandemic<br>• Clarity has been forthcoming in terms of COIVD response funding for the first 6 months of 2021/22 with the allocation of £21.6m to the Health Board from Welsh Government.<br>• A clear financial plan for 2021/22 is in place but this has not yet been formally agreed with Welsh Government and there remain a number of additional systems in place to allow the Health Board to respond to COVID.<br>• As the Health Board moves out of direct COVID response and into COVID recovery there remains a real risk that some additionality cost and some service change cost could be part of the run rate of the Health Board and this could be exposed when additional funding ceases.<br>• Many of the service delivery models across the Health Board have had to change as a result of COVID-19 pandemic. Some of the changes to service delivery and ways of working will remain in place post pandemic which may recurrently increase the cost base of the Health Board. |
| **Level of Control**<br>= 25% | | **Rationale for target score:**<br>By ensuring that opportunities are taken to drive forward efficiency opportunities and service changes to support improved service and financial sustainability. |
| **Date added to the HB risk register**<br>July 2020 | | |

| **Controls (What are we currently doing about the risk?)** | **Mitigating actions (What more should we do?)** | | |
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| The Health Board is doing the following: - | **Action** | **Lead** | **Deadline** |

| | | | |
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| • Active participation in weekly Director of Finance calls to shape All Wales response<br>• Finance Review Meetings with Units to explore opportunities to maintain cost control, savings delivery and a proportionate COVID-19 response<br>• Transparent exchange of position with Finance Delivery Unit<br>• Clear financial plan in place for 2021/22<br>• Clear understanding of underlying impact of changes to service models and costs of new service models.<br>• Review all of KPMG pipeline savings opportunities to test whether these can be accelerated in the light of COVID-19 impact.<br>• Commenced work with Finance Delivery Unit on longer term financial recovery plan.<br>• System of internal control proposed and will be implemented in quarter 1 2021/22 | Impact of reset and recovery to be assessed through QIA process to ensure clear understanding of impact on underlying cost base. | COO | 31st March 2021<br>Monthly ongoing |
| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>The Health Board financial performance is reviewed and monitored through:<br>• Monthly financial recovery meetings<br>• Performance and Finance Committee<br>• Routine reporting to Board of most recent monthly position and impact on year end forecast of changes in response to the disease and national funding streams | **Gaps in assurance**<br>**(What additional assurances should we seek?)**<br>Reporting on savings opportunities and service change impacts to be developed. | | |
| **Current Risk Rating**<br>**5 x 4 = 20** | **Additional Comments**<br>Monthly financial review and assessment of savings to be included in financial reporting – Action closed. Savings update now part of every FRM with service groups and routinely reported to PFC.<br>The residual cost base risk remains unchanged and whilst the Health Board is working hard to control underlying run rate and to seek out savings opportunities wherever possible, there is currently understandable uncertainty as to the resource arrangements for 2021/22.<br>04.05.21 update – Action closed - Savings opportunities and pipeline to be reviewed and options for development of plans taken forward through SLT | | |

**Risk Score Calculation**

For each risk identified, the LIKELIHOOD & CONSEQUENCE mechanism will be utilised. Essentially this examines each of the risks and attempts to assess the likelihood of the event occurring (PROBABLILITY) and the effect it could have on the Health Board (IMPACT). This process ensures that the Health Board will be focusing on those risks which require immediate attention rather than spending time on areas which are, relatively, a lower priority.

| Risk Matrix | LIKELIHOOD (*) | | | | |
|---|---|---|---|---|---|
| CONSEQUENCE (**) | 1 - Rare | 2 - Unlikely | 3 - Possible | 4 - Probable | 5 - Expected |
| 1 - Negligible | 1 | 2 | 3 | 4 | 5 |
| 2 - Minor | 2 | 4 | 6 | 8 | 10 |
| 3 - Moderate | 3 | 6 | 9 | 12 | 15 |
| 4 - Major | 4 | 8 | 12 | 16 | 20 |
| 5 - Catastrophic | 5 | 10 | 15 | 20 | 25 |