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

HEALTH BOARD RISK REGISTER
October 2022

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.

Together, Improve Well-being and Healthcare for all

Better Health, Better Care, Better Lives

Support better health and wellbeing by actively promoting and empowering people to live well in resilient communities

- Partnerships for improving Health and Well-being
- Co-production and Health Literacy
- Digitally Enabled Health and Well-being

Deliver better care through excellent health and care services achieving the outcomes that matter most to people

- Best Value Outcomes from High Quality Care
- Partnerships for Care
- Excellent Staff
- Digitally Enabled Care
- Outstanding research, Innovation, Education and Learning

HEALTH BOARD RISK REGISTER
DASHBOARD OF ASSESSED RISKS – October 2022

Impact/Consequences						
	5		**75:** Whole Service Closure	**53:** Compliance with Welsh Language Standards **66:** Access to Cancer Services – SACT **67:** Access to Cancer Services – Radiotherapy **79**: Finance Recovery of Access Times	**16:** Access to Planned Care **51:** Compliance with Nurse Staffing Levels (Wales) Act 2016 **60:** Cyber Security **69:** Adolescents being admitted to Adult MH wards **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. **74:** Induction of Labour (IOL) **86:** Storage Area Network (SAN)	**01:** Access to Unscheduled Care Service **50:** Access to Cancer Services **64:** H&S Infrastructure **81:** Critical Staffing Levels: Midwifery
	4			**13:** Environment of Health Board Premises **37:** Operational and strategic decisions are not data informed **48:** Child & Adolescence Mental Health Services **(Reduced from 16)** **52**: Engagement & Impact Assessment Requirements	**27:** Digital Transformation to Deliver Sustainable Clinical Services **36:** Electronic Patient Record **41:** Fire Safety Regulation Compliance **57:** Non-compliance with Home Office Controlled Drug Licensing requirements **58:** Ophthalmology Clinic Capacity **61:** Paediatric Dental GA Service – Parkway **63:** Screening for Fetal Growth Assessment in line with Gap-Grow (G&G) **82:** Risk of closure of Burns Service **84:** Cardiac Surgery	**03:** Workforce Recruitment of Medical and Dental Staff **04:** Infection Control **65:** CTG Monitoring in Labour Wards **72:** CRL & Capital Plan **80:** Inability to Transfer Patients **85:** Non Compliance with ALN Act **88:** Non-delivery of AMSR programme benefits
	3				**43:** DOLS/LPS Authorisation and Compliance with Legislation **78:** Nosocomial Transmission	
	2					
	1					
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[1]	Controls	Last Reviewed	Scrutiny Committee
Best Value Outcomes from High Quality Care	1 (738)	**Access to Unscheduled Care Service** If we fail to provide timely access to Unscheduled Care then this will have an impact on quality & safety of patient care as well as patient and family experience and achievement of targets. There are challenges with capacity/staffing across the Health and Social care sectors.	20	25	➔	➔	October 2022	Performance & Finance Committee
	4 (739)	**Infection Control** Risk of patients acquiring infection as a result of contact with the health care system, resulting in avoidable harm, impact on service capacity, and failure to achieve national infection reduction goals.	20	20	➔	➔	October 2022	Quality & Safety Committee
	13 (841)	**H&S Compliance: Environment of Premises** Risk of failure to meet statutory health and safety requirements.	16	12	➔	➔	October 2022	Health & Safety Committee
	16 (840)	**Access to Planned Care** There is a risk of harm to patients if we fail to diagnose and treat them in a timely way.	16	20	➔	➔	October 2022	Performance & Finance Committee
	37 (1217)	**Information Led Decisions** Risk that operational and strategic decisions are not data informed.	16	12	➔	➔	October 2022	Audit Committee

[1] This indicates whether there has been an increase / decrease in risk score since the previous month's HBRR.

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	41 (1567)	**Fire Safety Compliance** 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.	15	16	→	→	October 2022	Health & Safety Committee
	43 (1514)	**DoLS** Due to a lack of Best Interest Assessor resource, there is a risk of failure to complete and authorise the assessments associated with Deprivation of Liberty/Liberty Protection Safeguards within the legally required timescales, exposing the health board to potential legal challenge and reputational damage.	16	12	→	→	October 2022	Quality & Safety Committee
	48 (1563)	**CAMHS – Reduced from 16** Failure to sustain Child and Adolescent Mental Health Services (CAMHS).	16	12	→	↑	October 2022	Performance & Finance Committee
	50 (1761)	**Access to Cancer Services** There is a risk of delay in diagnosing patients with cancer, and consequent delay in commencement of treatment, which could lead to poor patient outcomes and failure to achieve targets.	20	25	→	→	October 2022	Performance & Finance Committee
	57 (1799)	**Controlled Drugs** Non-compliance with Home Office Controlled Drug Licensing requirements.	20	16	→	→	October 2022	Audit Committee
	63 (1605)	**Screening for Fetal Growth Assessment in line with Gap-Grow** There is not enough Ultrasound capacity within Swansea Bay UHB to offer all women serial ultrasound scan screening in the third trimester in line with the UK perinatal Institute Growth Assessment Programme (GAP).	12	16	→	→	October 2022	Quality & Safety Committee

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny 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	➔	➔	October 2022	Health & Safety Committee
	66 (1834)	**Access to Cancer Services (SACT)** Delays in access to SACT treatment in Chemotherapy Day Unit.	25	15	➔	➔	October 2022	Quality & Safety Committee
	67 (89)	**Risk target breaches – Radiotherapy** Clinical risk – Target breeches of radical radiotherapy treatment	16	15	➔	➔	October 2022	Quality & Safety Committee
	69 (1418)	**Safeguarding** Adolescents are being admitted to adult mental health wards	20	20	➔	➔	October 2022	Quality & Safety Committee
	72 (2449)	**CRL & Capital Plan** Reduced discretionary capital funds and reduced National NHS funds requiring a restricted Capital Plan for 2022-23	20	20	➔	➔	October 2022	Performance & Finance 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	➔	➔	October 2022	Performance & Finance Committee
	74 (2595)	**Delays in Induction of Labour (IOL)** Delays in IOL can introduce avoidable risk and unnecessary intervention which can lead to poor clinical outcome for mother and/or baby. Delays in IOL lead to increased complaints and decreased patient satisfaction.	20	20	➔	➔	October 2022	Quality & Safety Committee

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	75 (2522)	**Whole Service Closure** Risk that services or facilities may not be able to function if there is a major incident or a rising tide that renders current service models unable to operate.	20	10	➔	➔	October 2022	Performance & Finance Committee
	78 (2521)	**Nosocomial Transmission** Nosocomial transmission in hospitals could cause patient harm; increase staff absence and create wider system pressures (and potential for further harm) due to measures that will be required to control outbreaks.	20	12	➔	➔	October 2022	Quality & Safety Committee
	79 (2739)	**Finance - Recovery of Access Times** Potential risk that resource available is below the ambition of the board to provide improved access.	15	15	➔	➔	October 2022	Performance & Finance Committee
	80 (1832)	**Inability to Transfer Patients** If the health board is unable to discharge clinically optimised patients there is a risk of harm to those patients as they will decompensate, and to those patients waiting for admission.	20	20	➔	➔	October 2022	Quality & Safety Committee
	81 (2788)	**Critical Staffing Levels: Midwifery** Midwifery absence rates are outside of 26.9% uplift leading to difficulty in maintaining midwifery rotas in the hospital and community setting.	25	25	➔	➔	October 2022	Quality & Safety Committee
	82 (2554)	**Risk of closure of Burns service if Burns Anaesthetic Consultant cover not sustained** There is a risk that adequate Burns Consultant Anaesthetist cover will not be sustained, resulting in closure to this regional service and the associated reputational damage. This is caused by: • Decreasing consultant numbers due to retirement • Anaesthetists not gaining CCT with appropriate ICM and Burns experience.	12	16	➔	➔	October 2022	Performance & Finance Committee

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	84 (3036)	**Cardiac Surgery** A Getting It Right First Time review identified concerns in respect of cardiac surgery (including patient pathway/process issues) that present risks to ensuring optimal outcomes for all patients	25	16	→	→	October 2022	Quality & Safety Committee
	85 (2561)	**Non-Compliance with ALN Act** There are risks to the Health Board's ability to meet its statutory duties and establish the effective collaborative arrangements required by the ALN Act, which is being implemented through a phased approach.	25	20	→	→	October 2022	Quality & Safety Committee
	88 (3110)	**Non-delivery of AMSR programme benefits** There is a risk that the Acute Medical Service Re-Design (AMSR) programme may not deliver the expected performance & financial benefits in a timely way.	20	20	→	→	October 2022	Performance & Finance Committee
Excellent Staff	3 (843)	**Workforce Recruitment** Risk of failure to recruit medical & dental staff	20	20	→	→	October 2022	Workforce & OD Committee
	51 (1759)	**Nurse Staffing (Wales) Act** Risk of Non Compliance with the Nurse Staffing (Wales) Act	16	20	→	→	October 2022	Workforce & OD Committee
Digitally Enabled Care	27 (1035)	**Digital Transformation to Deliver Sustainable Clinical Services** Inability to deliver sustainable clinical services due to lack of digital transformation.	16	16	→	→	October 2022	Audit Committee

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny 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.	20	16	➔	➔	October 2022	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	➔	➔	October 2022	Audit Committee
	65 (329)	**CTG Monitoring on Labour Wards** Misinterpretation of cardiotocograph and failure to take appropriate action is a leading cause for poor outcomes in obstetric care leading to high value claims.	16	20	➔	➔	October 2022	Quality & Safety Committee
	86 (3052)	**Storage Area Network (SAN)** Extended outages of locally hosted systems due to failure of the Health Board's Storage Area Network (SAN) which would impact delivery of clinical and non clinical services.	20	20	➔	➔	October 2022	Audit Committee
Partnerships for Improving Health and Wellbeing	58 (146)	**Ophthalmology - Excellent Patient Outcomes** Risk of failure to provide adequate clinic capacity to support follow-up patients within the Ophthalmology specialty.	12	16	➔	➔	October 2022	Quality & Safety Committee
	61 (1587)	**Paediatric Dental GA Service – Parkway** Safety risk of general anaesthetic procedures performed on children outside of an acute hospital setting.	15	16	➔	➔	October 2022	Quality & Safety Committee

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
Partnerships for Care	52 (1763)	**Statutory Compliance: Engagement & Impact Assessment** The Health Board does not have sufficient resource in place to undertake engagement & impact assess in line with Statutory Duties	16	12	➔	➔	October 2022	Performance & Finance Committee
	53 (1762)	**Welsh Language Standards** Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.	15	15	➔	➔	October 2022	Health Board (Welsh Language Group)

Risk Schedules

Datix ID Number: 738 **Health & Care Standard: 5.1 Timely Care**	**HBR Ref Number: 1** **Target Date: 31/12/2022**	**Current Risk Rating** **5 x 5 = 25**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Inese Robotham, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee **For information:** Quality & Safety Committee	
Risk: Access to Unscheduled Care If we fail to provide timely access to Unscheduled Care then this will have an impact on quality & safety of patient care as well as patient and family experience and achievement of targets. There are challenges with capacity/staffing across the Health and Social care sectors.	**Date last reviewed:** October 2022	

Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 5 x 5 = 25 Target: 3 x 4 =12	Risk Score: 25 25 25 25 25 25 25 25 25 25 25 25 Target Score: 12 12 12 12 12 12 12 12 12 12 12 12 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Target Score Risk Score	**Rationale for current score:** Post wave 2 of COVID 19 Morriston and Singleton have experienced a steady increase in emergency demand to pre-covid levels. Capacity is limited due to covid response and therefore remains a high risk. Current score raised due to increasing pressures. Recent implementation of All Wales Immediate Release Protocol puts additional pressure on already overcrowded ED dept.
Level of Control = 50%		**Rationale for target score:** Our annual plan is to implement models of care that reflect best practice. This will improve patient flow, length of stay and reduce emergency demand.
Date added to the HB risk register 26.01.16		

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

- Programme management office in place to improve Unscheduled Care.
- Daily Health Board wide conference calls/ escalation process in place.
- Regular reporting to Executive and Health Board/Quality and Safety Committee.
- Increased reporting as a result of escalation to targeted intervention status.
- Targeted unscheduled care investment of £8.5m in the annual plan, including a new Acute Medical Model focused on increasing ambulatory care.
- Development of a Phone First for ED model in conjunction with 111 to reduce demand.
- 24/7 ambulance triage nurse in place
- Joint WAST Stack review by GP and APP (Advanced Paramedic Practitioner)
- OPAS (Older People's Assessment Service) have undertaken training with nursing homes (on management of patient falls) & set up direct contact details with nursing homes
- Frailty short-stay unit re-established

Additionally, actions to improve the discharge of clinically optimised patients (risk HBR80) expected to assist with patient flow, are anticipated to free capacity to assist to address this risk HBR1 also.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Re-establish short stay unit on ward D at Morriston. Realign wards to specialties at Morriston Hospital including short stay unit on Ward D.	SGD (Morriston)	31/12/2022
Review roles & service models in order to increase SDEC working hours and throughput of patients sustainably.	SGD (Morriston)	01/12/2022
OPAS – exploring internal & external funding options	SDEC Clinical Lead	31/01/2023
Primary care group are looking at FNOF pathway and use of virtual wards to reduce length of stay.	PCT SGD	31/10/2022
Breaking the Cycle week planned for w/c 7th November 2022.	Morriston & Singleton SGDs	07/11/2022
Morriston are setting up a workstream to	Morriston UND	30/11/2022

<table>
<tr><td rowspan="2"></td><td>review SAFER discharge.</td><td></td><td></td></tr>
<tr><td>AMSR programme due to be implemented in December 2022 – subject to OCP.</td><td>COO</td><td>01/12/2022</td></tr>
<tr><td>Assurances (How do we know if the things we are doing are having an impact?)
• New Urgent & Emergency Care Board is meeting monthly</td><td colspan="3">Gaps in assurance (What additional assurances should we seek?)
The need to deliver sustained service.</td></tr>
<tr><td colspan="4">Additional Comments / Progress Notes
03/05/2022 controls & actions updated. Two actions completed - Re-establish the frailty short stay unit on RDU and Third phase of procurement to be undertaken to commission additional care home beds.
08/06/2022: AMSR business case has been approved & the next stage is OCP process.
28/07/2022: OCP commenced 13/06/2022. Due to conclude 29/07/2022. Short stay unit delayed slightly due to significant covid pressures.
22/08/2022: OCP concluded. Two-week evaluation being undertaken.
21/09/2022: Evaluation concluded – shared staff side 8/9. Project now planning the implementation phase. Linked to AMSR risk. 3 Actions completed - OPAS developing a proposal to assess elderly patients at home. Introduce Band 6 navigator role in ED for better streaming of patients. Five-day in-reach by virtual wards will commence in August.
24/10/2022: A go/no go gateway for AMSR is scheduled on 16th November 2022.</td></tr>
</table>

Datix ID Number: 843 Health & Care Standard: Staff & Resources 7.1 Workforce	HBR Ref Number: 3 Target Date: 31st March 2023	Current Risk Rating 4 x 5 = 20
Objective: Excellent Staff	**Director Lead:** Debbie Eyitayo, Director of Workforce and OD **Assuring Committee:** Workforce and OD Committee	
Risk: Workforce recruitment of medical & dental staff	**Date last reviewed:** October 2022	

Risk Rating
(consequence x likelihood):
Initial: 5 x 4 = 20
Current: 4 x 5 =20
Target: 4 x 3 = 12

Level of Control
= 70%

Date added to the HB risk register
April 2012

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Target Score	12	12	12	12	12	12	12	12	12	12	12	12
Risk Score	20	20	20	20	20	20	20	20	20	20	20	20

Rationale for current score:
National shortages of numbers in some areas can lead to:

- Inability to recruit sufficient numbers of trainees to fulfil rotas on all sites
- Inability to attract non training grades to complete rotas
- Inability to fill Consultant grade posts in some specialties with adverse effects on patient safety and employer relations. Inability to recruit sufficient registered nursing staff.

Rationale for target score:
This remains a challenge and is also a national problem.

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

- Regular monitoring of recruitment position with reports to Executive Team and Board via Medical Director and Medical Workforce Board.
- 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.
- Engagement of the Deanery about recruitment position.
- Weekly workforce delivery meetings with CEO to review progress against critical medical and clinical posts
- Working with specialist agency and head hunters to improve chances to fill hard to recruit posts
- Plan to work with a marketing agency to develop a branding and attraction campaign for the health board.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Medical training initiatives pursued in a number of specialties to ease junior doctor recruitment	Director W&OD	31/03/2023
The Medical Workforce Board continues to monitor recruitment and junior doctor's rotas.	Director W&OD	31/03/2023
Continue to recruit internationally.	Director W&OD	31/03/2023
Continue to work with head hunters	Director W&OD	31/03/2023

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

- General situation monitored through W&OD Committee
- Communication with Deanery
- Recruitment campaigns
- Monitoring by Executive Teams and specialty based local workforce boards
- Workforce planning and deployment taskforce meetings with service groups
- Weekly workforce delivery meetings with CEO as above

Gaps in assurance (What additional assurances should we seek?)
Locum cover
Adequate supply of doctors who can work in this country
Ability to flexibly deploy doctors in training.
Dedicated work between workforce and finance to review and confirm budgeted medical workforce establishment by service group to confirm SIP and vacancy factor.

Additional Comments / Progress Notes
May 2022: Action Targets and Gaps in Assurance updated.
June 2022: No updates to report this month.

Datix ID Number: 739 **Health & Care Standard: 2.4 Infection Prevention & Control & Decontamination**	**HBR Ref Number: 4** **Target Date: 31st March 2023**	**Current Risk Rating** **4 x 5 = 20**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality and Safety Committee	
Risk: Risk of patients acquiring infection as a result of contact with the health care system, resulting in avoidable harm, impact on service capacity, and failure to achieve national infection reduction goals.	**Date last reviewed:** October 2022	

Risk Rating
(consequence x likelihood):
Initial: 4 x 5 = 20
Current: 4 x 5 = 20
Target: 4 x 3 =12

Level of Control
= 40%

Date added to the HB risk register
January 2016

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Target Score	12	12	12	12	12	12	12	12	12	12	12	12
Risk Score	20	20	20	20	20	20	20	20	20	20	20	20

Rationale for current score:
Health Board incidence of key Tier 1 infections per 100,000 population above All Wales rates, indicating Health Board's population at greater risk of infection. High occupancy rates & frequent ward moves associated with increased risk of infection transmission. Lack of decant facilities compromises environment deep cleaning & decontamination, and planned preventative maintenance programmes.

Rationale for target score:
Improved governance structures for IPC and antimicrobial stewardship will drive improved local ownership and embed responsibility for these priorities for all levels of staff. Adequately maintained & clean environments facilitate good IPC & minimise infection risks. Reduced occupancy & frequency of patient moves mitigate against infection transmission. Compliant ventilation systems and water safety minimise infection risks. Access to timely data on infections, training, antimicrobial stewardship, cleaning at ward/unit/practice level enables Service Groups to identify areas for focused QI programmes, drive improvement, & effectively measure outcomes.

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

- Policies, procedures, protocols and guidelines supplement the National Infection Control Manual.
- Infection Prevention & Control related training provided programmes.
- Surveillance of infections, with early identification of increased incidence, and instigation of controls.
- Infection Prevention Improvement Plans, monitored by Infection Control Committee and Management Board.
- Provision of cleaning service to meet National Standards of Cleanliness.
- Engineering controls for water safety, ventilation, and decontamination.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Drive improvements in prudent antimicrobial prescribing	Cons. Antimicrobial Pharmacist	31/03/23
Develop ward to board Dashboard on key Tier 1 infections	HoN IP&C & Digital Intelligence	31/12/22
Achieve compliance with IPC mandatory training	Service Group Triumvirates	31/03/23
Reduce Key Tier 1 Infections to no more than WG maximum quarterly profile	Head of Infection Control	31/03/23

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

- Clear Corporate and Service Group IPC Assurance Framework in place.
- Infection Prevention Improvement Plans for HB and Service Groups with progress reported at SG Infection Control Committees, HB Infection Control Committee and at Management Board.

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

- High occupancy rates & frequent ward moves associated with increased risk of infection transmission.

These include trajectories to meet national targets and report performance against them. This is also reported to Quality & Safety Committee. • Ongoing monitoring of infection control rates. • IPC, antimicrobial, decontamination and cleaning audit programmes. • Compliance and validation systems for water safety, ventilation systems and decontamination.	• Lack of decant facilities compromises environment deep cleaning & decontamination, and planned preventative maintenance programmes. • Lack of robust system for Board oversight regarding IPC and ANTT training compliance due to ESR limitations.

Additional Comments / Progress Notes

Progress update re Tier 1 infection reduction goals - 30/09/22 - cumulative infection cases 01 April – 30 September 2022:

- C. difficile - 92 (cumulative profile - 49 maximum)
- E. coli bacteraemia - 137 (cumulative profile - 127 maximum)
- Pseudomonas aeruginosa bacteraemia - 20 (cumulative profile - 12 maximum)
- Staph. aureus bacteraemia - 78 (cumulative profile - 39 maximum)
- Klebsiella spp. bacteraemia - 51 (cumulative profile - 37 maximum)

Datix ID Number: 841 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**	**HBR Ref Number: 13** **Target Date: TBC**	**Current Risk Rating** **4 x 3 = 12**
Objective: Best Value Outcomes	**Director Lead:** Darren Griffiths, Director of Finance **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:** October 2022	

Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 =12 Target: 4 x 3 = 12	Chart: 30, 25, 20, 15, 10, 5, 0; 12 12 12 12 12 12 12 12 12 12 12 12; Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22; Risk Score, Target Score	**Rationale for current score:** The accommodation is varied in age, tired and in need of upgrading/refurbishment to enable improved condition and compliance to regulations and WHBN/WHTMs.
Level of Control = 90% **Date added to the HB risk register** April 2012		**Rationale for target score:** Risk assessments of premises.

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

- Key areas where performance linked to health & safety/fire issues. Health & Safety and Quality & Safety Committees and agreed actions to mitigate impacts.
- Actions addressed through site meetings trade improvements on the 2 acute hospital sites.
- Primary Care premises, audits commissioned and delayed due to covid.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Members of the estates, health and safety and capital planning team will meet in September 2022 to bring together estates risks, the 6 facet survey and the strategy to develop a prioritised plan of action for the estate. This action is linked to Estates Strategy development (action below).	Director of Finance & Performance	Closed
6 facet survey findings will present to estates utilisation group on 31/08/22. This is being incorporated into the Estates Strategy (separate action below).	Assistant Director of Operations (Est)	Closed
A review is currently taking place of current PCST structures and governance arrangements for estates and H&S to cover key compliances and escalation processes, with a draft report targeted for 30/12/2022	Service Group Director (PCT) & Assistant Director of Health & Safety	30/12/2022
Estates strategy has been developed and a draft will be received at the estates utilisation group on 15/11/22	Assistant Director of Operations (Est)	30/11/2022

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**

Additional Comments / Progress Notes

Update 18.03.22 – Update on 'Change for the Future' and '6 Facet survey' actions – The Health Board has commissioned a six facet review with equality access assessment included within the specification. Work has commenced and is due to be completed by the end of March 2022.

Update 30.08.22 - Work has commenced and a final draft has been received for scrutiny – see mitigating actions above. Updated 24.10.22 - Due to the 6 FACET survey analysis and the DCP the aim is to present a draft estates strategy to the estates utilisation group on 15/11/22. After this, the risk score will be reviewed to ensure it reflects the information obtained from 6 facet survey and identified mitigations going forward.

Datix ID Number: 840 Health & Care Standard: 5.1 Timely Care	HBR Ref Number: 16 Target Date: 30/11/2022	Current Risk Rating 5 x 4 = 20
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Inese Robotham, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee **For information:** Quality & Safety 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:** October 2022	

Risk Rating		
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 4 = 20 Target: 4 x 2 = 8		**Rationale for current score:** 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 during the pandemic increased the number of patients now breaching 36 and 52 week thresholds.
Level of Control = 90%		
Date added to the HB risk register January 2013		**Rationale for target score:** There is scope to reduce the likelihood score to reduce the overall risk to an acceptable level. The Risk target date indicates when we expect to see some reduction in waiting lists – albeit the overall risk level may remain as work continues.

Month	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Risk Score	25	25	25	20	20	20	20	20	20	20	20	20
Target Score	8	8	8	8	8	8	8	8	8	8	8	8

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

- 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.
- There is a bi-weekly recovery meeting for assurance on the recovery of our elective programme.
- Specialty level capacity and demand models set out the baseline capacity and identify solutions to bridge the gap. Non-recurring pump – prime funding is available to support initial recovery measures. Fortnightly performance reviews track progress against delivery.
- A focused intervention is in train to support to the 10 specialties with the longest waits.
- Long waiting patients are being outsourced to the Independent Sector
- Additional internal activity is being delivered on weekends (via insourcing)
- Planned care trajectories developed and submitted to WG as part of IMTP.
- Governance process put in place to monitor performance against trajectories internally, and with Welsh Government

Mitigating actions (What more should we do?)

Action	Lead	Deadline
External & internal validation has commenced. Impact to be reviewed during October 2022. Internal validation has commenced, but external validation will now start from 1st week November.	Deputy COO	30/11/2022
Morriston Service Group is looking at a plan for dedicated elective orthopaedic bed capacity at Morriston site.	Morriston SGD	30/11/2022
Recovery trajectory has been reviewed and shows further improvement – awaiting final signoff.	Deputy COO	31/10/2022

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

- Weekly meetings in place to ensure patients with greatest clinical need are treated first.

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

Additional Comments / Progress Notes

03/05/2022: Paper was presented to Management Board 20/04/22 detailing progress and plans for 2022/2023.
08/06/2022: Looking to free up Theatres Admission Unit of outliers to return use to surgical patients.
28/07/2022: Action commenced: Implement demand management initiatives between primary and secondary care to reduce the number of new patients awaiting outpatient appointments

(some initiatives identified and being taken forward - review for opportunities will continue). Action complete: Implement a full range of interventions to support patients to be kept active and well whilst on a waiting list – focusing on cancer patients awaiting surgery and long waiting orthopaedic patients. Action complete: Develop robust demand & capacity plans for delivery in 2022/23. Planned care trajectories developed and submitted to WG as part of IMTP.
21/09/22: Trajectories have been revised and show more favourable position but are still falling short of ministerial ambition. The Service Groups jointly with Deputy COO are looking at further efficiency opportunities. Action completed - Exploring options to maximise efficiency and productivity through validation and efficient use of existing capacity.
19/10/22: External validation of longest waiting patients is about to commence. Impact to be monitored.
24/10/2022: Planned Care will be part of enhanced monitoring arrangements with Welsh Government. We are awaiting the template to agree remedial actions.

Datix ID Number: 1035 Health & Care Standard: Effective Care 3.1 Clinically Effective Care	HBR Ref Number: 27 Target Date: 31st July 2023	Current Risk Rating 4 x 4 = 16
Objective: Digitally enabled care	**Director Lead:** Matt John, Director of Digital **Assuring Committee:** Audit Committee	
Risk: Digital Transformation Inability to deliver sustainable clinical services due to lack of Digital Transformation. There are insufficient resources to: • invest in the delivery of the ABMU Digital strategy, • support the growth in utilisation of existing and new digital solutions • replace existing technology infrastructure and the end of its useful life.	**Date last reviewed:** October 2022	

Risk Rating		Rationale
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 5 x 2 = 10	Oct-21, Nov-21, Dec-21, Jan-22, Feb-22, Mar-22, Apr-22, May-22, Jun-22, Jul-22, Aug-22, Sep-22 Risk Score: 12, 12, 12, 12, 12, 12, 16, 16, 16, 16, 16, 16 Target Score: 10, 10, 10, 10, 10, 10, 10, 10, 10, 10, 10, 10	**Rationale for current score:** 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. L- Reduction in capital funding in 22/23 has increased the likelihood of HB not being able to replace aging infrastructure such as the SAN. Acceleration of the CTM SLA disaggregation has been proposed and there are further pressures on revenue funding.
Level of Control = 50%		**Rationale for target score:** C – Of failure will increase as the reliance and proliferation of the use of digital solutions increases. 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.
Date added to the HB risk register 2012		

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

- Digital Strategy has been approved by the Health Board and outlines requirements
- HB Capital priority group considers digital risks for replacement technology which is fed into the annual discretionary capital plan
- Digital Services prioritisation process is in place Digital Leadership Group provides the overarching governance to the delivery of the Digital Strategic Plan including financial considerations.
- Digital Services revenue requirements are included in 21/22 annual plan

Mitigating actions (What more should we do?)

Action	Lead	Deadline
To continue discussions with Finance on the identified requirement, both in-year for 2022/2023 and recurrent full year effect.	Assistant Director of Digital: Business Management and Information Governance	31/03/2023
Continue to develop the 10yr investment plan that has been submitted to WG, which will inform the Health Board IMTP submission.	Assistant Director of Digital: Business Management and Information Governance	31/03/2023

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

- Progress has been made in securing capital investment both internally and externally.
- The Digital Services plan is being delivered.
- Financial plan for 21/22 agreed and aligned to Digital Plan

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

- Lack of certainty over future capital and revenue funding streams makes planning and implementation difficult/less effective.

Additional Comments / Progress Notes
Update 14.03.2022 - Reviewed by the Digital Services Risk Management Group on the 8th March 2022 and no further updates required for the Executive Risk Management for this month. Update 14.04.2022 - Recommendation approved by the Digital Services Risk Management Group to increase the likelihood of this risk from 3 to 4 to 16. Action completed – Establish 5year financial plan for Digital including the risks of the termination of the CTM SLA. Reviewed at the Risk Meeting on the 21/06/2022 and no amendments for this month's submission. 24.08.2022 – Action completed - Assessment of funding gaps and the opportunities to bridge them to be undertaken with Finance. Update 20/09/2022 – Action deadlines inserted.

Datix ID Number: 1043 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**HBR Ref Number: 36** **Target Date: 31st March 2023**	**Current Risk Rating** **4 x 4 = 16**

Objective: Digitally enabled care

Director Lead: Matt John, Director of Digital
Assuring Committee: Audit Committee
For information: Health & Safety 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. There is an increased fire risk where medical records are stored outside of the medical record libraries.

Date last reviewed: October 2022

Risk Rating
(consequence x likelihood):
Initial: 4 x 5 = 20
Current: 4 x 4 = 16
Target: 3 x 3 =9

Level of Control
= 70%

Date added to the HB risk register
June 2016

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Risk Score	16	16	16	16	16	16	16	16	16	16	16	16
Target Score	9	9	9	9	9	9	9	9	9	9	9	9

Rationale for current score:
C - Inability to find records for patients could delay care/increase length of stay over 15 days. Could also mean patients receive incorrect treatment. Increased risk of fire where records are stored outside of the medical record libraries.
L - we know this happens from incidents raised

Rationale for target score:
C - The increased development and adoption of the digital record will reduce the need for the paper health record being available at the point of care.
L - The increased development and adoption of the digital record, the introduction of RFID and the approach to management of the paper record identified in the Business case process should reduce the amount of paper required to be stored and managed.

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

- There is a plan in place to increase the functionality of the electronic record to document patient care. The delivery of the plan is overseen by the Digital Leadership Group and progress provided to Management Board. (Supported by individual project boards as appropriate)
- Records managed by the Medical Records libraries are RFID tagged and location tracked
- Medical Record libraries are regularly risk assessed for fire by health and safety
- Alternative offsite storage arrangements have been identified.
- All records must be documented on the Information Asset Register (IAR)

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Develop Business Case for the scanning of patients records.	Head of Health Records & Clinical Coding	31st October 2022
Relocate Health records to the new site.	Head of Health Records & Clinical Coding	30th September 2023

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

- RFID has been implemented for the acute record improving the management and storage of records
- Health Records performance reports 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 and electronic sources
- Monitoring complaints and incident reporting.
- Electronic record is being implemented in accordance with the plan eg implementation of WNCR, ETR, HEPMA etc.

Gaps in assurance (What additional assurances should we seek?)
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.
Process for ensuring clinical adoption of electronic ways of working and cessation of adding information to the paper record that is already available electronically needs to be agreed and enforced by the Health Board.

	Impact of the infected Blood Inquiry on the health boards ability to destroy notes has considerably increased the pressure on storage capacity and negating some of the mitigating actions that are in place.

Additional Notes
Reviewed in Risk Management Meeting on 21/6/2022 and one new action has been populated. Update 24/08/2022 - Risk reviewed and no update for this month's submission. 20/09/2022 – Risk reviewed and no update for this month’s submission.

Datix ID Number: 1217 **Health & Care Standard: Effective Care 3.1 Safe & Clinically Effective Care**	**HBR Ref Number: 37** **Target Date: 31st March 2023**	**Current Risk Rating** **4 x 3 = 12**
Objective: Best Value Outcomes from Quality Care	**Director Lead:** Matt John, Director of Digital **Assuring Committee:** Audit Committee	

Risk: Operational and strategic decisions are not data informed:

- Business intelligence and information already available is not utilised
- Users are unable to access the information they require to make decisions at the right time
- Gaps in information collection including patient outcome measures

Date last reviewed: October 2022

Risk Rating
(consequence x likelihood):
Initial: 4 x 3 = 12
Current: 4 x 3 = 12
Target: 4 x 2 = 8

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Risk Score	12	12	12	12	12	12	12	12	12	12	12	12
Target Score	8	8	8	8	8	8	8	8	8	8	8	8

Level of Control = 70%

Date added to the HB risk register
June 2016

Rationale for current score:
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.
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.

Rationale for target score:
C- will remain the same or increase due to increased reliance in information
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?)

- BI partner roles have been funded and will be introduced to support the SDG's to become more data driven.
- COVID19 Dashboards Developed and utilised to inform the decision making process at Gold
- The Health Board has invested in interactive dashboards with the addition of the Power BI Business Intelligence software and infrastructure to support it.
- 33 dashboards in place including Cancer, Patient Flow, Outpatients, Mortality, Clinical Variation, Primary & Community Care Delivery Unit Dashboard and Ward Dashboard
- Safety Huddle implemented in Morriston has improved data quality and improved operational working
- Investment and revised ways of working across the coding department has achieved coding and data quality targets
- Information Dept. working with Planning and Finance leads to develop meaningful indicators, utilising dashboards to present information in a user friendly way
- New technologies being reviewed for advanced analytics and integration into a new Health Board analytics platform.
- Health Board has representation on national groups such as the Advanced Analytics Group (AAG), all Wales Business Intelligence and Data Warehousing Group and Welsh Modelling Collaborative.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Establishment of data literacy programme educating users on data concepts, skills and tools	Assistant Director of Digital Intelligence	31st March 2023
Natural Language Process capability to allowing users access to clinic letter/documents converted into meaningful analytics	Assistant Director of Digital Intelligence	31st December 2022
Establishment of certified training programme for trained users to create their own dashboards – March 2023	Assistant Director of Digital Intelligence	31st March 2023

Assurances (How do we know if the things we are doing are having an impact?) More evidence based and proactive decisions being made. Dashboard technology; assist in developing indicators / triangulating information to identify issues	**Gaps in assurance (What additional assurances should we seek?)** Culture of the organisation needs to change to focus on information and Business intelligence for operational rather than reporting purposes. Capability of operational staff to utilise the tools and capacity to act on the intelligence provided.
Additional Comments / Progress Notes Reviewed at the Risk Meeting on the 21/06/2022 and no amendments for this month's submission. 24.08.2022 - Reviewed in the Risk Management Group and no updates for this month's submission. 20.09.2022 - Risk reviewed and no update for this month's submission. 21.10.2022 - BI Partner roles updated to 5 and now fully established. Investment and revised ways of working across the coding department has achieved coding and data quality targets to be removed from controls as unsuccessful.	

Datix ID Number: 1567
Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety

HBR Ref Number: 41
Target Date: February 2024

Current Risk Rating
4 x 4 = 16

Objective: Best Value Outcomes

Director Lead: Darren Griffiths, Director of Finance & Performance
Assuring Committee: Health and Safety Committee

Risk: Fire Regulation Compliance
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: October 2022

Risk Rating
(consequence x likelihood):
Initial: 5 x 3 = 15
Current: 4 x 4 = 16
Target: 3 x 3 = 9

Level of Control
= 50%

Date added to the HB risk register
31/05/2018

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Risk Score	16	16	16	16	16	16	16	16	16	16	16	16
Target Score	9	9	9	9	9	9	9	9	9	9	9	9

Rationale for current score:
Cladding applied to Singleton Hospital front flank is not compliant with fire regulations. General compliance with fire regulations and WHTM/WHBN requirements.

Rationale for target score:
Once sufficient resources and the cladding is replaced the risk score will reduce significantly. This will be reduced in stages as resources are implemented and cladding replaced.

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

- Fire risk assessments.
- Evacuation plans (vertical and horizontal).
- Fire safety training.
- Professional advice sought on compliance of panels.
- East flank panels removed
- Business case being developed for south panel removal and updating.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Change in fire evacuation plans and alarm and detection cause and effect	Head of Health & Safety	01/11/2023
Replacing the existing cladding and insulation with alternative specifications and inserting 30 minute fire cavity barriers where appropriate	Service Improvement Manager	28/02/2024

Assurances (How do we know if the things we are doing are having an impact?)
- Monitoring through the H&S committee to receive assurance and or identify gaps for key compliance and adherence to applicable legislation.
- NWSSP internal audits
- Site visits/tours to identify compliance and gaps in compliances.
- Completion of FRA's within targeted schedule

Gaps in assurance
(What additional assurances should we seek?)
Suitable resources to be in place, all fire risk assessments and actions from them completed. Fire safety audits carried out internally. Fire compartmentation surveyed to provide assurance of fire stopping. Fire schematics updated and fire evacuation drawings updated in in place.

Additional Comments / Progress Notes
17.01.22: Cladding project board met on 14.01.22 for an update on the progress of the cladding project, due to a number of reasons (Asbestos removal - Expert witness investigations). The latest expected completion date is March 2024. The cladding replacement works (fire integrity) is not now expected to be completed until March 2024, therefore, this will impact on the ability to reduce the risk rating at present and will be continually reviewed.
15.06.22: Currently there is no change and nothing to add.
12.09.22: Works continue in line with updated programmes, with no change in completion date or risk level.
24.10.2022 - Works continue in line with updated programme issued by Kier Construction indicating projected completion of March 2024, with no change in current risk level.

Datix ID Number: 1514 Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety	HBR Ref Number: 43 Target Date: 30th September 2022	Current Risk Rating 3 x 4 = 12
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality and Safety Committee	
Risk: Due to a lack of Best Interest Assessor resource, there is a risk of failure to complete and authorise the assessments associated with Deprivation of Liberty/Liberty Protection Safeguards within the legally required timescales, exposing the health board to potential legal challenge and reputational damage.	**Date last reviewed:** October 2022 **Rationale for current score:** Although processes have been planned in order to reduce the breach position they have yet to be fully implemented. The impact is yet to be realised. The position will be reviewed next month.	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 3 x 4 = 12 Target: 3 x 2 = 6 **Level of Control** = 40% **Date added to the HB risk register** July 2017	**Rationale for target score:** Consequences of DoLS breaches for the Health Board will not change. With controls in place, over time likelihood should decrease.	

Month	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Target Score	6	6	6	6	6	6	6	6	6	6	6	6
Risk Score	16	16	16	16	16	16	16	12	12	12	12	12

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

Additional supervisory body signatories in place – this is being undertaken as overtime using additional WG funds
BIA rota now implemented but limited uptake due to inability to release staff. BIA Training undertaken for 9 nursing staff (7 within the Long Term Care Team). Able to undertake assessments utilising additional monies from WG.
Team Leader band 7 WTE is a qualified BIA and supports in the most complex cases.
1 band 6 BIA WTE commenced 1st August 2022.
DoLS database updated and DoLS dashboard in place, monitoring applications and breaches via dedicated BIAs and Admin.
Delivery of DOLS Action plan reviewed monthly
Regular reporting to Mental Health and Legislative Committee (MHLC)
Health Board presence at National and regional meetings relating to DoLS / LPS
Increased IMCA services to support increased BIA resource
Additional funding received from WG to manage the backlog of DoLS assessments and implementation of LPS.
Current MCA practice reviewed to support MCA DoLS issues in practice
Use of WG funding to support changes to service model.
Use of WG funding to commission 250 assessments from private provider Liquid Personnel to address the backlog of DoLS assessments.
Bid successful£102k from WG for additional funding to address the ongoing DoLS breaches and MCA

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Business case for revised service model (cannot be finalised prior to WG consultation)	Head of Nursing LPS	09/12/2022
Agency commissioned to support backlog of assessments	GND Primary and Community	Ongoing
Overtime agreed to fund sign off from nurse assessor team to process the backlog assessments	GND Primary and Community	Ongoing
Recruitment process underway for substantive BIA	GND Primary and Community	Actioned. To commence 01.08.2022

training.			
Assurances (How do we know if the things we are doing are having an impact?) Regular scrutiny at Service Group and Safeguarding Committee and by DoLS Internal Audit; monitoring via DoLS Dashboard this will provide real-time accurate data. Update report to MHLC, impact of backlog of DoLS breaches and new LPS implementation	**Gaps in assurance (What additional assurances should we seek?)**		

Additional Comments / Progress Notes

27.06.2022 - BIA has now been appointed and due to start 1st August 2022.
Current backlog is 56.
Additional 3 BIA's have been allocated by Liquid Personnel to meet the backlog of DoLS. Currently 37 assessments have been undertaken since commenced 11 weeks ago which is significantly below the projected number. Escalated to Liquid Personnel lead who has increased the allocation of BIA's. Agreement for 10 assessments to be completed on a weekly basis which would meet the backlog and ongoing DoLS submissions to prevent breaches. This is being reviewed on a weekly basis. No change to current risk score.
WG Draft Code of Practice remains in consultation period until 14th July 2022. A regional and separate health board response is being developed and led by LPS Head of Nursing.
Phase 1 bid has been agreed by WG with allocation of £102k. Phase 2 funding has been made available. Bids to be submitted by 1st August 2022 for up to £152K, to support workforce plans including the recruitment of staff and the wider preparations needed in order to prepare for the LPS and can include;

- Development of data capacity
- Additional DoLS backlog work
- Additional advocacy arrangements
- Additional training needs identified through development of local workforce and training plan

This funding bid is to be submitted 1st August 2022.
11.08.2022 – Newly appointed BIA commenced on 1st August 2022.
Current DoLS backlog is 42. Liquid Personnel have completed 58 to date with 192 remaining of the 250 assessments commissioned. Due to the summer period there has been a reduction in weekly assessments completed by Liquid Personnel (approximately 3-4 a week). It is anticipated that the number of completed assessments will increase by September 2022. This is being reviewed on a weekly basis with the lead coordinator for Liquid Personnel. There remains to be no changes to the current risk score.
Consultation regarding the Draft Code of Practice was submitted to WG as planned. Phase 2 bid was submitted on the 1st August 2022 to WG by LPS Head of Nursing for additional £152,000 funds to support workforce plans, recruitment of staff and wider preparation in order to prepare for LPS.
23.09.2022 – Current DoLS backlog is 42. Liquid Personnel have completed 116 assessments to date with 134 remaining of the 250 assessments commissioned. Number of assessments completed by Liquid Personnel has increased and it is anticipated that all commissioned assessments will be completed by December 2022. Further assessments to be commissioned utilising WG funding from Phase 1 bid to support with assessments until end of financial year. Phase 2 bid has been agreed. Proposal to be put forward to provide additional staff to support the implementation for LPS and MCA training.
20.10.2022 – Current DoLS backlog for 1st October 2022 is 47. Liquid Personnel are completing on average 20 per month. Fortnightly meetings are taking place with the agency to request further allocation of BIA's. External BIA's and substantive BIA's are completing 10-15 per month. On average 60 referrals are received on a monthly basis in which 30 are granted. The breach time is approximately 6 weeks. Additional external BIA's are being sought to help address the backlog. Head of Nursing for LPS is preparing a workforce proposal utilising WG monies from phase 1 & 2 in preparation for LPS implementation.

Datix ID Number: 1563 **Health & Care Standard: Safe Care 5.1 Access**	**HBR Ref Number: 48** **Target Date: 31st March 2023**	**Current Risk Rating** **4 x 3 = 12 Reduced from 16**

Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee:** Performance and Finance Committee, Health Board **For information:** Quality & Safety Committee
Risk: Failure to sustain Child and Adolescent Mental Health Services	**Date last reviewed:** October 2022

Risk Rating
(consequence x likelihood):
Initial: 4 x 4 = 16
Current: 4 x 3 = 12
Target: 4 x 2 = 8

Level of Control = 50%

Date added to HB the risk register
31/05/2018

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Risk Score	16	16	16	16	16	16	16	16	16	16	16	12
Target Score	8	8	8	8	8	8	8	8	8	8	8	8

Rationale for current score:
Difficulties with sustainable staffing affecting performance. Due to improvements being made within the service the current score is on track to be reduced next month.

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 was established by Summer 2019 which gave further stability to service.
- Staffing of service is being strengthened & supplemented by agency staff
- External support secured to determine future delivery arrangements and more immediate performance improvements.
- Following a service review, and option appraisal, the Health Board approved the preferred option – to repatriate Swansea Bay CAMHS at its September Board meeting.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
The Network is seeking to recruit agency staff to fill existing and upcoming vacancies to ensure that core capacity is maximised.	Assistant Director of Strategy	05/12/2022

Assurances
(How do we know if the things we are doing are having an impact?)
As a result of focussed work, the vacancy rate has improved considerably. Utilisation of agency will continue to improve the backlog, and support the trajectories received.
% Patients waiting < 28 days
The number of referrals reduced to 138 in August, compared to 259 in May when referrals were at their highest this year. The proportion of referrals redirected/not accepted has increased in August to 55% reflecting the average for 21/22.
The number of patients on the waiting list at the end of August has decreased from 324 in May to 100. The current waiting time for assessment as at 23rd September, is included within the table below.

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

Team	Total waiting	Waiting >28 days	% compliance	Average wait (weeks)
CAMHS Swansea Bay	100	31	69%	2.7

Additional Comments / Progress Notes

Update 22.02.2022 - Potential for repatriation of CAMHS service from Cwm Taf Morgannwg HB being considered through commissioning additional external support to review.
Action complete 01.04.22 - Improvement plan has been shared by CTM and is monitored monthly. Action to mitigate the risk to young people waiting is being taken including utilisation of the third sector for support. An update went to the performance & finance committee in March.
Update: August 2022 – work has been progressed to develop options for the repatriation of CAMHS, and these are due to be reviewed by Management Board in August. A service specification has been drafted, and engagement is ongoing. Trajectories have now been received aligned to the schemes in the Improvement Plan – these will be monitored via the monthly commissioning arrangements.
Update: September 2022 – Service Specification complete and preferred option confirmed for future repatriation of service to Swansea Bay UHB. Recommended that risk is downgraded in October 2022. Two actions completed - Service Specification being developed. Engagement on Specification is now complete, document has been finalised and endorsed by CTM and SBUHB via the commissioning arrangements in place. Board to consider future delivery arrangements. Option appraisal complete – preferred option approved by Management Board and by Health Board members at the September meetings.

Datix ID Number: 1761
Health & Care Standard: Timely Care 5.1 Access

HBR Ref Number: 50
Target Date: 31/10/2022

Current Risk Rating
5 x 5 = 25

Objective: Best Value Outcomes from High Quality Care

Director Lead: Inese Robotham, Chief Operating Officer
Assuring Committee: Performance and Finance Committee
For information: Quality & Safety Committee

Risk: Access to Cancer Services A backlog of patients now presenting with suspected cancer has accumulated during the pandemic, creating an increase in referrals into the health board which is greater than the current capacity for prompt diagnosis and treatment. Because of this there is a risk of delay in diagnosing patients with cancer, and consequent delay in commencement of treatment, which could lead to poor patient outcomes and failure to achieve targets.

Date last reviewed: October 2022

Risk Rating
(consequence x likelihood):
Initial: 4 x 5 = 20
Current: 5 x 5 = 25
Target: 4 x 3 = 12

Level of Control
= 70%

Date added to the HB risk register
April 2014

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Target Score	12	12	12	12	12	12	12	12	12	12	12	12
Risk Score	25	25	25	25	25	25	25	25	25	25	25	25

Rationale for current score:
Risk score updated based on being off trajectory for SCP and Backlog increasing.

Rationale for target score:
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 Urgent Suspected Cancer Pathway. Enhanced monitoring & weekly monitoring of action plans for top 6 tumour sites.
- Initiatives to protect surgical capacity to support USC pathways have been put in place
- Additional investment in MDT coordinators, with 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. This will form part of the remit of the Cancer Performance Group.
- Weekly cancer performance meetings are held for both NPTS and Morriston Service Groups by specialty.
- The top 6 tumour sites of concern have developed cancer improvement plans – weekly monitoring arrangements have been put in place.
-
- Additional work being undertaken as part of diagnostic recovery and theatre recovery workstreams.
- Endoscopy contract has been extended for insourcing.

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.	Service Group Manager	31/03/2023
Demand & capacity plans worked through for top 6 tumour sites.	Deputy COO	Complete

Assurances (How do we know if the things we are doing are having an impact?)
Backlog trajectories updated at Management Board and will be going to Performance & Finance Committee in August. Cancer Performance Group established to support execution of the services delivery plans for improvements and meeting regularly.

Gaps in assurance (What additional assurances should we seek?)
Performance and activity data monitored, but delays to treatment continue while sustainable solutions found.

Additional Comments / Progress Notes
27/06/2022: Deputy COO with support for CIT have developed Cancer Backlog trajectories for top 6 tumour sites. 22/08/2022: Backlog trajectories have been presented to Management Board and will be going to Performance & Finance Committee in August. 21/09/2022: PFC received the trajectories and tumour site specific recovery plan. Endoscopy capacity remains a constraint and updated recovery plan is to be presented at Management Board in October. Action completed - Demand & capacity plans worked through for top 6 tumour sites. 24/10/2022: Cancer will be part of enhanced monitoring arrangements with Welsh Government. We are awaiting the template to agree remedial actions.

Datix ID Number: 1759 Health & Care Standard: Staff & Resources 7.1 Workforce	HBR Ref Number: 51 Target Date: 30th September 2022	Current Risk Rating 5 x 4 = 20
Objective: Excellent Staff	**Director Lead:** Gareth Howells, Executive Director of Nursing **Assuring Committee:** Workforce and OD Committee	
Risk: Non Compliance with Nurse Staffing Levels Act (2016)	**Date last reviewed:** October 2022	

Risk Rating (consequence x likelihood):
Initial: 4 x 4 = 16
Current: 5 x 4 = 20
Target: 4 x 3 = 12

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Target Score	8	8	8	8	8	8	8	8	8	8	8	12
Risk Score	20	20	20	25	20	20	20	20	20	20	20	20

Level of Control = 80%

Date added to the HB risk register
November 2018

Rationale for current score:

- Pressures at Morriston and Singleton Hospitals remain high.
- Clinically optimised patient numbers continue to be high.
- Ongoing cladding works in SH continue, with split wards.
- Impact of AMSR not fully understood, although affecting staffing in NPTSH site currently.
- Vacancies remain high.
- Non-attendance of agency staff increasing risk.

Rationale for target score:

- The Health Board is ensuring we have the structures and processes in place to provide reassurance under the Act and are allocating resources accordingly.
- Health Boards are duty bound to take all reasonable steps to maintain nurse staffing levels.
- Student Streamlining will provide additional qualified nurses to the workforce, overseas recruitment continues. Cladding work at Singleton Hospital might still be ongoing by 31.10.22

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

The Health board has put the following controls in place:

- Designated person confirmed as Director of Nursing & Patient Experience.
- 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, and Operations.
- The Ward Sister / Charge Nurse and Senior Nurse should continuously assess the situation and keep the designated person formally apprised.
- The Health Board NSA Steering group continues to meet on a monthly basis, ensuring risks are presented at each meeting, chaired by the Interim Deputy Director of Nursing and reports to NMB and Workforce & Organisational Development Committee
- Health Board has representation at the All-Wales Nurse Staffing Group and its sub groups.
- Bi-annual acuity audits, calculations and scrutiny undertaken across all acute Service Delivery Units for calculating and reporting nurse staffing requirements.
- Mandatory Assurance Report submitted to November Board and May Assurance Board Paper undertaken

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Student Streamlining and Overseas recruitment	Executive Director of Nursing	31/10/2022 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. Implementation of Safecare, commenced 1st February, roll out plan is 32 weeks.	Executive Director of Nursing	31/01/2023 Monthly ongoing

annually.

- Workforce planning & redesign, training and development. recruitment and retention continues. Workforce meetings for each Service Group, on a rotation basis continue.
- Student Streamlining and Overseas recruitment continues, bi-annually for adult training nurses, annually for paediatric nurses.
- Robust roster scrutiny is undertaken to optimise nursing workforce
- Implementation of SafeCare underway. Completion date for roll out is 30th November 2022. Planning for further support to ensure full use of the Safecare system operationally to support the reporting potential of system.
- Workforce Plans remain in place for each Service Group to agree staffing in light of escalation, with consideration of all reasonable steps.
- Service groups continue daily staffing huddles and daily staffing tool and escalate as appropriate
- Risk register reviewed monthly.

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

- 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 and recruitment team.
- Accurate reporting of Acuity data and governance around sign off.
- Agreed establishments funded.
- E-Rostering implemented and roster scrutiny undertaken, ensuring effective staff allocation
- All Wales Templates are visible informing patients/visitors of planned roster on each Section 25B ward.
- At least Annual Board reports outlining compliance and any key risks.
- Assurance reports to Board in May and November, with three yearly report to Welsh Government due Spring 2024.

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

- Issue raised regarding Information Technology barriers around the capture of data required for the Act on an All- Wales and Health Board basis. All Wales work with Allocate (Safecare) to improve reporting capabilities of Safecare.
- Implementation of SafeCare, due to complete roll out by 30th Nov 2022, next phase is to support service group to ensure Safecare is used to its full potential for both operational and reporting use.
- Ongoing work across Wales to ensure IT systems are compatible with each other for operational and reporting purposes.

Additional Comments / Progress Notes

21.09.2022 – Corporate Nurse Staffing Risk score remains unchanged at 20. Monthly NSA Steering Group discussed scores.
MHSG score = 20, NPTSHSG Adults = 20, Paediatrics and Neonatal = 20, Maternity = Two risks a. related to BirthRate Plus = 20 b. Critical Midwifery Staffing = 25, District nursing = 20, Mental Health = 15. Despite Maternity reporting critical midwifery staffing risk score of 25, the consensus across the group is that the overall HB NSA risk score should remain at 20 this month and will be reviewed at October NSA meeting or earlier if required.
Target scores further discussed on 20.09.22, agreement for final target score to be set at 12, with interim score to be set at 16. For review at monthly at HB NSA meeting.
June bi-annual acuity undertaken, visualisers prepared through Power BI. Service groups currently finalising NSA templates. Corporate Scrutiny undertaken on 7th October 2022.
Safecare roll out continues in line with plans, aiming for completion by 30th November 2022, now a time to embedded system into every day practice.
Student streamlining and overseas recruitment continues. Retention of staff remains a high priority. Increased uptake of exit interviews.
Vacancies reported on 12.10.22 are 337 Band 5 and 167 Band 2.
Nurse Staffing Level Mandatory Report to Board being written and for Board on 24th November 2022, on agenda for discussion at HB NSA meeting on 18th October 2022.

Datix ID Number: 1763 **Health & Care Standard: Staff & Resources 7.1 Workforce**		**HBR Ref Number: 52** **Target Date: 31st July 2022**	**Current Risk Rating** **4 x 3 = 12**	
Objective: Partnerships for Care – Effective Governance		**Director Lead:** Nick Samuels, Interim Director of Communications and Engagement **Assuring Committee:** Performance and Finance Committee		
Risk: The Health Board does not have sufficient skills & resource in place to undertake impact assessments in line with strategic service change and policy development.		**Date last reviewed:** October 2022		
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 = 12 Target: 4 x 2 = 8	Chart: Oct-21 to Sep-22 – Risk Score 12 each month; Target Score 8 each month	**Rationale for current score:** • Current lack of required skills / staff to deliver requirements.		
Level of Control = 50%		**Rationale for target score:** • 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 November 2018				

Controls (What are we currently doing about the risk?)	**Action**	**Lead**	**Deadline**
• Head of EDI to be appointed to support equality impact assessment – funding agreed, recruitment planned for Q4. • Creation of DICE has led to additional resource within Engagement Team. • Robust policies and processes to be in place for Impact Assessment going forward. • EIA responsibilities incorporated into wider Impact Assessments. • Development of Strategic Equality Group across organisation to support processes.	Appoint Head of EDI	Assistant Director of Insight, Engagement & Fundraising - DICE	31/12/2022
	Review of the current process for developing Equality Impact Assessments around service change, engagement and consultation.	Assistant Director of Insight, Engagement & Fundraising - DICE	31/03/2023
	Robust policies and processes to be in place for Impact Assessment going forward.	Assistant Director of Insight, Engagement & Fundraising - DICE	31/06/2023
	Roll out Impact Assessment process across organisation.	Assistant Director of Insight, Engagement & Fundraising - DICE	30/09/2023

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

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Advice on Equality Impact Assessment and then wider Impact Assessments available across organisation supported by robust policies and procedures, overseen by Strategic Equality Group.	Participation from across organisation in Strategic Equality Group.

Additional Comments / Progress Notes

Update 22.02.2022 – Due to long term absence of Assistant Director of Strategy action not completed. Will now be progressed with Director of Workforce and OD when Assistant Director returns to work.
Interim Director of Communications developing proposals to strengthen Communication and Engagement mechanisms within the Health Board which will provide further support, and reduce risk score. Timescale to be finalised.

Datix ID Number: 1762 Health & Care Standard: Staff & Resources 7.1 Workforce	HBR Ref Number: 53 Target Date: 31st December 2022	Current Risk Rating 5 x 3 = 15
Objective: Partnerships for Care	**Director Lead**: Hazel Lloyd, Interim Director of Corporate Governance **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:** October 2022	

Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 3 = 15 Target: 3 x 3 = 9	Chart	**Rationale for current score:** 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. This position has been confirmed/verified via an independent baseline assessment.
Level of Control = 60%		**Rationale for target score:** 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 November 2018		

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

- An independent baseline assessment of the Health Board's position against the Standards has been undertaken. This is in addition to the Health Board's own self-assessment.
- Work to implement the recommendations contained within the above baseline assessment has commenced.
- An online staff Welsh Language Skills Survey has been launched.
- Close constructive working relationships are in place with the Welsh Language Commissioner's Office
- Strong networks are in place amongst WLO across NHS Wales to inform learning and development of responses to the Standards.
- 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.
- Meetings of the Welsh Language Standards Delivery Group have recommenced (March 2022)

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Ensure the Board is fully sighted on the UHB's position through regular reporting to the Health Board.	Head of Compliance	30/09/2022
Recruit to current vacancy within the Welsh language Translation Team.	Welsh Language Officer	30/09/2022

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

1. Compliance with Statutory requirements outlined in Welsh Language Act and related Standards.
2. Meetings with the Welsh Language Commissioner.
3. Self-Assessment against the requirements of More Than Just Words.
4. Production of an Annual Report.

Gaps in assurance
(What additional assurances should we seek?)
Formal and regular reporting to the Board will recommence with the production of the next annual report.

Additional Comments / Progress Notes

March 2022 - Risk reviewed and updated. Meetings of the Welsh Language Standards Delivery Group have recommenced. Risk score remains unchanged.
July 2022 - The initial attempt to fill the current vacancy within the Welsh Language Translation Team was unsuccessful, with no suitable candidate identified. A second recruitment is now underway with a revised job advertisement. Risk reviewed and updated. Risk score remains unchanged.
August 2022 - A second recruitment has identified a suitable candidate for a trainee translator position and the admin process to bring that individual into the team is now underway.
September 2022 – Risk reviewed. No change at this time.

Datix ID Number: 1799
Health & Care Standard: Controlled Drug 2.6 Medicines Management

HBR Ref Number: 57
Target Date: 31st December 2022

Current Risk Rating
4 x 4 = 16

Objective: Best Value Outcomes of High Quality Care

Director Lead: Richard Evans, Executive Medical Director (tb reviewed)
Assuring Committee: Audit Committee

Risk: Non-compliance with Home Office (HO) CD Licensing requirements. The Health Board (HB) currently has limited assurance regarding compliance with HO CD Licensing requirements, nor does it have processes in place in respect of future service change compliance.

Date last reviewed: October 2022

Risk Rating
(consequence x likelihood):
Initial: 5 x 4 = 20
Current: 4 x 4 = 16
Target: 4 x 2 = 8

Level of Control
= 40%

Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22
Risk Score: 16 16 16 16 16 16 16 16 16 16 16 16
Target Score: 8 8 8 8 8 8 8 8 8 8 8 8

Date added to the HB risk register
January 2019

Rationale for current score:
Risk: That the HB is operating in breach of the law by managing CDs without an appropriate HO CD License. Legal advice received has indicated that failure to comply with the HO CD licensing requirements could result in criminal and civil action, both against responsible individuals and the HB as a public body. The HB ratified a policy to determine requirements for HO Licenses in August 2020 however the content of the policy differs from HO advice received to date – the HB are awaiting response from the HO 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 HO direction and associated consequences still stand.
Risk: That the HB is maintaining unnecessary HO CD Licenses. Alternatively, the Health Board may be required to purchase further licenses in order to ensure compliance with the legal requirements. Each HO CD license costs around £3k plus additional administrative set-up and maintenance costs.

Rationale for target score:
Following either the HO agreeing with the content of the HB 'Policy to determine the requirement for HO CD 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?)

PW, Director of Corporate Governance, has formally written to the HO to share a copy of the HB's, 'Policy to determine the requirement for HO CD Licenses,' and to ask for a meeting at their earliest convenience to discuss difference of opinion regarding number and nature of licenses required. In the meantime, in response to difficulties sourcing CDs from the pharmaceutical wholesale system for HMP Swansea due to uncertainty around whether a HO CD license is required at this site, the HB have decided to apply for such a license. This decision, whilst not in line with above HB policy, does follow HO direction and is anticipated will result in resumption of normal supply of CDs to HMP Swansea.
Additionally, the CD Accountable Officer is currently working with Service Group Triumvirates to strengthen CD Governance. This will provide an opportunity to expedite some of the actions outlined in this register entry once position agreed with HO.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
HB to discuss and agree a policy position on the requirements for HO CD Licenses with the HO.	CD Pharmacy	01/12/2022
Upon agreement of policy with the HO: HB to undertake baseline assessment of current CD management (including any HO CD licenses currently held) in line with agreed policy on requirements for HO CD licenses	CD Pharmacy	01/12/2022
Upon agreement of policy with the HO: HB to develop and implement a control system to ensure compliance with agreed policy on HO license requirements.	CD Pharmacy	01/12/2022

Assurances (How do we know if the things we are doing are having an impact?)
The HB policy on HO CD licenses is referred to when issues are raised in order to provide consistency in arrangements.

Gaps in assurance (What additional assurances should we seek?)
The HB 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.

Additional Comments / Progress Notes

We are awaiting advice from the Home Office. The intention is review this risk following receipt of that advice with a view to de-escalating if appropriate.
Action complete - Apply for a HO CD License for HMP Swansea. – The Health Board is now in receipt of a Home Office Controlled Drug License for HMP Swansea (issue date 10/05/22).
Update 18.05.22 - No change since previous update of 12.04.22.
Update 27/06/22 - The Acting Director of Corporate Governance received a response from the Home Office regarding the Health Board's Home Office CD License Policy position on the 8th June 2022. This response indicated that the Home Office did not concur with several aspects of the Health Board's policy statements and indicated that the Health Board would require a number of additional Home Office Controlled Drug licenses for activity currently undertaken. Both the Controlled Drug Accountable Officer and the Acting Director of Corporate Governance have agreed further legal advice is required at this point which has been commissioned.
11.08.22 Acting Director of Corporate Governance /CDAO/CDAO Support pharmacist met with Counsel to discuss the advice received back from the HO which is at odds with our policy. Further clarity sought from the HO identified that their view is unchanged and could require the Health Board to apply for further licenses. We await further legal advice before progressing.
12.09.22 - Following further legal advice a meeting between the Acting Director of Corporate Governance /CDAO/CDAO Support pharmacist has been arranged for 22/09/22 to discuss next steps.
14/10/22 - The Director of Corporate Governance and CDAO are seeking a meeting with senior representatives from the Home Office to discuss this issue further.

Datix ID Number: 146 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**HBR Ref Number: 58** **Target Date: 31/03/2023**	**Current Risk Rating** **4 x 4 = 16**
Objective: Excellent Patient Outcomes	**Director Lead**: Inese Robotham, Chief Operating Officer **Assuring Committee**: Quality and Safety Committee	
Risk: Failure to provide adequate clinic capacity for follow-up patients in **Ophthalmology** results in a delay in treatment and potential risk of sight loss.	**Date last reviewed:** October 2022	

Risk Rating (consequence x likelihood):	Chart	**Rationale for current score:**
Initial: 4 x 3 = 12 Current: 4 x 4 = 16 Target: 4 x 2 = 8	Risk Score: Oct-21 20, Nov-21 20, Dec-21 20, Jan-22 20, Feb-22 20, Mar-22 20, Apr-22 20, May-22 20, Jun-22 16, Jul-22 16, Aug-22 16, Sep-22 16 Target Score: Oct-21 8, Nov-21 8, Dec-21 8, Jan-22 8, Feb-22 8, Mar-22 8, Apr-22 8, May-22 8, Jun-22 8, Jul-22 8, Aug-22 8, Sep-22 8 Target Score / Risk Score	Risk rating increased to 20 in July 2020 due to Covid-19 pandemic but has now been decreased due to the progress made by the department to reduce the number of delayed followed appointments.
Level of Control = 40% **Date added to the HB risk register** December 2014		**Rationale for target score:** Mitigation plan via outsourcing of work to optometrists where possible and re-introduction of pre-covid capacity levels.

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

- All patients are categorised by condition in order to quantify issue.
- Community optometry scheme successfully implemented to reduce number of diabetic retinopathy patients on follow up list.
- Scheme developed for assessment of glaucoma patients by community optometrists for virtual review by consultant ophthalmologists to reduce follow up backlog.
- Outsourcing of cataract activity to reduce overall service pressures.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
An overall Regional Sustainability Plan to be delivered	Service Group Manager Surgical Specialties	31/03/2023

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

- Deputy COO holds Gold Command meetings on a monthly basis to monitor progress.

Gaps in assurance
(What additional assurances should we seek?)
Regular liaison with patients on extended waiting list/times and validation.

Additional Comments / Progress Notes

12/09/2022 – Risk reviewed and no further updates.

Datix ID Number: 2003 Health & Care Standard: Effective Care 3.1 Clinically Effective Care	HBR Ref Number: 60 Target Date: 31st December 2022	Current Risk Rating 5 x 4 = 20
Objective: **Digitally Enabled Care**	**Director Lead:** Matt John, Director of Digital **Assuring Committee:** Audit Committee	
Risk: Cyber Security - high level risk The level of cyber security incidents is at an unprecedented level and health is a known target. The health board's digital services (users, devices and systems) increases year on year and therefore the impact of a cyber-security attack is much higher than in previous years. Risks of large fines associated with outages of systems and loss of data with associated UK regulations. The largest risks to the organisation are on user awareness, unsupported software and devices not managed by the ICT department, for example medical devices.	**Date last reviewed:** October 2022	

Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 5 x 3 = 15	**Rationale for current score: C and L** Global tensions have increased the risk of cyber-attack, along with the use of Russian Security Software in the Health Board now posing additional risk. The Ireland Health Service were subjected to a ransomware attack (May 2021) by a Russian gang. The increase in users and devices increases the threat landscape. Mandatory training not adopted to date. New Risk Factor • Cyber Warfare- Increased risk of Cyber Security war directly or indirectly impacting SBU.
Level of Control	**Rationale for target score:** C- Will remain the same or increase due to increased reliance in information L- The overall likelihood score would decrease to 3 if mandatory Cyber Security training is achieved and implemented across the Health Board
Date added to the HB risk register July 2019	

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Target Score	15	15	15	15	15	15	15	15	15	15	15	15
Risk Score	20	20	20	20	20	25	25	20	20	20	20	20

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?) Action	Lead	Deadline
Cyber Security Manager and Cyber Team in place, proactive approach to cyber security adopted. National and security tools in place which actively protect digital services, highlight vulnerabilities and provide warnings when potential attacks are occurring. A patching regime has been in place for which ensures desktops, laptops and servers are protected against any known security vulnerabilities. Work ongoing to replace out of date systems. Complete annual Cyber Security Assessment as part of annual NIS compliance work with Cyber Resilience Unit in DHCW Digital Services Management Group established to ensure systems are compliant with security standards. Cyber Security training and phishing stimulation in place to increase staff awareness. The risk of a cyber-attack had increased globally as a result of the Russian invasion of Ukraine, with UK Government encouraging the continuous review and testing of Business Continuity plans for if a cyber-attack were to take place.	Adopt mandatory Cyber training across SBUHB, or identify alternative options- WG Procurement underway for national solution.	Assistant Director of Digital Technology	1st December 2022 Ongoing awaiting national update

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
Submissions of the Cyber Assessment Framework response to the Cyber Resilience Unit (onto Welsh Government) as part of NIS compliance will identify recommendations and actions to undertake as part of an annual assessment and continuous improvement cycle. We have successfully replaced Kaspersky on all laptops/Desktops with Microsoft Defender, and on all Servers with Trend Micro.	Cyber Security Training is not mandatory and the biggest risk is our staff's awareness to identify phishing/scam emails and malicious websites. CTM Princess of Wales devices still on SBU network but running Kaspersky – negotiated removal of Kaspersky with CTM with plan to remove and manage with Defender by 20/05/22

Additional Comments / Progress Notes

Update 17.05.2022 - Welsh Government confirmed ongoing procurement of a National Training Package for Cyber Security training – expectation Welsh Government will make its use mandatory.
Update Post Management Board 15.06.2022: Risk level reduced following decommissioning of Kaspersky infrastructure.
Two actions completed - Decommission Kaspersky infrastructure following removal of Kaspersky from all Clients/Servers. Complete an Improvement Plan based on the Assurance Report from the Cyber Security Resilience Unit.
Update 20/09/2022 - Risk reviewed and no update for this month's submission.

Datix ID Number: 1587
Health & Care Standard: 3.1 Safe and Clinically Effective Care

HBR Ref Number: 61
Target Date: 31st May 2023

Current Risk Rating
4 X 4 = 16

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: Inese Robotham, Chief Operating Officer
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: October 2022

Risk Rating
(consequence x likelihood):
Initial: 5 x 3 = 15
Current: 4 x 4 = 16
Target: 4 x 2 = 8

Level of Control
= 60%

Date added to the HB risk register
4th July 2018

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Target Score	8	8	8	8	8	8	8	8	8	8	8	8
Risk Score	16	16	16	16	16	16	16	16	16	16	16	16

Rationale for current score:
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

Rationale for target score:
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?)

Consultant Anaesthetist present for every General Anaesthetic clinic.
Assurance Documentation supplied by Parkway Clinic including confirmation of arrangements in place with WAST and Morriston Hospital for transfer and treatment of patients
New care pathway implemented - no direct referrals to provider for GA.
Multi-drug sedation ceased from Sep 2018 in line with WHC 2018 009
Revised SLA/Service Specification
HIW Inspection Visit Documentation provided to HB
All extended GA cases require approval from paediatric specialist prior to treatment

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Transfer of services from Parkway.	Interim Head of Primary Care	31/05/2023

Assurances (How do we know if the things we are doing are having an impact?)
RMC collate referral and treatment outcome data for review by Paediatric Specialist
Regular clinical meeting arranged with Parkway to discuss individual cases/concerns
Regular clinical/ management meeting for CDS/primary care management team to discuss service pathway /concerns/issues arising
Roll out of new pathway to encompass urgent referrals
T&F Group established to lead transfer from community centre to MHSDU.

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

Additional Comments / Progress Notes

25.04.2022: Current position reviewed at Senior Management Board April 2022. Extension agreed until 31st May 2023 due to current theatre challenges. Agree repatriation remains a priority and to be included in theatre planning. Deputy COO to re-establish TFG. 29.07.2022: T&F group to be re-established in September 2022.
23.08.2022: Reviewed at HoS meeting - PCT planning with service director in Morriston Hospital. No change to risk at present.
12.09.2022: Risk reviewed and no further updates.

Datix ID Number: 1605 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**	**HBR Ref Number: 63** **Target Date: 30th June 2022**	**Current Risk Rating** **4 X 4 = 16**
Objective: Screening for Fetal Growth Assessment in line with Gap-Grow (G&G)	**Director Lead**: Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality and Safety Committee	
Risk: There is not enough Ultrasound capacity within Swansea Bay UHB to offer all women serial ultrasound scan screening in the third trimester in line with the UK perinatal Institute Growth Assessment Programme (GAP). Welsh Government mandate fetal growth screening in line with the GAP programme. There is significant evidence of the increased risk for stillbirth or neonatal mortality/morbidity (hypoxic ischaemic encephalopathy (HIE)), where a fetus is growth restricted (IUGR) and/or small for gestational age fetus (SGA). Identification and appropriate management for IUGR/SGA in pregnancy will lead to improved outcomes for babies.	**Date last reviewed:** October 2022	

Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 4 = 16 Target: 3 x 4 = 12 **Level of Control** = 60% **Date added to the HB risk register** 1st August 2019	**Rationale for current score:** Although the frequency of stillbirth is low the health board are up to 10% above the national rate for stillbirth as published by MBRRACE. Although infrequent when IUGR/SGA baby is stillborn or diagnosed hypoxic ischaemic encephalopathy (HIE) which is deemed avoidable this impacts on: • the wellbeing of families • can lead to high value claims • loss of reputation and adverse publicity for the health board. *See also Progress Notes below* **Rationale for target score:** When the service is able to provide third trimester ultrasound scan in line with GAP recommendations we will be providing care in line with evidence based best national practice as mandated by Welsh Government.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
All staff are required to complete the GAP e-learning on an annual basis. Compliance is monitored via the Training & Education forum. All staff have received an email to present their certificate for 2021/22 A local policy is in place to identify the priority risk factors for the offer of serial growth scans while there is not enough capacity Health board maternity ultrasound group convened to develop future services Training 4 midwives for an advanced practice role in ultrasound scanning to reduce capacity gap Introduction of midwife third trimester scan service will increase USS capacity by a minimum 2,200 scans per annum (50 scans per week/44 weeks) commencing April 2022 Two midwives have commenced Ultrasound training course in UWE January 2022, in order to ensure sustainable service provision Two additional ultrasound rooms are fully equipped toward increased scan capacity	**Action**	**Lead**	**Deadline**
	All staff to submit GAP training certificates by 31/12/2022	Deputy Head of Midwifery	31/12/2022
	Administration for midwife sonographer clinics to be secured to ensure streamlined service	Maternity service business manager	30/06/2022
	Complete the governance framework for third trimester scanning to include CPD programme	Deputy Head of Midwifery	31/05/2022
	Two midwives to complete UWE course December 2022	Deputy Head of Midwifery	31/12/2022
Assurances (How do we know if the things we are doing are having an impact?) The third trimester ultrasound capacity will increase by a minimum 2200 scans per annum in year one	**Gaps in assurance (What additional assurances should we seek?)** Assurance of maintaining a sustainable third trimester ultrasound service.		

increasing to 4400 in year 2. The detection rate of IUGR/SGA will increase leading to improved antenatal management plans and intrapartum planning. We will report a reduced rate of stillbirth and/or neonatal mortality/morbidity with improved management of IUGR/SGA babies. The administration support for the service will be fully functional.	

Additional Comments / Progress Notes

March 2022 an all Wales group convened led by HEIW and National Imaging Academy (NIA), to support advance practice for ultrasound scan in Wales. SBU maternity services will be key stakeholders within this group to ensure ongoing USS service developments to meet future capacity & demand.
27/05/2022 - Midwife sonographer third trimester scanning lists have been added to WPAS, negotiations with central admin team to administer the clinics are ongoing.
There are now 2 fully functioning ultra-scan rooms with the ability to upload images to PACS. Lead midwife sonographer and radiology lead are developing a governance group who will link in to health board radiology governance group.
07/06/2022- due to the trained midwife sonographer role improved capacity for ultrasound scan referral within requisite timeframes with reduced incidents for non-completion of USS. Joint radiology/maternity operational governance group convened who will report into the health board radiology governance group and maternity Q&S group. USS scan schedules returned to pre-Covid pandemic schedules in line with local policy. Business case to be prepared for service in NPT on completion of current trainee midwife sonographers programme (December 2022). This will ensure equity of service across the HB and ensure women receive care close to their home.
08/07/2022 - Admin support still unavailable. Clinics have commenced but unable to record capacity on WPAS.
04/08/2022 - Trainee midwifery sonographers will not be able to complete their training by September because their competencies cannot be signed by this time.
24/10/2022 – Due to service pressures the T&E group have prioritised completion of GAP training for community midwives and midwife sonographers. Extension to year end for all staff. The lack of administration support for the ultrasound service means the increased capacity forecast is not fully achieved as sonographers provide own administration tasks.

<table>
<tr><td colspan="2">Datix ID Number: 2159
Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety</td><td colspan="2">HBR Ref Number: 64
Target Date: 31st March 2023</td><td>Current Risk Rating
5 X 5 = 25</td></tr>
<tr><td colspan="2">Objective: Best Value Outcomes</td><td colspan="3">Director Lead: Darren Griffiths, Director of Finance & Performance
Assuring Committee: Health and Safety Committee</td></tr>
<tr><td colspan="2">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. .</td><td colspan="3">Date last reviewed: October 2022</td></tr>
<tr><td>Risk Rating
(consequence x likelihood):
Initial: 5 x 4 = 20
Current: 5 x 5 = 25
Target: 4 x 3 = 12
Level of Control
= 70%
Date added to the HB risk register
September 2019</td><td>25 25 25 25 25 25 25 25 25 25 25 25
12 12 12 12 12 12 12 12 12 12 12 12
Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22
Target Score Risk Score</td><td colspan="3">Rationale for current score:
The Health Board received 12 Health & Safety Executive (HSE) improvement notices during 2019-20 covering various Health & Safety legislative breaches covering a range of areas. There is the potential for future multiple notices for not meeting legislative requirements. Possible reduction in score once two new posts are filled.
Rationale for target score:
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 and 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.</td></tr>
<tr><td colspan="2">Controls (What are we currently doing about the risk?)</td><td colspan="3">Mitigating actions (What more should we do?)</td></tr>
<tr><td colspan="2" rowspan="3">Assistant Director of Health and Safety in post to support strengthening and develop the H&S function to support the organisation. Business case submitted for additional resources.
Health and Safety Operational Group and the Health and Safety Committee monitor compliance. Refreshed the Fire Safety Group with additional controls in place.
Fire risk assessments are being prioritised with temporary additional resources put in place in March 2021 to reduce the number of FRA overdue.
Fire training in place and fire wardens in place
Fire risk assessment schedule in place for the next 12 months to maintain 100% compliance of completion and is regularly reviewed</td><td>Action</td><td>Lead</td><td>Deadline</td></tr>
<tr><td>Health and safety structure review to be presented to the H&S Committee when funding has been agreed.</td><td>Assistant Director of H&S</td><td>Closed (presented to HSC)</td></tr>
<tr><td>It has been agreed to identify posts to progress recruitment on a phased approach over the next 12/24 months. This will be dependent upon availability of funding.</td><td>Assistant Director of H&S</td><td>31/10/2024</td></tr>
<tr><td colspan="2">Assurances (How do we know if the things we are doing are having an impact?)
Monitoring through the appropriate group/committees (H&S committee) to receive assurance and or identify gaps for key compliance and adherence to applicable legislation.
Site visits/tours to identify compliance and gaps in compliances.</td><td colspan="3">Gaps in assurance (What additional assurances should we seek?)
Agreement of funding for resources identified in business case to implement structure in business case by Q2/3 2022/23 financial year.</td></tr>
<tr><td colspan="5">Additional Comments / Progress Notes
04.05.22 - It has been agreed by the health board to recruit one H&S Advisor and one Manual Handling Trainer/Advisor. Verifications form completed and post will be advertised in Q1 2022/23, with an end Q1 or beginning of Q2 for successful candidates to commence. Given that the posts will take time to have any impact on training and audit, it is possible that the risk score can be reduced slightly in 6 months' time after successful recruitment with a targeted reduction in Q4.
15.06.22 - H&S advisor and MH adviser/trainer will be uploaded to Trac in June, interview dates in July with targeted commencement in Aug/Sept 2022.
30.08.22 – Interviews held and two manual handler advisors appointed as per plan on 24/08/22. As soon as appointees come in to post the risk will be adjusted.
12.09.22 – Advisors for H&S and MH going the TRAC appointment process, with appointees expected to commence in Q3/4 dependant on notice period.</td></tr>
</table>

24.10.22 – Recruitment process through Trac in final stages with commencement dates expected in Q4 2022/23, once staff members are embedded (anticipated March 2023), risk scores will be reviewed with the aim of being able to reduce the risk from 25 to 20 initially.

<table>
<tr><td colspan="2">Datix ID Number: 329
Health & Care Standard: 3.1 Safe and Clinically Effective Care</td><td colspan="2">HBR Ref Number: 65
Target Date: 31st October 2022</td><td>Current Risk Rating
4 x 5 = 20</td></tr>
<tr><td colspan="2">Objective: Digitally enabled Care</td><td colspan="3">Director Lead: Gareth Howells, Executive Director of Nursing
Assuring Committee: Quality & Safety Committee</td></tr>
<tr><td colspan="2">Risk: Misinterpretation of cardiotocograph and failure to take appropriate action is a leading cause for poor outcomes in obstetric care leading to high value claims. The requirement to retain maternity records and CTG traces for 25 years leads to the fading/degradation of the paper trace and in some instances traces have been lost from records which makes defence of claims difficult.</td><td colspan="3">Date last reviewed: October 2022
Rationale for current score:
The K2 central monitoring system has been purchased by the health board however is not yet installed. A project team is being established to ensure oversight of installation and training. Full use of the system will be available from December 2022 when the risk will reduce as appropriate.</td></tr>
<tr><td>Risk Rating
(consequence x likelihood):
Initial: 4 x 4 = 16
Current: 4 x 5 = 20
Target: 4 x 2 = 8
Level of Control
= 50%
Date added to the HB risk register
31st December 2011</td><td>Risk Score: 20 20 20 20 20 20 20 20 20 20 20 20
Target Score: 8 8 8 8 8 8 8 8 8 8 8 8
Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22
Target Score / Risk Score</td><td colspan="3">Rationale for target score:
A central monitoring station will enable senior clinicians to support decision making across the service, and from home, leading to senior involvement in management decisions toward improved outcomes. All CTG traces will be stored electronically and therefore will not fade and cannot be lost.</td></tr>
<tr><td colspan="2">Controls (What are we currently doing about the risk?)</td><td colspan="3">Mitigating actions (What more should we do?)</td></tr>
<tr><td colspan="2" rowspan="4">All staff receive annual training in fetal surveillance as mandated by Welsh Government.
SBU have appointed a midwife and obstetric lead for training and development of staff
Compliance with training is reported annually in 2021/2022 the training year has been extended due to the service ability to release staff for training
A “fresh eyes” protocol in place requiring intrapartum CTG classification hourly by two clinicians which is monitored via audit of records
A “jump call” policy is available to request additional support where there is disagreement over CTG classification
CTG prompt labels in use to support staff with CTG categorisation.</td><td>Action</td><td>Lead</td><td>Deadline</td></tr>
<tr><td>Fetal surveillance leads to set up training team for transition to use of electronic labour record. TNA analysis to be completed for all staff</td><td>Fetal surveillance leads</td><td>31/12/2022</td></tr>
<tr><td>For the project Board to complete a risk assessment to manage the changeover from paper based to electronic monitoring to ensure all risks are captured</td><td>Project Board</td><td>31/07/2022</td></tr>
<tr><td>Arrange backfill for fetal surveillance midwife secondment to maintain training and reflections</td><td>Deputy Head of Midwifery</td><td>30/11/2022</td></tr>
<tr><td colspan="2">Assurances (How do we know if the things we are doing are having an impact?)
All Wales Fetal Surveillance Standards for 6hrs Fetal Surveillance Training per year</td><td colspan="3">Gaps in assurance (What additional assurances should we seek?)
Assurance all staff are able to transition to a new way of working</td></tr>
<tr><td colspan="5">Additional Comments / Progress Notes
27/05/2022 - Project board has held first meeting. Projected installation date December 2022- January 2023. SIGNAL installation to coincide in January 2023.
7/06/2022 – Project group have held first meeting, development of sub groups. Training sub group essential to ensure all staff are able to transition to new way of working. Key action.
08/07/2022 - Potential delay with installing Central Monitoring, however still currently on track for December 2022.
07/10/2022 - Demonstration for staff on Monday 10th October, rolling out training in Oct/Nov. Implementation by the end of December 2022.</td></tr>
</table>

24/10/2022 – Fetal surveillance midwife appointed to MAT/NEO safety programme for 6 months. Backfill TBA.

Datix ID Number: 1834 Health & Care Standard: 5.1 Timely Care	HBR Ref Number: 66 Target Date: 31st January 2023	Current Risk Rating 5 X 3 = 15
Objective: Best values outcomes from high quality care	**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee:** Quality and Safety Committee	
Risk: The demand & complexity of planned treatment regime for cancer patients requiring chemotherapy currently exceed the available chair capacity, risking unacceptable delays in access to SACT treatment in Chemotherapy Day Unit with impact on targets and patient outcomes.	**Date last reviewed:** October 2022	

Risk Rating (consequence x likelihood):
Initial: 5 x 5 = 25
Current: 5 x 3 = 15
Target: 2 x 2 = 4

Level of Control =

Date added to the HB risk register 30/11/2019

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Target Score	4	4	4	4	4	4	4	4	4	4	4	4
Risk Score	20	20	20	20	20	20	20	20	20	15	15	15

Rationale for current score: Risk reduced to 15 (July) – last 3 months have now consistently delivered 100 additional patients per month via CDU.

Rationale for target score:
Reduced delays in treatment will reduce risk of harm.

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

Review of CDU by improvement science practitioner was completed in 2020. Resulted in change to booking processes to streamline booking process and deferral.
Review of scheduling by staff to ensure all chairs used appropriately.
Business case endorsed by CEO for shift of capacity to home care to be considered by the Management Board
A Daily scrutinizing process in progress to micro manage individual cases, deferrals etc

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Business Case for phase 2 home care expansion based on moving further treatments to community service. Paper with CEO for comments, prior to going to BCAG	Associate Service Group Director – Cancer Division	30th September 2022
Paper to support extended day working every Saturday	Service Director Lead for Cancer	30th December 2022
Relocation of SACT linked to AMSR programme and phase 2 of home care expansion case brought forward	Service Director Lead for Cancer	January 2023 (dependant on AMSR moving Sept 2022)

Assurances (How do we know if the things we are doing are having an impact?)
Additional funding agreed to support increase in nurse establishment to appropriately staff the unit during its main opening hours. Additional scheduling staff also agreed.
Pre-assessment process has been separated from start date in an attempt to fill deferral slots at short notice where possible.
Improved communication between MDT to streamline booking and deferral process.
Continue to monitor patient experience via friends and family and under our PTR procedures.
Monitoring our waiting times against new SACT metrics, which is a measure based on treatment intent and is no longer reported as average waiting time so is more linked to expected outcomes

Gaps in assurance (What additional assurances should we seek?)
Capital & Revenue assumptions & resources for second business case for increasing chair capacity in 2022/23 to meet increased demand.

etc. This performance metric is included in our Cancer Performance report we send to WG and Management Board and internally via governance arrangements with NPTSSG where Oncology services sit.	

Additional Comments / Progress Notes

27/08/2022 - Average waiting times have improved to 3.5wks. Work remains ongoing to deliver improvements in waiting times as per SACT WCN reported targets for P1,P2 and P3. due to further rise in Covid additional 3 chairs have not been reintroduced yet.

12/09/22 - We continue to see stabilising of CDU waiting times although there remains operational concerns with specific points in pathways effecting efficiency and effectiveness of delivery linked to aseptic and consultant workload pressures. We monitoring monthly compliance of SACT WCN reports. Which shows slight deterioration performance in August compared to July, but still average waiting remains around 3wks.

Datix ID Number: 89 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 67** **Target Date: 31st October 2022**	**Current Risk Rating** **5 X 3 = 15**
Objective: Best values outcomes from high quality care		**Director Lead**: Richard Evans, Executive Medical Director **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:** October 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 3 = 15 Target: 2 x 2 = 4 **Level of Control** = **Date added to the HB risk register** 30/11/2019	Oct-21, Nov-21, Dec-21, Jan-22, Feb-22, Mar-22, Apr-22, May-22, Jun-22, Jul-22, Aug-22, Sep-22 Risk Score: 15 15 15 15 15 15 15 15 15 15 15 15 Target Score: 4 4 4 4 4 4 4 4 4 4 4 4	**Rationale for current score:** Waiting times deteriorating for elective delays patients, particularly prostates discussed in Oncology business meeting. Current Risk reduced to 15. At present 70 patients to be outsourced which increases capacity. New Linac building work underway, which will increase capacity in near future. **Rationale for target score:** Reduced delays in treatment will reduce risk of harm	

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

Implementation of revised radiotherapy regimes for specific tumour sites, designed to enhance patient experience and increase capacity. Breast hypo fractionation in place.
Requests for treatment and treatment dates monitored by senior management team.
Protected capacity rate set as part of 2020/21 Operational Plan.
Outsourcing of appropriate radiotherapy cases. Additional outsourcing for Prostate RT commenced June 2021.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
New Linac required – Linac case agreed with WG	Service Manager Cancer Services	01/04/2023 (on track)
Operationalise plans for offering hypo fractionated prostate treatment	Service Manager Cancer Services	30/11/2022 (on track)

Assurances
(How do we know if the things we are doing are having an impact?)
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
(What additional assurances should we seek?)
Performance and activity data monitored, but delays to treatment continue while sustainable solutions found.

Additional Comments / Progress Notes

11.08.22 - Now offering hypo-fraction in-house due to cessation of Rutherford activity.
13.09.22 - Wait Times have dipped in August with the biggest contributing factor being late localisation. Demand- After 2 months of high demand, the levels returned to a more 'normal' level in August. It will be interesting to see if this was due to consultant leave and if the demand returns to higher levels once everyone is back. Demand for breast treatment has seen the highest rise over the past 12 months with a 39% increase (325 pts increasing to 451 pts). Capacity- August was a very busy month on the linacs as we treated the high levels of demand seen in July. With four matched linacs in operation we were able to start 206 courses of treatment, almost matching our previous highest record.
03.10.22 - Lin 5 building work has begun. Capacity increasing should be full capacity by end December 2022.

Datix ID Number: 1418 **Health & Care Standard: 5.1 Timely Access**	**HBR Ref Number: 69** **Target Date: 31st January 2023**	**Current Risk Rating** **5 X 4 = 20**

Objective: Best values outcomes from high quality care

Director Lead: Inese Robotham, Chief Operating Officer / Gareth Howells, Executive Director of Nursing
Assuring Committee: Quality & Safety 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: October 2022

Risk Rating
(consequence x likelihood):
Initial: 2 x 3 = 6
Current:5 x 4 = 20
Target: 2 x 3 = 6

Level of Control
=

Date added to the HB risk register
27/02/2020

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Target Score	6	6	6	6	6	6	6	6	6	6	6	6
Risk Score	20	20	20	20	20	20	20	20	20	20	20	20

Rationale for current score:
Every health board is required to have an admission facility for adolescent MH patients. Whilst ward F has been identified as the single point of access in SBU and a dedicated bed is ring-fenced for adolescent admissions it is a mixed sex adult ward. Therefore the facilities are less than ideal for young patients in crisis.

Rationale for target score:
The longer term aim for the HB remains to create an admission facility for adolescent MH patients.

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

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.
Only Adolescents within 16-18 age range are admitted to the adult ward.
The health board works with CAMHS to make sure that the length of stay is as short as possible.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Next service group review of effectiveness of current controls.	MH&LD Head of Operations & Clinical Directors	31st March 2023

Assurances (How do we know if the things we are doing are having an impact?)
Individual Rooms with en Suite Facilities, Joint working with CAMHS, monitoring of staff training, Monitoring of admissions by the MH & LD SG legislative Committee of the HB. The ongoing issues with the risks presented by the use of this has recently been raised at an all Wales level with Welsh Government and a formal review is anticipated. The Service Group continues to flag the risk particularly in light of Ward F being identified as the SPOA for AMH in the HB which has resulted in an increase in acuity and a greater concentration of individuals who are experiencing the early crisis of admission - this has served to increase the already identified risks for young people in the environment.

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

Additional Comments / Progress Notes

29/07/2022 – MHLD SG confirmed there is no change on the status of this risk.
22/08/2022 – Action Closed: *The service group will review the effectiveness of current controls.* A further review date has been set.
24/10/2022 – No change. Next review date assigned.

<table>
<tr><td colspan="2">Datix ID Number: 2449
Health & Care Standard: 2.1.1 Managing Financial Risk</td><td colspan="2">HBR Ref Number: 72
Target Date: 30th September 2022</td><td>Current Risk Rating
4 X 5 = 20</td></tr>
<tr><td colspan="2">Objective: Best Value Outcomes from High Quality Care</td><td colspan="3">Director Lead: Darren Griffiths, Director of Finance
Assuring Committee: Performance and Finance Committee</td></tr>
<tr><td colspan="2">Risk: Reduced discretionary capital funds and reduced National NHS funds requiring a restricted Capital Plan for 2022-23</td><td colspan="3">Date last reviewed: October 2022</td></tr>
<tr><td>Risk Rating
(consequence x likelihood):
Initial: 5 x 4 = 20
Current: 5 x 4 = 20
Target: 5 x 1 = 5</td><td rowspan="3">Risk Score: 20 20 20 20 20 20 20 20 20
Target Score: 5 5 5 5 5 5 5 5 5
Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22
Target Score — Risk Score</td><td colspan="3">Rationale for current score:
• The Health Board has been advised that its discretionary capital allocation for 2022/23 as been reduced from £11.1m to £8.5m.
• The funding available within the Capital Resource Limit (CRL) will not meet the demands for capital investment. Discretionary capital is deployed to replace ageing medical devices & equipment; to address backlog maintenance of premises; and to support small scale, non-National service improvements with capital investments
• The current Health Board assessment of the carry forward and previously agreed commitments for inclusion in the 2022/23 capital plan currently suggests a requirement for an additional £7.5m to balance the plan.
• It is likely that due to slippage on capital schemes, this over-commitment will reduce.
• There is potential for further capital requirements arising from service model changes which will need to be managed.
• Potential consequences of this risk are the inability to achieve the ambitions set out within health board plans; the potential failure of ageing equipment leading to service disruption; the exposure to potential environmental health & safety risks.
• The plan has been balanced with £5m of planned spend on hold. This spend could be released if slippage identified in year. CRL will be met but the funding remains insufficient to meet Health Board needs.</td></tr>
<tr><td>Level of Control
= 25%</td><td colspan="3" rowspan="2">Rationale for target score:
The target score expresses the aspiration of the health board for addressing this risk. The target date indicated above reflects the point which the current actions are anticipated to reduce the risk, though knowledge of the actual funding available is required to reduce it further and this is not available until some months into the financial year.</td></tr>
<tr><td>Date added to the risk register
January 2022
(re-opened)</td></tr>
<tr><td colspan="2">Controls (What are we currently doing about the risk?)</td><td colspan="3">Mitigating actions (What more should we do?)</td></tr>
<tr><td colspan="2" rowspan="2">The Health Board is doing the following: -
• Regular dialogue with Welsh Government regarding capital requirements.
• Clear communication and reporting of the capital position, the risks and limitations.</td><td>Action</td><td>Lead</td><td>Deadline</td></tr>
<tr><td>Routine review and flexing of plan as spending is committed through the year. Routine monitoring processes will identify any potential slippage and will deploy this on risk based basis.</td><td>Director of Finance & Performance</td><td>Monthly throughout financial year</td></tr>
</table>

<table>
<tr><td>Close management of all schemes to ensure slippage is understood along with the impact on service.
Clear prioritisation of any new requirements recognising the current constraints
Routine assessment of local demands for discretionary capital spend through internal capital prioritization group which meets monthly.</td><td>Assessment of income assumptions related to business case fees from WG.</td><td>Assistant Director of Finance (Strategy & Planning)</td><td>Monthly throughout financial year</td></tr>
<tr><td>Assurances (How do we know if the things we are doing are having an impact?)
The Health Board capital position is reviewed and monitored through:
Monthly capital prioritisation group
Performance and Finance Committee monthly finance report
Monthly Monitoring Returns to Welsh Government.</td><td colspan="3">Gaps in assurance (What additional assurances should we seek?)
Reporting on impact of constraints to the capital programme on service delivery.</td></tr>
<tr><td colspan="4">Additional Comments / Progress Notes
The risks of not being able to deliver a balanced CRL has been mitigated through the Board-approved balanced plan. The ongoing risk reflected in this score relates to the capital available being considerably less than the expenditure required to meet the Health Board’s needs in 2022/23.
Actions complete – Apprise Welsh Government of content of revised capital plan to consider possibilities of support for key areas and formal review of existing capital plan to revise schemes and scheduling of schemes to move to balance.
14.9.22 - The pressure to retain a balanced capital position is becoming fragile as there is very little remaining flexibility in the programme to manage emerging service and infrastructure risks. Along with the uncertainty around funding support being made available by Welsh Government to support the assumed income for business case fees, the risk of the plan shifting from balance to imbalance is now material with little mitigating options available to the Health Board to avoid this.</td></tr>
</table>

Datix ID Number: 2450 Health & Care Standard: 2.1.1 Managing Financial Risk	HBR Ref Number: 73 Target Date: 31st May 2022	Current Risk Rating 5 x 4 = 20
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Darren Griffiths. Director of Finance **Assuring Committee:** Performance and Finance Committee	
Risk: The Health Board underlying financial position may be detrimentally impacted by the COVID-19 pandemic. 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.	**Date last reviewed:** October 2022	

Risk Rating	Chart	Rationale for current score
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 5 x 1 = 5 **Level of Control** = 25%	20 20 20 20 20 20 20 20 20 20 20 20 5 5 5 5 5 5 5 5 5 5 5 5 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Target Score — Risk Score	**Rationale for current score:** • 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 • The residual cost base risk remains difficult to assess as the Health Board continues to respond to the impact of the pandemic (a formal review was started in February 2022 of all costs and their ability to be managed out and this is being refreshed following receipt of more detailed guidance on COVID response costs handling received from Welsh Government on 14th March 2022). The outcome of this work will feed the funding request process for 2022/23. • As the Health Board moves out of direct COVID response and into COVID recovery there remains a real risk that some additional 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. • Welsh Government has indicated that the funding available for COIVD response in 2020/21 and 2021/22 will be restricted only to vaccination, TTP and PPE for 2022/23 thereby rendering any cost remaining within the Health Board a matter for the Health Board to address.
Date added to the HB risk register July 2020		**Rationale for target score:** Mitigating actions around delivering efficiency opportunities and service changes will reduce likelihood of the risk emerging alongside improved systems of control.

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

The Health Board is doing the following: -

- Finance Review Meetings with Units to agree cost exit plans
- Transparent exchange of position with Finance Delivery Unit & Welsh Government
- Clear financial plan being developed for 2022/23

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Formal review to be undertaken by WG of Health Board accounting for COVID costs.	Director of Finance & Performance	31st October 2022
Review meetings held by CEO and DoF&P with service group teams to review costs and develop plans to reduce. (Initial round completed. Further discussion planned with CEO to implement a third round.)	Director of Finance & Performance	30th September 2022

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
The Health Board financial performance is reviewed and monitored through: • Monthly financial recovery meetings • Performance and Finance Committee • Routine reporting to Board of most recent monthly position and financial forecasts	Reporting on savings opportunities and service change impacts to be developed.

Additional Comments / Progress Notes
31.03.2022: The risk remains at 20 as whilst WG has confirmed allocations can be assumed, this based on funding available for 5 categories of cost. The scrutiny of these categories of cost will inform the level of funding to be allocated. There remains a risk that the funds to be allocated may not meet the cost within the Health Board and this will affect the balance of the financial plan if it cannot be mitigated. Action complete - All Wales work through Directors of Finance to benchmark costs and work with WG on solutions. 30.08.2022 - Initial round of reviews completed. Further discussion planned with CEO to implement a third round of reviews ahead of the WG assessment. 30th September.

Datix ID Number: 2595 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 74** **Target Date: 31st October 2022**	**Current Risk Rating** **5 X 4 = 20**	
Objective: Best Value Outcomes from High Quality Care		**Director Lead**: Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality and Safety Committee		
Risk: Delay in Induction of Labour (IOL) or augmentation of Labour Delays in IOL can introduce avoidable risk and unnecessary intervention which can lead to poor clinical outcome for mother and/or baby. Delays in IOL lead to increased complaints and decreased patient satisfaction.		**Date last reviewed:** October 2022		
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 4 = 20 Target: 2 x 3 = 6 **Level of Control** = 60% **Date added to the HB risk register** 30th April 2021	Risk Score: 20 20 20 20 20 20 20 20 20 20 20 20 Target Score: 6 6 6 6 6 6 6 6 6 6 6 6 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Target Score Risk Score	**Rationale for current score:** Delay in IOL is a frequent occurrence in maternity care (all delays are linked to the RR) and is multifaceted including; 1. High acuity 2. Maternity staffing levels 3. Neonatal staffing levels While adverse outcomes as a result of delay in care are infrequent, there may be long term consequences for mother and/or baby leading to high value claims. Avoidable harm is damaging to the reputation of the HB and can lead to adverse media coverage. **Rationale for target score:** IOL delays are minimal with increased patient flow, increased patient satisfaction and prevent avoidable poor outcomes		
Controls (What are we currently doing about the risk?)		**Mitigating actions (What more should we do?)**		
IOL rate is static at around 30% Maintain a maximum number of IOLs on a daily basis with emergency slot. Daily obstetric consultant ward round to review all women undergoing IOL. Ongoing/regular monitoring by cardiotocograph for fetal wellbeing during IOL on hold. Labour ward coordinator and labour ward obstetric lead ensure women on ward 19 for IOL are factored into daily planning of workload on labour ward. Obstetric consultant review when IOL on hold for appropriate pan of care. The MDT (Obstetric, Neonatal and Midwifery) consider individual risk factors and Escalation Policy is implemented. Neighbouring maternity units are contacted to ask if they are able to support by accepting the transfer of women. Daily acuity is gathered and sent to the senior midwifery management team who can anticipate potential problems and support the clinical team. The matron of the unit is contacted in office hours and the senior midwife manager on call is contacted out of hours. If required midwifery staffing are redeployed including the specialist midwives and the community midwifery on call team.		**Action**	**Lead**	**Deadline**
		Prepare midwifery workforce paper to present recommendation for future staffing levels in the obstetric unit to ensure adequate staffing each shift.	Head of Midwifery	30/12/2022
		Complete Birthrate+ Cymru assessment for future workforce needs on the obstetric unit.	Head of Midwifery	30/11/2022
		Manage Critical midwifery Staffing (HBRR ref 81) to minimise disruption in IOL delay.	Head of Midwifery	30/12/2022
Assurances (How do we know if the things we are doing are having an impact?) There will be minimal delays in IOL. We will reduce the number of clinical incidents related to this risk. We will receive fewer complaints related to IOL as women's experience will be improved. We will not report avoidable harm related to IOL process.		**Gaps in assurance (What additional assurances should we seek?)** Workforce plan in preparation to include review of staffing on the Obstetric unit to reduce risk related to midwifery staffing and high acuity		

Additional Comments / Progress Notes

08.03.22 - Recruitment of Band 6 midwives underway. Introducing NICE guidelines for IOL (being managed by AN Forum). Working with NN to ensure capacity issues for maternity & NN

services are managed appropriately.
20/04/22- Recruitment of Band 6 midwives unsuccessful. Will need to re-advertise. Streamlining for graduate midwives in 2022 has closed and shortlisting commenced.
23/05/2022 – 12 graduate midwives will be appointed through streamlining process. Advert for band 6 midwives on TRAC.
7/06/2022 – 11 graduate midwives have accepted the offer of a preceptorship programme in SBU. Advert for band 6 midwives closed 1st June 2022. Potential two band 6 midwives for interview.
08.07.2022 – Continue to monitor IOL, critical staffing continues.
24.10.22 – Ongoing monitoring of outcomes when delayed IOL. Birthrate+ Cymru due to report November 2022. Midwifery workforce position paper with CEO for comment prior to presentation to Executive Board.

Datix ID Number: 2522 Health & Care Standard: 5.1 Timely Care	HBR Ref Number: 75 Target Date: 31/12/2022	Current Risk Rating 5 x 2 = 10
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Inese Robotham, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee	

Risk: Whole-Service Closure
Risk that services or facilities may not be able to function if there is a major incident or a rising tide that renders current service models unable to operate

Date last reviewed: October 2022

Risk Rating
(consequence x likelihood):
Initial: 5 x 4 = 20
Current: 5 x 2 = 10
Target: 5 x 1 = 5

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Target Score	5	5	5	5	5	5	5	5	5	5	5	5
Risk Score	20	20	20	20	20	15	10	10	10	10	10	10

Level of Control
= 25%

Date added to the HB risk register
May 2021

Rationale for current score:
Risk reflects transition to business as usual as part of living with covid strategy. BCP plans in place.

Rationale for target score:
The strategy of moving towards living with Covid will eventually lower the risk level to target.

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

- Sites have business continuity plans and the impact of one site being overwhelmed by COVID demand has been reviewed.
- Monitoring of associated risks has been being transferred to appropriate forums such as UEC Board, Elective Care Board and Nosocomial Group with overall oversight by Management Board.
- Ongoing surveillance of epidemiology data for early warning and further change to risk level via live Covid dashboard.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Periodic review of risk	COO	31/10/22

Assurances (How do we know if the things we are doing are having an impact?)
Monitored via Management Board for early warning signs.

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

Additional Comments / Progress Notes
03/05/2022: Covid GOLD & SILVER have been stood down. Ongoing monitoring assimilated into business as usual.
22/08/2022: Risk reviewed (no change) – it will be reviewed again in 3 months. There is ongoing surveillance of epidemiology data via the live Covid dashboard.
24/10/2022: Risk reviewed (no change currently).

Datix ID Number: 2521 (& COV_Strategic_017) **Health & Care Standard:** 2.4 Infection Prevention and Control (IPC) and Decontamination	**HBR Ref Number: 78** **Target Date: 31st October 2022**	**Current Risk Rating** **3 x 4 = 12**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Richard Evans, Executive Medical Director **Assuring Committee:** Quality & Safety Committee	

Risk: Nosocomial transmission

Nosocomial transmission in hospitals could cause patient harm; increase staff absence and create wider system pressures (and potential for further harm) due to measures that will be required to control outbreaks.

Date last reviewed: October 2022

Risk Rating (consequence x likelihood):
Initial: 5 x 4 = 20
Current: 3 x 4 = 12
Target: 3 x 4 = 12

16 20 20 20 20 20 20 20 20
12 12 12 12 12 12 12 12 12 12 12 12
Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22
Target Score Risk Score

Level of Control = 40%

Date added to the HB risk register
May 2021

Rationale for current score:
11.08.2022 – Risk reduced to 12. Reasoning: (1) incidence reducing in the community (2) incidence reducing in hospital (3) current variants associated with low mortality in vaccinated population (4) communication to families has not resulted in adverse.

Rationale for target score:
Measures in place will require regular review and scrutiny to ensure compliance. Levels of community incidence or transmission may change and the HB will need to respond. Vaccination programme on going but not complete.

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

A nosocomial framework has been developed to focus on:
(a) prevention and (b) response.
Preventative measures are in place including testing on admission, segregating positive, suspected and negative patients, reinforcing PPE requirements, and a focus on behaviours relating to physical distancing.
As part of the response, measures have been enacted to oversee the management of outbreaks.
Process established to review nosocomial deaths. Audit tools developed to support consistency checking in key areas re: PPE, physical distancing. Testing on admission dashboard in use. Further guidance on patient cohorting produced.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Following dissolution of Gold and Silver COVID command structures, the function of monitoring nosocomial spread and implementing preventative actions will be taken on by the IP&C committee.	Executive Medical Director & Deputy Director Transformation	Monthly ongoing
Nosocomial Death Reviews using national toolkit. Need to ensure outcomes are reported to the HB Exec and Service Groups with lessons learnt	Executive Medical and Nursing Director	01/12/2022

Assurances
(How do we know if the things we are doing are having an impact?)
Monitor Outbreaks throughout the HB / Review Nosocomial Deaths and lessons learnt

Gaps in assurance
(What additional assurances should we seek?)
Audit compliance of sustainable IPC practices and training compliance
Implement lessons learnt from outbreaks and death reviews.

Additional Comments / Progress Notes

Update 02.05.2022 - Following dissolution of Gold and Silver COVID command structures, the function of monitoring nosocomial spread and implementing preventative actions will be taken on by the IP&C committee.
27.07.2022 - Significant progress being made to review cases of hospital acquired COVID 19 resulting in patients death.

The HB has started to contact families to notify them followed up by written information on the process. Working with the DU to standardise processes within each HB. Scrutiny Panels being established for September to feedback lessons learnt to Service Groups and estimate level of harm. Legal and Risk services have been asked to support reviews to ensure we are following correct processes. Board updated on a regular basis with progress.

Datix ID Number: 2739 Health & Care Standard: 2.1.1 Managing Financial Risk	HBR Ref Number: 79 Target Date: 31st May 2022	Current Risk Rating 5 x 3 = 15

Objective: Best Value Outcomes from High Quality Care

Risk: The COVID-19 pandemic has affected services in many different ways, in this risk specifically the impact on access to services, such as OP, diagnostic tests, IP&DC and therapy services. The recovery of access times will require additional human, estates and financial resource to support it. There is potential for resource available is below the ambition of the board to provide improved access.

Director Lead: Darren Griffiths. Director of Finance
Assuring Committee: Performance and Finance Committee

Date last reviewed: October 2022

Risk Rating
(consequence x likelihood):
Initial: 5 x 3 = 15
Current: 5 x 3 = 15
Target: 5 x 1 = 5

Level of Control
= 25%

Date added to the HB risk register
May 2021

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Target Score	5	5	5	5	5	5	5	5	5	5	5	5
Risk Score	15	15	15	15	15	15	15	15	15	15	15	15

Rationale for current score:

- Significant backlog for patients to access across elective and cancer care in the following areas, diagnostics, OP, IP&DC, therapy, Oncology
- Welsh Government has set aside resource for the recovery of the health system with the areas above a clear area of focus. This is known as recovery funding and the Health Board has been allocated £21.6m recurrently for this purpose
- A prioritisation process is currently underway to determine the areas to be funded against the recovery money in the context of the overall Health Board financial plan for 2022/23 and beyond.
- Score reflects the high impact of not being able to address the access backlog due to affordability reasons, whilst the likelihood is 3 as resource is anticipated.

Rationale for target score:
The Health Board funding requirement is in excess of the funding available and therefore choices will need to be made on priority schemes for funding. The full list of ambitions/schemes is not affordable.

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

The Health Board is doing the following:

- Working with specialists to develop plans to maximise Health Board capacity safely and within extant COVID guidelines
- Developing more advanced service models to test scenarios to allow for accurate demand and capacity plans to be developed
- Ensuring that financial controls are in place to enable swift decisions to be made on allocation of additional resource but also ensuring that the commitment made do not exceed the allocation sum (when known)
- Transparent reporting to Performance and Finance Committee and Quality and Safety Committee on progress and plan development.
- Prioritising key services via clinical leaders.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Ensure that overall financial plan for 2022/23 can accommodate as much clinical capacity as possible by delivering savings and taking a risk assessed approach.	Director of Finance	30/06/2022

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
The Health Board financial performance is reviewed and monitored through: • Monthly financial recovery meetings • Performance and Finance Committee • Routine reporting to Board of most recent monthly position and availability of national funding support recovery	Management of access is prioritised based on clinical risk management.

Additional Comments / Progress Notes
The financial element of this plan will be managed to within the £21.6m COIVD recovery allocation received by the Health Board. The impact of the schemes identified within the £21.6m is currently being modelled and this will inform the Board of the forecast waiting times position through 2022/23. This will need to be considered by the Board and the risk adjusted to meet the outcome of the modelling and the discussion on impact on overall waiting times and waiting numbers. Action completed - Develop a final annual plan setting out recovery plans. Action Completed - Undertake a robust prioritisation exercise with clinical leaders to identify core service areas to be funded. This will be informed by modelling work to be carried out by the Healthcare Science Engineering Team.

<table>
<tr><td colspan="2">Datix ID Number: 1832
Health & Care Standard: : 3.1 Safe and Clinically Effective Care</td><td>HBR Ref Number: 80
Target Date: 31/12/2022</td><td>Current Risk Rating
4 x 5 = 20</td></tr>
<tr><td colspan="2">Objective: Best Value Outcomes from High Quality Care
Risk: If the health board is unable to discharge clinically optimised patients there is a risk of harm to those patients as they will decompensate, and to those patients waiting for admission.</td><td colspan="2">Director Lead: Inese Robotham, Chief Operating Officer
Assuring Committee: Quality & Safety Committee
Date last reviewed: October 2022</td></tr>
<tr><td>Risk Rating
(consequence x likelihood):
Initial: 4 x 5 = 20
Current: 4 x 5 = 20
Target: 4 x 2 = 8

Level of Control
= 25%

Date added to the HB risk register
May 2021</td><td>20 20 20 20 20 20 20 20 20 20 20 20
8 8 8 8 8 8 8 8 8 8 8 8
Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22
Target Score Risk Score</td><td colspan="2">Rationale for current score:
Sustained levels of clinically optimised patients (COPs) leading to overcrowding within ED, use of inappropriate or overuse of decant capacity in ED and delays in accessing medical bed capacity, clearly emerged as themes.
Constraints in relation to all patient flows out of Morriston to a more appropriate clinical setting, identified and included in an expanded risk.
Delay in discharge for clinically optimised patients can result in deterioration of their condition.
Rationale for target score:
Targeted reduction of Clinically Optimised patients remains a priority for the HB in order to minimise risk of avoidable harm to patients within the HB and in the wider community.</td></tr>
</table>

<table>
<tr><th>Controls (What are we currently doing about the risk?)</th><th colspan="3">Mitigating actions (What more should we do?)</th></tr>
<tr><td rowspan="4">Clinically optimised numbers are monitored and reviewed weekly by the MDU. Delays are reported and escalated to try to ensure timely progress along a patient's pathway.
Review on a patient by patient basis – with explicit action agreed in order to progress transfer to appropriate clinical setting.
Critical constricts in relation to access/time delays for social workers and assessment for package of care and social placement – lead times in excess of 5 weeks.
Patient COVID-19 status has added an additional level of complexity to decision making.
The health board has procured 63 additional care home beds to provide additional discharge capacity.</td><th>Action</th><th>Lead</th><th>Deadline</th></tr>
<tr><td>Deputy COO identified as lead for length of stay reduction and admission avoidance and will be putting in place a weekly oversight framework.</td><td>Deputy COO</td><td>Complete</td></tr>
<tr><td>CEO will meet with clinical leads to explore further opportunities for changing pathways with the aim of reducing length of stay. A meeting to be arranged by COO.</td><td>COO</td><td>Complete</td></tr>
<tr><td>COO and Medical Director to meet with WAST MD to review current pathways into ED with aim to identify opportunities for admission avoidance.</td><td>COO/EMD</td><td>31/10/2022
(Meeting arranged for 25/10/2022.)</td></tr>
<tr><td></td><td>Primary care group are looking at FNOF pathway and use of virtual wards to reduce length of stay</td><td>PCT SGD</td><td>31/10/2022</td></tr>
</table>

<table>
<tr><td>Assurances (How do we know if the things we are doing are having an impact?)
• Patient level dashboard allows breakdown by delay type
• Close management of utilization of additional care home beds</td><td>Gaps in assurance (What additional assurances should we seek?)</td></tr>
<tr><td colspan="2">Additional Comments / Progress Notes
28/07/22: Action completed: The HB has engaged and are having bi-weekly meeting with LA colleagues and the national lead for the Social Care taskforce.
21/09/22: Detailed presentation on the length of stay reductions and admissions avoidance schemes was received by Management Board 21/09/2022. Progress against delivery will be monitored by Management Board on a bi-weekly basis. 2 Actions completed - A dedicated task & finish group to be established to develop plans to close 90 contingency beds, as per AMSR plan. A plan will be presented to Management Board in September. Two focused groups established to look at different categories of COPs and provide senior oversight. To commence in August.
24/10/2022: Actions completed: Deputy COO identified as lead for length of stay reduction and admission avoidance and has put in place a weekly oversight framework; CEO met with clinical leads to explore further opportunities for changing pathways with the aim of reducing length of stay.</td></tr>
</table>

Datix ID Number: 2788 Health Care Standards: 7.1 Workforce	HBR Ref Number: 81 Target Date: 31st October 2022	Current Risk Rating 5 x 5 = 25

Objective: Best value outcomes

Director Lead: Gareth Howells, Executive Director of Nursing
Assuring Committee: Quality & Safety Committee
For Information: Workforce & OD Committee

Risk: Critical staffing levels – Midwifery
Vacancies and unplanned absences resulting from Covid-19 related sickness, alongside other long term absences including maternity leave, have resulted in critical staffing levels, which undermine the ability to maintain the full range of expected services safely, increasing the potential for harm, poor patient outcomes and/or choice of birthplace. Poor service quality or reduction in services could impact on organisational reputation.

Date last reviewed: October 2022

Risk Rating (consequence x likelihood):
Initial: 4 x 5 = 20
Current: 5 x 5 = 25
Target: 4 x 4 = 16

Level of Control = %

Date added to the risk register
12/10/2021

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Target Score	12	16	16	16	16	16	16	16	16	16	16	16
Risk Score	25	25	25	20	20	20	20	20	20	25	25	25

Rationale for current score:
Pressure on staffing increased at the end of June 2022 as a result of increasing short term sickness, particularly COVID-19 related - 12.24wte midwives are absent due to COVID-19 which equates to 7.6% of the overall clinical midwifery workforce. Vacancies exist within the service however and two rounds of recruitment for Band 6 midwives have failed to fully appoint to the vacancies available. A third round of recruitment is progressing to interview stage. Some aspects of service provision have been suspended in order to ensure resource is best directed to support safe provision. Increased to 25.

Rationale for target score:
It is intended that through actions currently identified to address vacancies we can reinstate services fully and reduce the likelihood of the need to suspend elements further.

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

- All midwives are working at the hours they require up to full time.
- Specialist midwives and management redeployed to support clinical care as required
- Birth rate plus Intrapartum acuity tool completed 4 hourly to guide safe service provision and escalation;
- Escalation meeting now daily to review rotas and reallocate staff as required – this is Director led
- Morning safety huddle for community midwifery teams
- Additional shifts offered via Bank, additional hours and overtime – targeted enhanced overtime rates offered for 3 weeks (from 24/06/2022) with authorisation of Executive Director of Nursing and subject to daily review. Plus enhanced bank rate offered to registered midwives.
- Utilisation of off-contract midwifery agency authorised by Executive Director of Nursing (from 24/06/2022) – prospective bookings in place to end of January 2023.
- Six Graduate midwives employed October 2022
- Open advert for recruitment on TRAC
- On-Call Manager Rota in place.
- Medical team support used when required.
- Continue to suspend services in the FMU at NPT.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Complete workforce paper with HR and finance to establish vacancy position and develop vacancy tracker going forward. Support for Cwm Taf secured to develop this.	Head of Midwifery	30/12/2022
Complete Birthrate+ Cymru assessment.	Head of Midwifery	Closed as separate action – to be considered as part of above
Review the role and capacity of the HCSW to maximise registered midwife capacity.	Deputy Head of Midwifery	31/10/2022

• International recruitment campaign initiated with MEDACS. • Offer of additional support worker shifts particularly in the postnatal area for additional support for women • Absences in senior roles supported mitigated as follows: Head of Safeguarding supporting the governance team; Temporary extension of Interim Midwifery Matron post to support oversight of the governance team; Retired Head of Midwifery mentoring new Deputy Head; Intrapartum Lead Midwife (Cwm Taf) is supporting development of future workforce requirements; WG offer of advice/support where required. • Regular communication with stakeholders includes: Early warnings to Welsh Government; Verbal and formal communication with CHC; Internal communications on home births, RCM updates; weekly staff briefings and bulletins.			

Assurances (How do we know if the things we are doing are having an impact?) We will be able to maintain safe staffing rotas and women and families will receive safe and effective care wherever they chose to birth. We will report increased staff satisfaction. We will have a reduction in complaints to the service. we will have reduced sickness rates. We will be able to effectively support secondments for staff development without depleting the clinical service. Long term sickness and maternity leave will not impact on our ability to sustain staffing levels within the clinical areas. The following assurance mechanisms in place currently: Birth-rate Plus Intrapartum acuity tool completed 4 hourly Daily Director-led midwifery staff escalation meetings which considers sickness & other absences and daily review of safety and quality outcomes. The Group Head of Quality Safety & Risk is supporting daily oversight of Datix incidents (commenced July 2022). Red flag events are monitored and reported in accordance with NICE Guidance 2021: • Cancelled elective caesarean sections; • Missed or delayed care; • Delayed or cancelled induction of labour; • Delay of 2 hours or more between admission for induction of labour and beginning of process; • Delay of 30 minute or more between presentation and triage.	**Gaps in assurance (What additional assurances should we seek?)** Incorporate Birthrate+ Cymru required staffing levels when available. To restructure the management SIP for robust management and governance including succession planning for management roles in line with RCM recommendations Evidence has shown midwifery led intrapartum services have high value from reduced intervention rates and improved satisfaction/experience as well as financial benefits as births in midwifery led intrapartum care has lower financial cost to obstetric unit births. SBU are reporting an increase in the caesarean section rates year on year. The ability to recruit graduate midwives to the commissioned numbers.

Additional Comments / Progress Notes

03/08/2022: Management Board has approved proposal to suspend home births until end Sept to support effective deployment of staff on open services.
Work being undertaken to maximise the centralisation of community services between Neath, Swansea and Port Talbot including a modified schedule of routine antenatal and postnatal care directed by RCOG/RCM recommendations to support better deployment of staff resource. Enhanced bank rate implemented until further notice and continued use of off contract agency midwifery staff. CHC have been formally informed of the suspension of home birth services.
12.08.2022 – Situation reviewed – Risk score increased to 25 following discussions with WG as we are still unable to resume home births or reopen the birth centre.
3 actions complete - Shortlist for band 6 midwifery vacancies following closure date. Fourth recruitment round to be initiated. Interview dates to be confirmed. SBAR to be prepared for vacancy panel to advertise for Band 5 midwives where band 6 recruitment cannot be achieved.
Updated 12.9.22 - Daily meetings still taking place. Risk score remains the same at 25.
A task & finish group has been established to review the current midwifery establishments and roster templates with Finance. Update - 4/10/22 - establishments reviewed and compared to BR+; paper sent to Mgt Board due to be presented 4th November. Action completed – Task and Finish group established.

14/10/2022 - 5 x Band 5 Midwives commenced induction in October 2022. Meeting held with Community Midwives 13.10.22 - action plan presented and agreed for rotation of midwives to community posts. ..... Band 6 have commenced in October 2022. Suspension of home birth and NPT Birth Centre remains in place with a fortnightly review. Centralised community midwifery service in place. Use of agency and bank midwifery staff approved by the Executive Team until end of January 2023. Rolling recruitment for midwives on TRAC.
Options for overseas recruitment being considered.
24/10/2022- Homebirth and FMU birth remain suspended. Six of thirteen commissioned graduate midwives able to commence employment immediately. Two actions complete – recruitment for Band 6 midwives. Recruitment for Band 8a Lead Midwife for Intrapartum Services.

Datix ID Number: 2554 **Health & Care Standard:** Standard 5.1 Timely Access	**HBR Ref Number: 82** **Target Date: 1st December 2023**	**Current Risk Rating** **4 x 4 = 16**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Richard Evans**,** Executive Medical Director **Assuring Committee**: Performance & Finance Committee **For Information**: Quality & Safety Committee, Workforce & OD Committee	
Risk: Risk of closure of Burns service if Burns Anaesthetic Consultant cover not sustained There is a risk that adequate Burns Consultant Anaesthetist cover will not be sustained, potentially resulting in closure to this regional service, harm to those patients would require access to it when closed and the associated reputational damage. This is caused by: • Significant reduction in Burns anaesthetic consultant numbers due to retirement and long-term sickness • Inability to recruit to substantive burns anaesthetic posts • The reliance on temporary cover by General intensive care consultants, and Consultants from the Morriston General on-call and Paediatric Anaesthesia rotas, to cover while building work is completed in order to co-locate the burns service on General ITU • Reliance on capital funding from Welsh Government to support the co-location of the service	**Date last reviewed:** October 2022	

Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 4 = 16 Target: 3 x 1 = 3	Oct-21, Nov-21, Dec-21, Jan-22, Feb-22, Mar-22, Apr-22, May-22, Jun-22, Jul-22, Aug-22, Sep-22 Risk Score: 25, 20, 20, 20, 20, 16, 16, 16, 16, 16 Target Score: 3, 3, 3, 3, 3, 3, 3, 3, 3, 3 — Target Score — Risk Score	**Rationale for current score:** This risk was increased due to closure of the Burns Unit due to staffing levels, and reduced from 25 to 20 having secured the agreement of the general ITU consultants to provide cross-cover while enabling capital works are completed. Propose reduce risk to 16 now and reduce to 12 when funding confirmed by WG.
Level of Control = **Date added to the HB risk register** December 2021		**Rationale for target score:** This is a small clinical service with staff with highly specialised skills. While a small service may always be vulnerable to challenges (eg staff) the intention will be to operate a more resilient clinical model that is supported by other clinical groups.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• The general ITU consultants, and some Consultants from the Morriston General and Paediatric Anaesthetists to support the Burns service on a temporary basis, supporting the remaining burns anaesthetic colleagues to provide cover for the Burns service. • The agreement reached is that they will cover the current Burns Unit on Tempest ward at Morriston hospital for 6-9 months while capital work is underway on general ITU to enable co-location of the service. • Capital works will be completed by mid-2023 to co-locate the burns patients within the GICU footprint. • WHSSC as commissioners of the service have been kept fully informed, as has the South West (UK) Regional Burns Network • Other UK burns units have ICU co-located with Burns ICU, removing the need for dual certified consultants	WG have agreed funding in principle for capital works to progress. Scoping document submitted to WG and discussions ongoing about expediting a decision on an outline/full business case.	Morriston Service Group	30th November 2022

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
Effect on patients of the temporary closure of the burns service in Swansea is mitigated by maintaining an urgent assessment/stabilisation service for patients in Wales with severe burns, with onward transfer for inpatient care to another unit in the UK following the initial assessment. The service reopened fully on 14/02/2022.	

Additional Comments / Progress Notes
31.03.22: The service reopened fully on 14/02/2022. Action completed - Securing the agreement of GITU consultants to cover pending completion of capital work. 13/05/22: Scoping document submitted to WG; meeting 17/05/22 to agree timescale for submission of business case. Risk score reviewed – interim arrangements working well; no concerns raised. Propose reduce risk to 16 now and reduce to 12 when funding confirmed by WG. 27.06.22 – Action complete: Submission of bid for capital funding to Welsh Government for both phases of work required. 11.08.22 – EMD has secured agreement for continued support of the Burns service by anaesthetics and critical care pending the completion of capital works. While there is willingness to provide that cover, staffing vulnerabilities remain in those clinical areas.

Datix ID Number: 3036
Health Care Standards: 4.1 Dignified Care, 2.1 Managing Risk & 7.1 Workforce

HBR Ref Number: 84
Target Date: 31st December 2022

Current Risk Rating
4 x 4 = 16

Objective: Best value outcomes

Director Lead: Richard Evans, Executive Medical Director
Assuring Committee: Quality & Safety Committee

Risk: Cardiac Surgery – A Getting It Right First Time review identified concerns in respect of cardiac surgery (including patient pathway/process issues) that present risks to ensuring optimal outcomes for all patients. Potential consequences include the outlier status of the health board in respect of quality metrics, including mortality following mitral valve surgery and aortovascular surgery. This has resulted in escalation of the service by WHSSC.

Date last reviewed: October 2022

Risk Rating
(consequence x likelihood):
Initial: 5 x 5 = 25
Current: 4 x 4 = 16
Target: 4 x 3 = 12

Level of Control
= %

Date added to the risk register
March 2022

Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22
Risk Score: 16 16 16 16 16 16 16
Target Score: 12 12 12 12 12 12 12
Target Score — Risk Score

Rationale for current score:
De-escalation of service by WHSSC from Stage 4 to Stage 3
Assurance of processes in place through implementation of the improvement plan.

Rationale for target score:
Cardiac surgery is frequently high-risk surgery and an element of risk will remain.

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

- Invited Service Review by Royal College of Surgeons to advise on outcomes, good practice and areas for improvement;
- Implementation of local action plan to address areas of concern; widespread engagement among clinicians in the department.
- All surgery is now only undertaken by consultants and mitral valve repair surgery is undertaken by two mitral valve specialists; a third consultant undertakes mitral valve replacements as agreed with WHSSC.
- Complex heart valve MDT established to make decisions on appropriate surgery including MV repair and MV replacement and to direct to the appropriate consultant.
- Internal review of deaths following mitral valve surgery.
- High Risk MDT implemented, outcome decision documented on Solus.
- Dual surgeon operating mandated for complex cases (determined by the MDT) to improve outcomes.
- MDT discussion to be undertaken for all patients who develop deep sternal wound infections.
- Quality & Outcomes database established capture case outcome metrics in real time.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Develop actions for improvement as advised by RCS	Executive Medical Director	31st January 2023

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

- An improvement plan has been developed in conjunction with WHSSC and agreed. Progress is monitored by Gold Command arrangements.
- Quality & Outcomes database established capture case outcome metrics..

Gaps in assurance (What additional assurances should we seek?)
Assurance sought via RCS Invited Review on outcomes and governance in the department

Additional Comments / Progress Notes
WHSSC have de-escalated the service to Stage 3 following an agreed pathway for aorta-vascular cases. Update 14/04/22 - The Royal College of Surgeons undertook a review of the service in March 2022; formal report anticipated in 8-10 weeks' time. Action completed - Commission an Invited Review of Service with support from Royal College of Surgeons. Update 11/05/22: The Royal College of Surgeons undertook a review of the service in March 2022. Interim letter received with feedback; formal report anticipated in 6-8 weeks' time. Update 20/06/22 - Weekly meetings occur for the project leads, Fortnightly meeting occur at a Silver level with service manager, head of nursing, Clinical director and unit medical director to monitor progress. Monthly Exec led meetings are held with the executive medical director, these meetings monitor governance and risk associated with the delivery of the recommendations, to ensure that processes and safety concerns are discussed and any changes made are sustainable for the future of the service. All progress is fed back to Welsh Health Specialised Services Committee. A further review process is now underway via RCS Action plan any outstanding actions will be reviewed via the RCS action Plan. 01/07/22 – Action complete: Implementation of local improvement plan targeting areas of concern and implementing actions to reduce variation. 11/08/22 – Additional visit from RCS to review an individual surgeon's outcomes. Verbal feedback received with no immediate patient safety concerns. Report from site visit still awaited. Regular escalation meetings with WHSSC note continued improvement is systems and processes in the service.

<table>
<tr><td colspan="2">Datix ID Number: 2561
Health & Care Standard: Effective Care 3.1 Safe & Clinically Effective Care</td><td>HBR Ref Number: 85
Target Date: 30th September 2022</td><td colspan="2">Current Risk Rating
4 x 5 = 20</td></tr>
<tr><td colspan="2">Objective: Best value outcomes</td><td colspan="3">Director Lead: Christine Morrell, Director of Therapies & Health Sciences
Assuring Committee: Quality & Safety Committee</td></tr>
<tr><td colspan="2" rowspan="2">Risk: Non-Compliance with ALNET Act
There are risks to the Health Board's ability to meet its statutory duties and establish the effective collaborative arrangements required by the ALN Act, which is being implemented through a phased approach.
This risk is caused by:
Lack of staff resource needed to carry out the additional work needed to comply with the ALN Act for operational services, especially those in the PCST Service Group. The size of the gap in terms of staff resource is now better understood.
Issues around multi-agency working which may impact on levels of demand on operational services, and on existing SLAs through which the Health Board delivers some services to partner LAs.
Implementation of the Act for those of above compulsory school age (post-16) commences in September 2023, though transition planning will commence from September 2023. Significant preparedness work is required to mitigate the risks this will present.
Multiple pressures for operational services are impacting on capacity / engagement of leads within impacted services to progress tasks that need to be undertaken to mitigate the risks.
Potential consequences of this risk are: parent / carer and young peoples' dissatisfaction leading to complaints, Educational Tribunals and Judicial Reviews (this is new legislation with many points of ambiguity and is highly likely to be legally 'tested'); reputational impact; and children failing to access the multi-agency support that they need with their learning needs, leading to poor outcomes.</td><td colspan="3">Date last reviewed: October 2022</td></tr>
<tr><td colspan="3">Rationale for current score:
Risk score reflects that while controls are in place, there are multiple areas of risks (relating to compliance with legislation; governance and assurance; workforce and OD; and sustainable services); and high probability (especially given multiple risk areas) of at least one of these areas of risk being realised. Caused by implementation timetable for the ALN Act, slippage against plan and need for strengthened governance (as described in 'Risk' section).</td></tr>
<tr><td>Risk Rating
(consequence x likelihood):
Initial: 5 x 5 = 25
Current: 4 x 5 = 20
Target: 2 x 3 = 6</td><td rowspan="3">Risk Score: 20 20 20 20 20
Target Score: 6 6 6 6 6
Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22
Target Score, Risk Score</td><td colspan="3" rowspan="3">Rationale for target score:
As the ALN Act is new legislation, there remains some ongoing likelihood of risk events during the initial phases of implementation, though with lessened consequences as a result of mitigating actions.</td></tr>
<tr><td>Level of Control
=</td></tr>
<tr><td>Date added to the HB risk register
14/05/2022</td></tr>
<tr><td colspan="2" rowspan="2">Controls (What are we currently doing about the risk?)</td><td colspan="3">Mitigating actions (What more should we do?)</td></tr>
<tr><td>Action</td><td>Lead</td><td>Deadline</td></tr>
</table>

- Progressing the necessary work within an appropriate structure (see under 'ACTIONS') are constrained by financial and/or service delivery pressures.
- DECLO (Designated Educational Clinical Lead Officer) is in post - this is a statutory requirement.
- Health Board ALN Steering Group has been established, with structure agreed for Operational Group working under the governance of this
- Work is being progressed with Local Authority partners to ensure that activity relating to the ALN Act is grounded in a shared vision and principles to support collaborative working.
- Initial operational processes relating to statutory processes (through which Local Authorities access Health Board involvement) have been established and are in effect and work is being progressed with partners to refine operational approach.
- Advice has been received from WG to resolve key areas of particular ambiguity relating to Health Board duties under the Act.
- Regarding demand / capacity and staffing resource challenges, WG has a phased implementation timetable for the Act for the period through to summer 2024. From summer 2024, the Act will be fully in 'delivery as usual'. The phased implementation offers partial short-term mitigation of the risks.
- Awareness has been raised at Board level through Development session and thrice-yearly updates are provided to the Quality and Safety Committee.
- A multi-agency group supported by the national ALN post-16 Implementation Lead has been formed to progress key activity in relation to post-16 implementation.

Action	Lead	Date
Work with LA partners to be progressed to establish and implement a prudent, longer-term operational model through which statutory referrals / requests to the Health Board will be made.	DECLO	31/10/2022
Finalise ALN workplan to be progressed by the ALN Operational Group, including allocation of leads to individual workstreams and have plan approved through ALN Steering Group.	DECLO	09/12/2022
Work with Performance colleagues to ensure greater visibility in Performance and Q&S dashboards of data relating to compliance with statutory duties	DECLO	30/11/2022
Work with Informatics colleagues to ensure robust data regarding compliance with statutory duties	DECLO	30/11/2022
Work with LA colleagues to establish future SLA arrangements for Paediatric Therapies services and to establish the impact of any changes on the Health Board	Interim Head of Speech & Language	30/12/2022
Discussion in Steering Group to explore solutions to ongoing capacity / engagement issues that are slowing progress on tasks needed to mitigate risks.	DoTHS	09/12/2022

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

- There is regular reporting in respect of the ALN Act through the Quality and Safety Committee.
- ALN Steering Board has been established, ensuring oversight at a senior level within all impacted operational and corporate areas
- DECLO meets regularly with ADOTHS / DoTHS of the 3 health boards of South-West and Mid Wales for update and assurance.
- National ALN Reform Steering Group has been formed and will include Health representation (SBU Deputy DOTHS). This will provide a national forum for consideration of risks.

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

- Extent of gap in staffing resource (gap between work required and capacity available) has been provisionally quantified, but data is imperfect and there remains some uncertainty. This is in a context where demands will increase significantly over the next year.

Additional Comments / Progress Notes

13.09.2022 – good progress is being made on work to improve operational processes. It is anticipated that thi will be completed and in implementation within 1 month. An externally-facilitated workshop to establish a shared vision and identifty priorities for collaboration has been held (action closed) and next steps are being agreed with partners. The ALN Operational Group is making good progress on finalising the workplan, with leads having been identified for most areas, including for post-16 work, which has been identified as a key area of risk. Work with Performance and Informatics colleagues to address data quality issues and improve the visibility of key ALN data is being progressed. Start date for ALN Project Manager confirmed (20.09.2022). Action closed - Externally-facilitated work with LA partners to ensure that operational activity and discussions are grounded in a shared vision for collaborative working under the ALN Act, with a workplan to support this.

21.10.22 – The ALN workplan has been developed but has not yet been formally approved by the ALN Steering Group, whose last meeting was cancelled as non-quorate. Actions within the

'working draft' workplan have are not consistently being progressed at the required pace by ALN Operational Group members. Both issues reflect the pressure that staff from operational services are experiencing, which is directly impacting on the capacity / engagement of staff to engage in work that is needed to mitigate the ALN risks. This issue will be addressed directly in the next meeting of the ALN Steering Group, scheduled for 2nd December. Work to finalise revised operational processes remains incomplete but is on track for completion this month. Action regarding ALN and 'dashboards' is in progress but not on track for deadline, which has been adjusted accordingly. The ALN Project Manager has now commenced in post, meaning there is additional support available to progress the ALN workplan. Target date for risk has been changed to July 2023 as major change in the risk status before this date is not realistic.

Datix ID Number: 3052 Health & Care Standard: Effective Care 3.1 Safer & Clinically Effective Care		HBR Ref Number: 86 Target Date: 31st March 2023	Current Risk Rating 5 x 4 = 20	
Objective: Best Value Outcomes from Quality Care		**Director Lead:** Matt John, Director of Digital **Assuring Committee:** Audit Committee		
Risk: Extended outages of locally hosted systems due to failure of the Health Board's Storage Area Network (SAN) which would impact delivery of clinical and non clinical services. The SAN and Virtual Server Infrastructure is approaching end of life (January 2023). The infrastructure delivers the majority >90% of locally hosted systems in SBU. A major failure would impact the whole of the organisation and would impact on patient care. Capital funding of £1.5m is required to replace the SAN and is not included in the 22/23 Health Board Capital plan. The option of a 2 year extended warranty usually offered by the supplier has been withdrawn and is no longer available to the Health Board. Furthermore the reduction in capital funding available to WG in 22/23 reduces the availability of slippage monies available at a national level in 22/23.		**Date last reviewed:** October 2022		
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 5 x 2 = 10	20 20 20 10 10 10 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Target Score Risk Score	**Rationale for current score:** C – A major failure could result in extended outages of key systems including SIGNAL, SBU Clinical Portal, E-Prescribing, TOMs, RADIS, DMS etc. This impact would affect SBU, Hywel Dda and CTM. L - Given the age of equipment, component failures are expected and it is essential that these are replaced in a timely manner. Disk failures occur on average every 5 weeks which are currently covered by a 4 hour response by Dell.		
Level of Control = 70% **Date added to the HB risk register** July 2022		**Rationale for target score:** C- will remain the same due to the significance of the services delivered via the SAN L- Supported in Warranty equipment will be proactively managed and replaced by the supplier to reduce the likelihood of failure and ensure impact of failures are minimised due to appropriate response times.		
Controls (What are we currently doing about the risk?)		**Mitigating actions (What more should we do?)**		
• Currently the equipment is within warranty and is fully supported by the supplier until January 2023 • The issue has been raised as part of the Capital Prioritisation Group process and identified as a priority for any slippage capital that becomes available • Capital Finance have been engaged and made aware of the issue • Discussions have been held with the current supplier to look at options for provision of the SAN going forward.		**Action**	**Lead**	**Deadline**
		Options paper to be developed, to include alternative financing models for SAN replacement, to be presented to the Capital Management Group and Management Board for	Assistant Director of Digital Operations	31/10/2022

	consideration		
	Procure the approved option	Assistant Director of Digital Operations	31/01/2023

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
An appropriately supported SAN would be in place. Performance of SBU digital solutions is monitored and managed through the HBs Digital Services Management Group, including the review of digital outages and major incidents, on a quarterly basis. Capital priorities/plans are managed/risk assessed through the Capital Management Group and the Capital Prioritisation Group with appropriate representation and information provided from Digital Services.	Capital funding routes with WG for large scale Digital infrastructure replacement are not clear since the introduction of DPIF. Changes in supplier policies with regards to extended warranties are not accounted for in current procurement processes.

Additional Comments
Reviewed at the Information Risk Meeting on the 21/06/2022 and request for escalation to HBRR approved. 20/09/2022 – Risk reviewed and no further updates.

Datix ID Number: 3110 Health Care Standards: 4.1 Dignified Care, 2.1 Managing Risk & 7.1 Workforce		HBR Ref Number: 88 Target Risk Date: 31/12/2022	Current Risk Rating 4 x 5 = 20
Objective: Best value outcomes		**Director Lead:** Inese Robotham, Chief Operating Officer **Assuring Committee:** Performance & Finance Committee **For Information:** Quality & Safety Committee	
Risk: Non-delivery of AMSR programme benefits There is a risk that the Acute Medical Service Re-Design (AMSR) programme may not deliver the expected performance & financial benefits in a timely way. The principal potential causes of this risk are: workforce (OCP and recruitment requirements), capacity constraints linked to significant number of clinically optimised patients (COP), financial affordability linked to 90 beds in Singleton hospital that are due to close in Q3 2023.		**Date last reviewed:** October 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 4 = 16	Chart: Oct-21, Nov-21, Dec-21, Jan-22, Feb-22, Mar-22, Apr-22, May-22, Jun-22, Jul-22, Aug-22, Sep-22; Risk Score: 20, 20, 20; Target Score: 16, 16, 16	**Rationale for current score:** Current score reflects the size and complexity of the programme. Whilst there are substantial mitigations in place, the residual risk remains high.	
Level of Control = %		**Rationale for target score:** When measures identified are implemented it is anticipated that this will increase the likelihood of success.	
Date added to the risk register July 2022			

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• AMSR Programme Board reporting to UEC (Urgent & Emergency Care) Board • Dedicated workstreams & workstream leads – all work streams have weekly assurance meetings where the sub groups provide updates on their specific tasks ○ OCP (Organisational Change Policy) workstream – supporting staff engagement ○ Workforce workstream – Focus on recruitment & retention. Dedicated sub groups with recruitment trackers and action plans.	The costs of service transfer will be met through transformation of out of hospital pathways. Should savings not be fully identified, by December 2022, there will be an increased CIP commitment in 2023/24. Review to be undertaken in December 2022.	Project Director	31/12/2022

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AMU (Acute Medical Unit) model workstream - focus on development of the operating policy for the AMU, including the interaction with the admitting units, WAST and specialist wards. Triage process has been agreed – system same as Emergency Department. Draft Standard Operating Procedure (SOP) created.
SDEC (Same Day Emergency Care) collaborative workstream – focus on further development of SDEC model. SOP developed, focusing on hospital pre admission, data sessions to assist with finalising pathways.
Specialist wards workstream – focus on role & operating model of specialist wards and interfaces. Agreement on patient criteria with preference of sub-acute /round rounds for singleton wards/ SOP template for all wards. Future – dedicated sub group on Discharge and flow hosting a work shop to standardise process across the health board & internal flow from Morriston to Singleton and Neath.
Estates workstream focus on capital work.

Communications – Project team have employed Freshwater to assist with communications for the programme. Focusing on shop floor communication across all hospitals with use of storyboards and TV screens providing updates at main entrances.
Governance arrangements agreed for go / no go gateways via management board
Assurance to Performance & Finance Committee (PFC) and (Quality & Safety Committee (QSC) and escalation to Health Board if required.

</td>
<td>A go/no go gateway for AMSR is scheduled for 16th November 2022.</td>
<td>COO</td>
<td>16/11/2022</td>
</tr>
<tr>
<td>Assurances (How do we know if the things we are doing are having an impact?)
Regular gateway reviews via Management Board
Assurance to PFC and QSC and escalation to Health Board if required.</td>
<td colspan="3">Gaps in assurance (What additional assurances should we seek?)
Capacity and capability gaps to support the programme and drive forward actions and provide adequate assurance. Operational site pressures impacting on AMSR programme deliverables. Lack of progress in reducing bed occupancy for medicine patients.</td>
</tr>
<tr>
<td colspan="4">Additional Comments / Progress Notes
01/08/2022: OCP commenced 13/06/2022 and concluded on 29/07/2022. Feedback is being collated. Programme on reducing clinically optimised patients is being scoped by the Project Director. Estates works progressing to plan.
22/08/22: As per risk HBR80 - Due to unforeseen need for leave of Project Director, the previously identified action (Targeted programme for reduction of COP focussing on improved operational efficiency (reduced length of stay improved discharge processes), implementation of Discharge-to-Assess and effective utilization of existing community capacity, strategic partnership solutions with Local Authority partners. Programme Plan to be presented at September 2022 Management Board.) has been closed and alternative arrangements put in place: The PCT Service Group Nurse Director has put in place a governance structure – Two groups will be established – the PCT Nurse Director will chair one focusing on patients with longest stays; the PCT Head of Nursing will chair the group reviewing patients who are experiencing delays in discharge processes (eg waits for therapies).
21/09/2022: Project is planning the implementation phase. Two main risks remain: Workforce and Capacity. Workforce risk is managed through a dedicated workstream looking at both local and international recruitment. See HBR1 in respect of LOS & capacity. 4 Actions completed - Workforce plan to be presented at the Management Board in September. Robust OCP process; consultation end date was 29/07/2022. Targeted programme for reduction of COP focussing on improved operational efficiency (reduced length of stay improved discharge processes), implementation of Discharge-to-Assess and effective utilization of existing community capacity, strategic partnership solutions with Local Authority partners. Two focused groups established to look at different categories of COPs and provide senior oversight. 24/10/2022: A go/no go gateway for AMSR is scheduled on 16th November 2022.</td>
</tr>
</table>

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