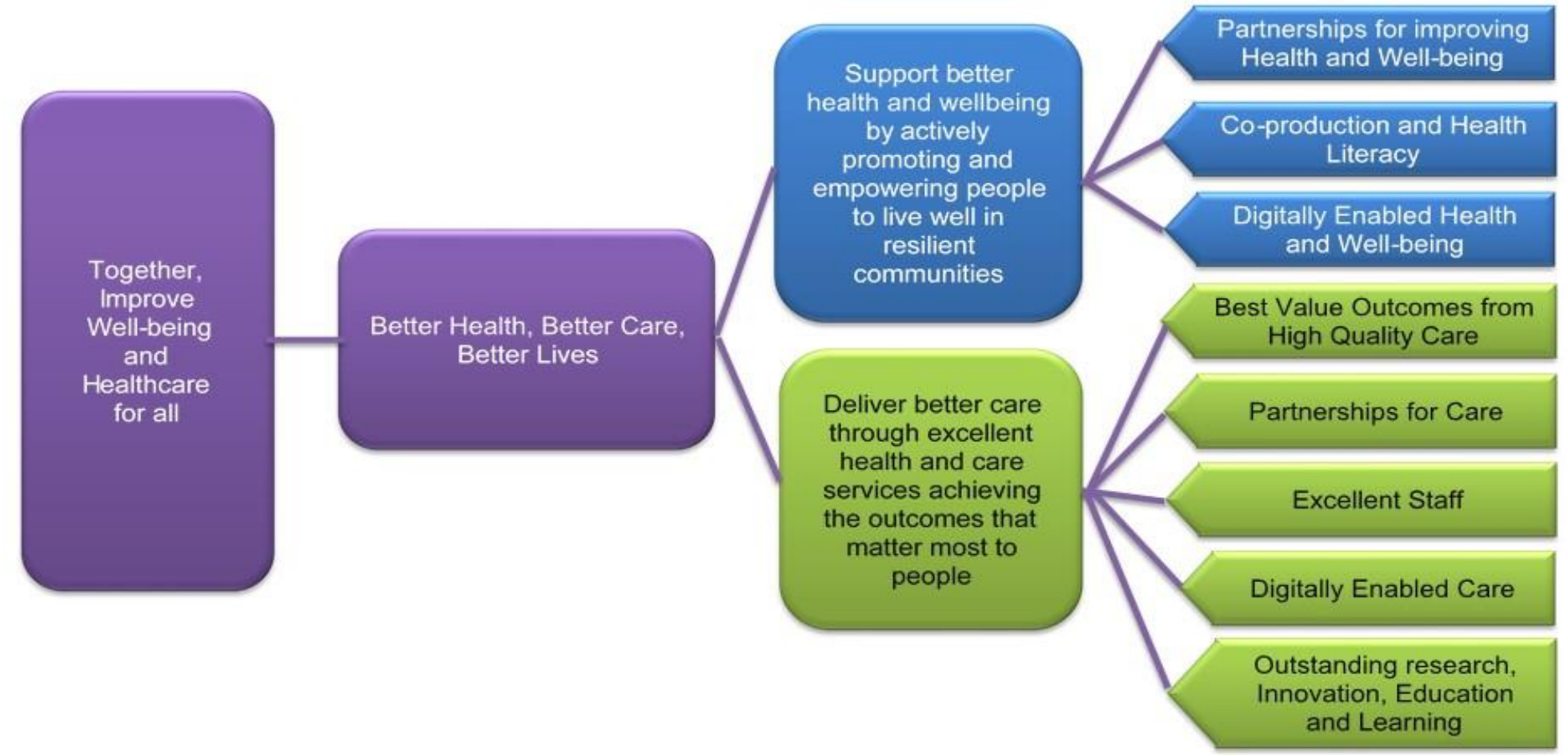
HEALTH BOARD RISK REGISTER
JUNE 2021

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

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



HEALTH BOARD RISK REGISTER
DASHBOARD OF ASSESSED RISKS – June 2021

Impact/Consequences						
	5			**53:** Compliance with Welsh Language Standards **79**: Finance Recovery of Access Times **NEW**	**15:** Population Health Improvement – **Risk Closed** **51:** Compliance with Nurse Staffing Levels (Wales) Act 2016 **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. **60:** Cyber Security **69:** Adolescents being admitted to Adult MH wards **74:** Induction of Labour (IOL) **NEW** **75:** Whole Service Closure **NEW** **76:** Partnership Working **NEW**	**16:** Access to Planned Care **50:** Access to Cancer Services **64:** H&S Infrastructure **66:** Access to Cancer Services - SACT **67:** Access to Cancer Services - Radiotherapy **77:** Workforce Resilience **NEW**
	4			**13:** Environment of Health Board Premises **37:** Operational and strategic decisions are not data informed **49:** TAVI Service **52**: Engagement & Impact Assessment Requirements **54:** No Deal Brexit **78**: Nosocomial **NEW**	**01:** Access to Unscheduled Care Service **27:** Sustainable Clinical Services for Digital Transformation **36:** Electronic Patient Record **39:** IMTP Statutory Responsibility **41:** Fire Safety Regulation Compliance **43:** DOLS Authorisation and Compliance with Legislation **48:** Child & Adolescence Mental Health Services **57:** Non-compliance with Home Office Controlled Drug Licensing requirements **61:** Paediatric Dental GA Service – Parkway	**03:** Workforce Recruitment of Medical and Dental Staff **04:** Infection Control **58:** Ophthalmology Clinic Capacity **63:** Screening for Fetal Growth Assessment in line with Gap-Grow (G&G) **65:** CTG Monitoring in Labour Wards **68:** Pandemic Framework **70:** Data Centre outages **80:** Inability to Transfer Patients **NEW**
	3					
	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** Failure to comply with Tier 1 target for Unscheduled Care could impact on patient and family experience of care.	20	16	→	→	June 2021	Performance and Finance Committee
	4 (739)	**Infection Control** Failure to achieve infection control targets set by Welsh Government could impact on patient and family experience of care.	20	20	→	→	June 2021	Quality and Safety Committee
	13 (841)	**Environment of HB Premises** Failure to meet statutory health and safety requirements.	16	12	→	→	June 2021	Health and Safety Committee
	16 (840)	**Access to Planned Care** Failure to achieve compliance with waiting times, there is a risk that patients may come to harm. Also, financial risk not achieving targets.	16	25	→	→	June 2021	Performance and Finance Committee
	37 (1217)	**Information Led Decisions** Operational and strategic decisions are not data informed.	16	12	→	→	June 2021	Audit Committee
	39 (1297)	**Approved IMTP – Statutory Compliance** Failure to have an approvable IMTP for 2022/23 then we will lose public confidence and breach legislation.	16	16	↓	→	June 2021	Performance and Finance Committee

[1] This trend reflects the change since the publication of Apr 2021 HBRR that was received by the Management Board and Audit Committee in May 2021.

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	41 (1567)	**Fire Safety Compliance** Fire Safety notice received from the Fire Authority – MH&LD Unit. Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance.re safety regulations.	15	16	↓	→	June 2021	Health and Safety Committee
	43 (1514)	**DoLS** If the Health Board is unable to complete timely completion of DoLS Authorisation, then the Health Board will be in breach of legislation and claims may be received in this respect.	16	16	→	→	June 2021	Quality and Safety Committee
	48 (1563)	**CAMHS** Failure to sustain Child and Adolescent Mental Health Services (CAHMS).	16	16	→	→	June 2021	Performance and Finance Committee
	49 (922)	**Trans-catheter Aortic Valve Implementation (TAVI)** Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI)	25	12	↓	→	June 2021	Quality and Safety Committee
	50 (1761)	**Access to Cancer Services** Failure to sustain services as currently configured to meet cancer targets could impact on patient and family experience of care.	20	25	→	→	June 2021	Performance and Finance Committee
	57 (1799)	**Controlled Drugs** Non-compliance with Home Office Controlled Drug Licensing requirements.	20	16	→	→	June 2021	Audit Committee
	63 (1605)	**Screening for Fetal Growth Assessment in line with Gap-Grow** Due to the scanning capacity there are significant challenges in achieving this standard.	12	20	→	→	June 2021	Quality and Safety Committee

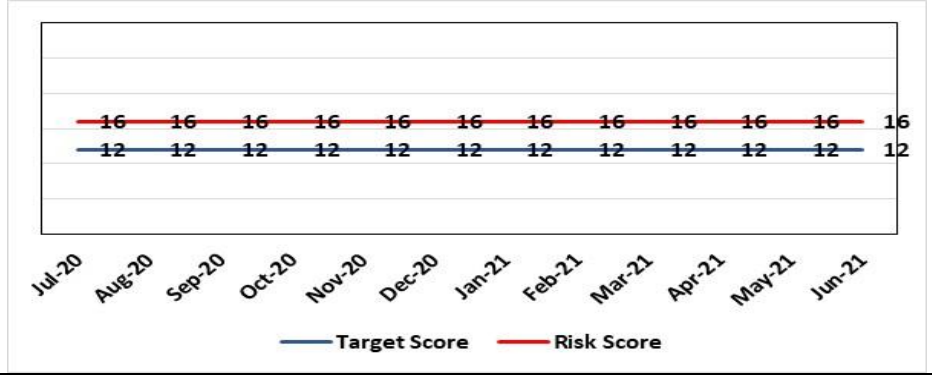
Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	64 (2159)	**Health and Safety Infrastructure** Insufficient resource and capacity of the health, safety and fire function to maintain legislative and regulatory compliance.	20	25	→	→	June 2021	Health and Safety Committee
	66 (1834)	**Access to Cancer Services** Delays in access to SACT treatment in Chemotherapy Day Unit	25	25	→	→	June 2021	Quality and Safety Committee
	67 (89)	**Risk target breaches – Radiotherapy** Clinical risk – Target breeches of radical radiotherapy treatment	16	25	→	→	June 2021	Quality and Safety Committee
	69 (1418)	**Safeguarding** Adolescents being admitted to adult MH wards	20	20	→	→	June 2021	Quality & Safety Committee
	73 (2450)	**Finance** There is a potential for a residual cost base increase post COVID-19 as a result of changes to service delivery models and ways of working.	20	20	→	→	June 2021	Performance and Finance Committee
	74 (2595)	**Induction of Labour (IOL)** Delay in IOL or augmentation of Labour **NEW**	20	20	New	New	June 2021	Quality and Safety 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. **NEW**	20	20	From Covid-19 Register	From Covid-19 Register	June 2021	Performance and 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. **NEW**	20	12	From Covid-19 Register	From Covid-19 Register	June 2021	Quality and Safety Committee

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	79 (2739)	**Finance - Recovery of Access Times** Potential risk that resource available is below the ambition of the board to provide improved access. **NEW**	15	15	New	New	June 2021	Performance and Finance Committee
	80 (1832)	**Inability to Transfer Patients** Avoidable harm as a result of inability to transfer patients out of Morriston Hospital including medically fit patients. **NEW**	20	20	New	New	June 2021	Quality & Safety Committee
Excellent Staff	3 (843)	**Workforce Recruitment** Failure to recruit medical & dental staff	20	20	➔	➔	June 2021	Workforce and OD Committee
	51 (1759)	**Nurse Staffing (Wales) Act** Risk of Non Compliance with the Nurse Staffing (Wales) Act	16	20	➔	➔	June 2021	Workforce and OD Committee
	76 (2377)	**Partnership Working** There are growing tensions between the Health Board and some trade union partners within SBUHB particularly in response to the supply of PPE which has the potential to create unrest in the workforce and hamper an effective response to COVID-19. **NEW**	25	20	From Covid-19 Register	From Covid-19 Register	June 2021	Workforce and OD Committee
	77 (2569)	**Workforce Resilience** Culmination of the pressure and impact on staff wellbeing - both physical and mental relating to Covid Pandemic. **NEW**	25	25	From Covid-19 Register	From Covid-19 Register	June 2021	Workforce and OD Committee
Digitally Enabled Care	27 (1035)	**Sustained Clinical Services** Inability to deliver sustainable clinical services due to lack of digital transformation.	16	16	➔	➔	June 2021	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	→	→	June 2021	Audit Committee
	60 (2003)	**Cyber Security – High level risk** The level of cyber security incidents is at an unprecedented level and health is a known target.	20	20	→	→	June 2021	Audit Committee
	65 (329)	**CTG Monitoring on Labour Wards** Risk associated with misinterpreting abnormal CTG readings in delivery rooms.	16	20	→	→	June 2021	Quality & Safety Committee
	70 (2245)	**National Data Centre Outages** The failure of national systems causes severe disruption across NHS Wales, affecting Primary and secondary care services.	20	20	→	→	June 2021	Audit Committee
Partnerships for Improving Health and Wellbeing	15 (737)	**Population Health Targets – Closed as new risk to be raised** Failure to achieve population health improvement targets leading to an increase in preventable disease amongst the population resulting in increased morbidity impacting on operational and financial pressures. **Schedule removed**	15	20	→	→	June 2021	Quality and Safety Committee
	58 (146)	**Ophthalmology - Excellent Patient Outcomes** There is a failure to provide adequate clinic capacity to support follow-up patients within the Ophthalmology specialty.	12	20	→	→	June 2021	Quality and Safety Committee

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	61 (1587)	**Paediatric Dental GA Service – Parkway** Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morriston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies.	15	16	➔	➔	June 2021	Quality and Safety Committee
	68 (2299)	**Pandemic Framework** Risk of declared pandemic due to Coronavirus Infectious Disease outbreak 2020.	20	20	➔	➔	June 2021	Quality and Safety Committee
Partnerships for Care	52 (1763)	**Statutory Compliance** The Health Board does not have sufficient resource in place to undertake engagement & impact assess in line with Statutory Duties	16	12	➔	➔	June 2021	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	➔	➔	June 2021	Health Board (Welsh Language Group)
	54 (1724)	**Brexit** Failure to maintain services as a result of the potential no deal Brexit	20	12	➔	➔	June 2021	Health Board (Emergency Preparedness Resilience and Response Group)

Risk Schedules

<table>
<tr><td colspan="2">Datix ID Number: 738
Health & Care Standard: 5.1 Timely Care</td><td>HBR Ref Number: 1
Target Date: 31st March 2022</td><td>Current Risk Rating
4 x 4 = 16</td></tr>
<tr><td colspan="2">Objective: Best Value Outcomes from High Quality Care</td><td colspan="2">Director Lead: Rab McEwan, Chief Operating Officer
Assuring Committee: Performance and Finance Committee</td></tr>
<tr><td colspan="2">Risk: If we fail to comply with Tier 1 target – Access to Unscheduled Care then this will have an impact on patient and family experience. Challenges with capacity /staffing across the Health and Social care sectors.</td><td colspan="2">Date last reviewed: Prepared for Management Board – July 2021</td></tr>
<tr><td>Risk Rating
(consequence x likelihood):
Initial: 4 x 5 = 20
Current: 4 x 4 = 16
Target: 3 x 4 =12</td><td rowspan="3"> 
</td><td colspan="2" rowspan="2">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.</td></tr>
<tr><td>Level of Control
= 50%</td></tr>
<tr><td>Date added to the HB risk register
26.01.16</td><td colspan="2">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.</td></tr>
<tr><td colspan="2">Controls (What are we currently doing about the risk?)</td><td colspan="2">Mitigating actions (What more should we do?)</td></tr>
<tr><td colspan="2">• 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.</td><td colspan="2"><table>
<tr><th>Action</th><th>Lead</th><th>Deadline</th></tr>
<tr><td>Implementation of Phone First for ED as one the initiatives set out in the National Unscheduled Care Programme – six goals.</td><td>Chief Operating Officer</td><td>31st October 2021</td></tr>
<tr><td>Phased implementation of the Acute Medical Services Redesign. Business case for ambulatory care element of service redesign submitted WG.</td><td>Chief Operating Officer</td><td>31st October 2021</td></tr>
</table></td></tr>
<tr><td colspan="2">Assurances
(How do we know if the things we are doing are having an impact?)
• New Urgent & Emergency Care Board to meet monthly</td><td colspan="2">Gaps in assurance
(What additional assurances should we seek?)
The need to deliver sustained service.</td></tr>
<tr><td colspan="4">Additional Comments
Risk transferred to Urgent & Emergency Care Board to task 11.05.2021.</td></tr>
</table>

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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• 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.	**Action**	**Lead**	**Deadline**
	Medical training initiatives pursued in a number of specialties to ease junior doctor recruitment	Interim Director W&OD.	31st March 2022
	The Medical Workforce Board continues to monitor recruitment and junior doctor's rotas.	Interim Director W&OD.	31st March 2022
	Continue to recruit internationally.	Interim Director W&OD.	31st March 2022

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance** **(What additional assurances should we seek?)**
• General situation monitored through W&OD Committee • Communication with Deanery • Recruitment campaigns • Monitoring by Executive Teams and specialty based local workforce boards	Locum cover Adequate supply of doctors who can work in this country Ability to flexibly deploy doctors in training.

Additional Comments

Risk covers all hospitals and multiple specialties. Participated in BAPIO rounds. Working with Medacs to replace long term locums. Invest to Save Bid for international overseas recruitment for nursing to upscale for 20/21. Recruitment remains a challenge but is also a national problem. During the pandemic we are still recruiting staff from overseas but have had to provide hotel accommodation for them to quarantine. Supply issues to the COVID areas have used doctors from other specialties where demand is currently low. We are over established locum posts in medicine, ITU and Anaesthetics. International medical recruitment - In progress but this has been delayed due to Covid. New approaches from Spring 21 onwards.

Datix ID Number: 739 **Health & Care Standard: 2.4 Infection Prevention & Control & Decontamination**		**HBR Ref Number: 4** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Christine Williams, Interim Director of Nursing & Patient Experience **Assuring Committee:** Quality and Safety Committee	
Risk: Failure to achieve Welsh Government infection reduction goals, and a higher incidence of Tier 1 infections than average for NHS Wales. Risk of nosocomial transmission of infection.		**Date last reviewed:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 =12		**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. Varying levels of IPC responsibility embedded across all disciplines and groups. Incomplete systems for recording compliance with IPC training for all staff groups. Need improved systems to allow Delivery Groups to review compliance reports for cleanliness scores, ventilation validation/compliance, water safety, and decontamination.	
Level of Control = 40%			
Date added to the HB risk register January 2016		**Rationale for target score:** 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 Quality Improvement programmes, drive improvement, & effectively measure outcomes.	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Policies, procedures, protocols and guidelines supplement the National Infection Control Manual. • Seven-day infection prevention & control service provides advice and support HB staff. • Medical microbiology & infectious diseases team provides expertise and support. • Infection Prevention & Control related training provided programmes. • Surveillance of infections, with early identification of increased incidence, and instigation of controls. • Provision of cleaning service to meet National Standards of Cleanliness. • Engineering controls for water safety, ventilation, and decontamination.	**Action**	**Lead**	**Deadline**
	Ensure maintained, clean and safe patient care environments, equipment/devices.	Facilities, Support Services & Service Group Directors	31st March 2022
	Review feasibility of increasing single room capacity.	SGD, Operational Services & Patient Flow	31st March 2022
	Reduce bed occupancy & patient moves.	SGD, Operational Services & Patient Flow	31st March 2022
	Use timely data to drive QI programmes.	HoN IPC, Digital Intelligence & SGD	31st March 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?)**
• Clear Corporate and Service Group IPC Assurance Framework in place. • Ongoing monitoring of infection control rates, with weekly feedback corporately & to Service Groups.	Review single room capacity. Poor condition of hospital estate requires investment. High activity limits access for planned preventative maintenance and necessary HTM validation/compliance checks. Seek improved Corporate and Service Group

• Infection Control Committee receives assurance reports, monitors infection rates, and identifies key actions to drive improvement. • Training compliance. • IPC, antimicrobial, decontamination and cleaning audit programmes. • Compliance and validation systems for water safety, ventilation systems and decontamination.	oversight of compliance with ventilation, water safety, decontamination & cleaning checks. Challenge to sustain cleaning workforce to achieve National Minimum Standards of Cleanliness. Review plans to reduce bed occupancy rates and patient multi-ward moves. Investment in ESR Self-service to provide data on IPC-related training compliance. Investment in digital intelligence systems to provide Board to Ward oversight of infection, antimicrobial, cleanliness, and training data.

Additional Comments

17/05/21 - The Health Board continues to have amongst the highest incidence of the Tier 1 infections in Wales. When improvements have been achieved, it has been challenging to sustain these improvements.

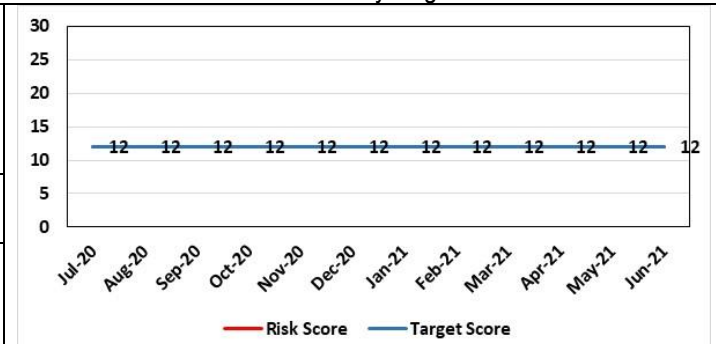
Clinical teams require renewed focus on:

• Antimicrobial stewardship - prudent use of broad-spectrum antibiotics; compliance with 72 hour review; reduction in overall use.

• prudent use of, and monitoring of continued need for, invasive devices, including evidence of compliance with insertion & maintenance bundles.

This risk has been reviewed and revised post-COVID, and has taken into account 2020/21 Tier 1 HCAI performance. Improvement will require IPC-related quality priorities to be integrated into crosscutting service plans.

Register content has been refreshed substantially by the Head of Nursing (Infection, Prevention & Control).

Datix ID Number: 841 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**		**HBR Ref Number: 13** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 3 = 12**
Objective: Best Value Outcomes		**Director Lead:** Rab McEwan, Chief Operating Officer/Sian Harrop-Griffiths, Director of Strategy **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:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 =12 Target: 4 x 3 = 12		**Rationale for current score:** HSE issued ten improvement notices in 2012 relating to accommodations not meeting statutory/health and safety requirements. This could have an adverse impact on citizens, staff, financial and operational performance.	
Level of Control = 90%		**Rationale for target score:** Risk assessments of premises.	
Date added to the HB risk register April 2012			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• 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 4 acute hospital sites. • Primary Care premises, audits commissioned and delayed due to covid.	**Action**	**Lead**	**Deadline**
	Develop a strategy to improve primary & community services estate.	Service Group Director P&C	31st July 2021
	Develop BJC's to improve the infrastructure of the 3 acute hospital sites (not including NPTH).	Assistant Director - Estates	31st July 2021

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

Planned interviews to take on board a SCP 1ST / 2ND Week of November 20. 3 months to undertake verification of our design by the SCP then submit to the WG for approval and funding.

Datix ID Number: 840 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 16** **Target Date: 31st March 2022**	**Current Risk Rating** **5 x 5 = 25**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Rab McEwan, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee	
Risk: Access and Planned Care. There is a risk of harm to patients if we fail to diagnose and treat them in a timely way.		**Date last reviewed:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 5 = 25 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 is obviously increasing the number of patients now breaching 36 and 52 week thresholds.	
Level of Control = 90%		**Rationale for target score:** There is scope to reduce the likelihood score to reduce the Risk to an acceptable level	
Date added to the HB risk register January 2013			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Post Covid 19 the focus is on minimising harm by ensuring that the patients with the high clinical priority are treatment first. The Health Board is following the Royal College of Surgeons guidance for all surgical procedures and patients on the waiting list have been categorised accordingly. • There is a bi-weekly Recovery meeting for assurance on the recovery of our elective programme. • The annual plan is based on specialty level capacity and demand models at specialty level that set out the baseline capacity and identify solutions to bridge the gap. Non-recurring pump – prime funding is available to support initial recovery measures. Monthly performance reviews track progress against delivery. • A focused intervention is in train support to the 10 specialties with the longest waits.	Develop and implement a full range of '**treat while you wait'** interventions at specialty level to minimise harm.	Service Directors	30th September 2021

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
• Weekly meetings in place to ensure patients with greatest clinical need are treated first.	

Additional Comments

23.04.2021 – Action closed - Development of a whole system model for NPTH as a centre for Orthopaedic and Spinal services, to include the scoping of ambulant trauma options and capital requirements - Strategic Outline Case submitted to WG awaiting outcome.

Datix ID Number: 1035 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**		**HBR Ref Number: 27** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 4 = 16**
Objective: Digitally enabled care		**Director Lead:** Matt John, Director of Digital **Assuring Committee:** Audit Committee	
		Date last reviewed: Prepared for Management Board – July 2021	
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.		**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- Significant growth in digital adoption during 20/21 has resulted in more digital solutions and devices to support with same resources. Disaggregation of the CTM SLA has commenced – unable to reduce resources required to provide services to SBUKB due to economies of scale.	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 5 x 2 =10		**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.	
Level of Control = 50%			
Date added to the HB risk register 2012			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• 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	Establish 5year financial plan for Digital including the risks of the termination of the CTM SLA.	Head of Digital Services Business Management	31st March 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?)**
• 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	• Lack of certainty over future capital and revenue funding streams makes planning and implementation difficult/less effective.

Additional Comments

Submitted two bids for HEPMA and TOMS for funding 2021/22.

Datix ID Number: 1043 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**		**HBR Ref Number: 36** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 4 = 16**
Objective: Digitally enabled care		**Director Lead:** Matt John, Director of Digital **Assuring Committee:** Audit Committee	
Risk: Paper Record Storage: Lack of a single electronic record means there is greater reliance on the provision of the paper record. If we fail to provide adequate storage facilities for paper records, then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if there is poor records management in some wards. There is an increased fire risk where medical records are stored outside of the medical record libraries.		**Date last reviewed:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 4 = 16 Target: 3 x 3 =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	
Level of Control = 70%		**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.	
Date added to the HB risk register June 2016			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• 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)	Develop Business Case for improved storage solution for both paper and digital records.	Head of Health Records & Clinical Coding	31st March 2022
	Implementation of WNCR at NPTH	Director of Digital	Ongoing
	Complete convergence with WCP (replace ABMU Clinical Portal with Welsh Clinical Portal at all inpatient locations)	Director of Digital	29th October 2021

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

Action - All SDU and corporate leads

Health Records Department are working with HB colleagues to develop a case for improved storage solution both for paper record
are now as follows:

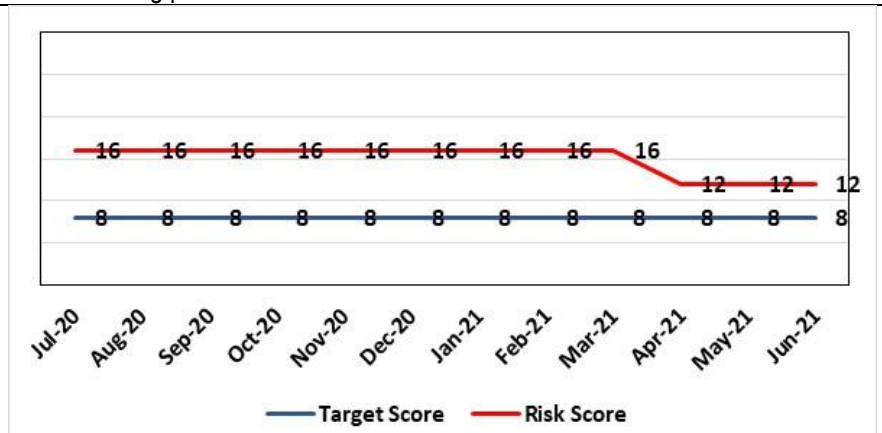
A scoping exercise has been undertaken across the Health Board to quantify the storage issues for All types of records as it has been evident for some time that the current capacity available to store records both within the main hospitals and off site storage areas is insufficient, and that current practices cannot continue, and a Health Board wide solution is required.

The outcome of the scoping exercise will be shared with the Health Board Space Management Work Stream. Once completed, a Business Case will be written, to document the scale of the issues that the Health Board is facing in storing all types of records on an indefinite basis. These updates are also being provided as part of the Health records papers that are submitted to IGG.

Within the Acute Health Records Service and across numerous Health board services that manage and store their records separately from the acute record thousands of records continue to be moved off site to a third party storage supplier called the Maltings at a significant cost to the Health Board due to a lack of capacity on-site to store the records.

Investigations have identified that other Health Boards are destroying records where appropriate digital solutions are in place. This will therefore be taken forward in the options appraisal of the business case. (See action above).

Action complete 31.05.2021:- Establish the legalities around the scanning and destruction of paper records in relation to the Blood Enquiry.

Datix ID Number: 1217 **Health & Care Standard: Effective Care 3.1 Safer & Clinically Effective Care**		**HBR Ref Number: 37** **Target Date: 31st March 2022**	**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:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 3 = 12 Target: 4 x 2 = 8		**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.	
Level of Control = 70%		**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.	
Date added to the HB risk register June 2016			

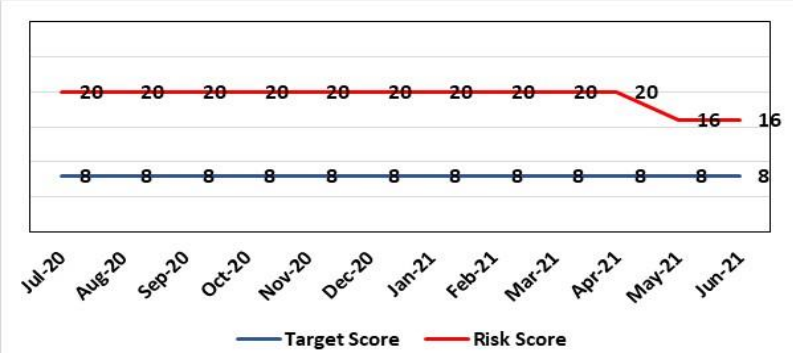
Controls (What are we currently doing about the risk?)

- 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
Investment and implementation of system to record patient outcome measures	Head of Digital Intelligence	24th September 2021
Produce Business Intelligence Strategy and get signed off by the Board	Head of Digital Intelligence	30th June 2021
Produce BI strategy implementation plan	Head of Digital Intelligence	30th September 2021

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
More evidence based and proactive decisions being made. Dashboard technology; assist in developing indicators / triangulating information to identify issues	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	
PROMS being collected in Lung Cancer (Morriston, Cataracts, Hip & Knee (Morriston), and Breast Cancer using PKB, also Heart failure, in one Community Clinic. COVID19 Dashboards Developed and are being used to inform the decision making process at Gold. Management Board have approved the investment for 4 BI partners to work with the SDGs to become more data driven.	

Datix ID Number: 1297 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**		**HBR Ref Number: 39** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 4 = 16**
Objective: Demonstrating Value and Sustainability .		**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee**: Health Board ,Performance and Finance Committee	
Risk: Operational and strategic decisions are not data informed: Failure to have an approvable IMTP for 2022/23 then we will lose public confidence and breach legislation.		**Date last reviewed:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 4 x 2 = 8		**Rationale for current score:** Our Organisational Strategy was approved by the Board in November 2018 Quarterly and half year plans submitted for 2020/21 The 2021/22 Annual Plan includes a balanced financial plan.	
Level of Control = 70%			
Date added to the HB risk register July 2017		**Rationale for target score:** If the IMTP is approved, it is likely our enhanced monitoring status will be improved when next reviewed and the risk can be closed.	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Welsh Government written statement published on the 7 October 2020 advising that SBUHB been de-escalated from targeted intervention status to 'enhanced monitoring' status. • The Health Board will develop a Service and Financial Recovery Plan to support its sustainability and provide the foundation to deliver an agreed IMTP for 2022/23.	Development of draft Annual Plan within 3 year context considered By board In Committee in Mar21 and submitted to WG	Dir of Strategy, Dir of Finance & Dir of W & OD	30th June 2021
	Annual Plan to be finalised during Q1 of 2021/22 for submission to Board and to WG.	Director of Strategy	30th June 2021

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance (What additional assurances should we seek?)**
IMTP Executive Steering Group provides oversight of IMTP, Performance and Finance Plans assured by P&F Committee. W&OD Committee reviews the workforce plan, Q&S Committee the Q&S elements. JET meetings with WG	EIA in development for Board assurance QIAs in development for joint Q&S/Board assurance

Additional Comments

14.04.21 Update – Need to note that P&F only looks at finance and performance, not the whole IMTP approval – that sits with Board. The HB submitted a draft Annual Plan to WG in March 2021 as a record of progress with our planning.

Datix ID Number: 1567 Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety	HBR Ref Number: 41 Target Date: 31st March 2022	Current Risk Rating 4 x 4 = 16
Objective: Best Value Outcomes	**Director Lead:** Christine Williams, Interim Director of Nursing and Patient Experience **Assuring Committee:** Health and Safety Committee	
Risk: Fire Regulation Compliance – one improvement notice received relating to MH&LD Unit. Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations.	**Date last reviewed:** Prepared for Management Board – July 2021	

Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 4 x 4 = 16 Target: 3 x 3 = 9		**Rationale for current score:** Improvement notice in relation to MH&LD Unit. Cladding applied to Singleton Hospital front flank is not compliant with fire regulations. General compliance with fire regulations and WHTM/WHBN requirements. Risk reduced from 20 to 16.
Level of Control = 50%		**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.
Date added to the HB risk register 31/05/2018		

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
• 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.	**Action**	**Lead**	**Deadline**
	Change in fire evacuation plans and alarm and detection cause and effect	Head of Health & Safety	31st October 2023
	Replacing the existing cladding and insulation with alternative specifications and inserting 30 minute fire cavity barriers where appropriate	Service Improvement Manager	31st October 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?)**
• 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	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

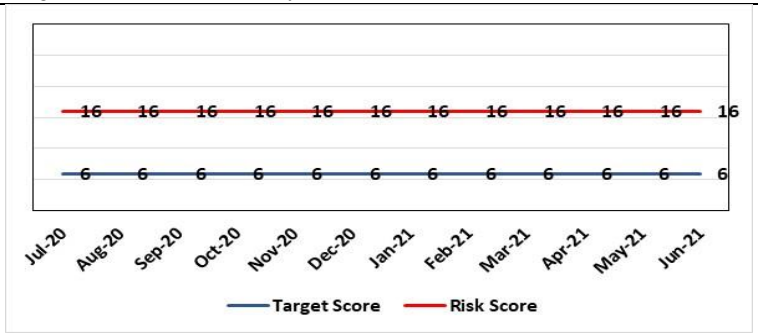
Cladding removal has commenced and will be a 2-3 year project. Working closely with NWSSP-SES (Authorised Engineer for Fire). Regular contact with MWWFRS. Reviewing fire warden numbers and training. Reviewing all fire risk assessment actions. Funding agreed for 2021-22 for updating automated fire system; fire door replacement; fire compartmentation works; lift call control. Potential of MWWFRS to inspect site, with a risk of enforcement action due to non-compliance to fire regulations.

The health & safety team have secured temporary resources to assist with reducing the number of overdue fire risk assessments, this includes those on the Singleton site to ensure all fire risk assessments are up to date and as of 10th May all risk assessments are up to date.

In addition a survey of fire compartmentation lines has been completed for the west block, with the next phase being the development of fire compartmentation drawings.

Due to the extent of the works and given current resources, this will have an impact on the support being able to be provided. The AD H7s is currently based at Singleton one day per week to assist the service group with fire safety enquiries/ challenges.

Update 28.06.21 - The flank walls were completed in 2019, it is the main façade of the tower block that is being replaced and is programmed to be completed in October 2023. There are no additional risks identified. Regular site and project updates taking place.
Update 01/07.21 - The main façade (cladding) to the tower block will be replaced with fully compliant cladding on a phased programme. The scaffolding for phase1 & 2 was completed in March 2021, with actual removal works commenced in April 2021. The target programme completion date is October 2023. The risk will be managed throughout the programme with regular site visits and project meetings.

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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Supervisory body signatories in place • BIA rota now implemented but limited uptake due to inability to release staff • 2 x substantive BIA posts and additional admin post in place • DoLS database updated and DoLS dashboard devised to enable more accurate monitoring and reporting • Regular reporting to Mental Health and Legislative Committee (MHLC) (Nov 20) • QIA completed for re-introduction of DoLS BIAs attending Ward as part of Reset and Recovery April 2021 • QIA reviewed and service stood down in light of increased COVID incidence Oct 2020, service recommenced April 2021 • Managing and supporting all referrals remotely • New legislation changes expected in April 2022 which will require a different service model, business case to meet existing and future requirements will be progressed March 21.	Delivery of DOLS Action plan reviewed monthly (change coding above also)	Director Primary & Community	Monthly Review
	DoLS dashboard in place, monitoring applications and breaches via dedicated BIAs and Admin.	UND Primary and Community	Monthly Review
	Report to Mental Health and Legislative Committee advising cessation of DoLS assessors visiting wards to minimise spread of COVID. Expertise, advice and support available to wards via substantive BIAs	UND Primary and Community	Monthly Review
	Business case for revised service model	UND Primary and Community	31st July 2021

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
• Regular scrutiny at Safeguarding Committee and by DoLS Internal Audit; monitoring via DoLS Dashboard this will provide real-time accurate data. • Update report to MHLC, impact of COVID and focus on urgent cases via virtual process and plan to progress business case by year end.	

Additional Comments

All actions attributable to safeguarding completed and Internal Audit aware. DoLS and MCA Training provided to doctors and managers by Solicitor from Legal & Risk Services in January and February 2021. Progress in implementing / reinstating controls has been updated and future dates refreshed, including an extension to the target date for the business case for the revised service model.

Datix ID Number: 1563 **Health & Care Standard: Safe Care 5.1 Access**		**HBR Ref Number: 48** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 4 = 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	
Risk: Failure to sustain Child and Adolescent Mental Health Services		**Date last reviewed:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 4 x 2 = 8		**Rationale for current score:** Difficulties with sustainable staffing affecting performance.	
Level of Control = 50%		**Rationale for target score:** New service model and improved performance	
Date added to HB the risk register 31/05/2018			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Performance Scrutiny - is undertaken at monthly commissioning meetings between Swansea Bay & Cwm Taf Morgannwg University Health Boards. Improved governance -ensures that issues and concerns are discussed by all interested parties including local authorities to support the network identify local solutions. • New Service Model agreed and being established by Summer 2019 which should give further stability to service.	**Action**	**Lead**	**Deadline**
	Additional investment expected - from Welsh Government	CAMHS network	30th September 2021
	Staffing of service being strengthened & supplemented by agency staff	CAMHS network	30th September 2021

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

Cwm Taf achieved the non-urgent 28 day target for specialist CAMHS and primary CAMHS in 2020, with performance deteriorating due to staff being relocated to Ty Llidiard to support pandemic. Performance has improved in 2021 towards achievement of targets.

01.04.21 – Action update – Additional demands as a result of Covid expected and will need additional investment either from MH development monies or from direct Welsh Government funding.

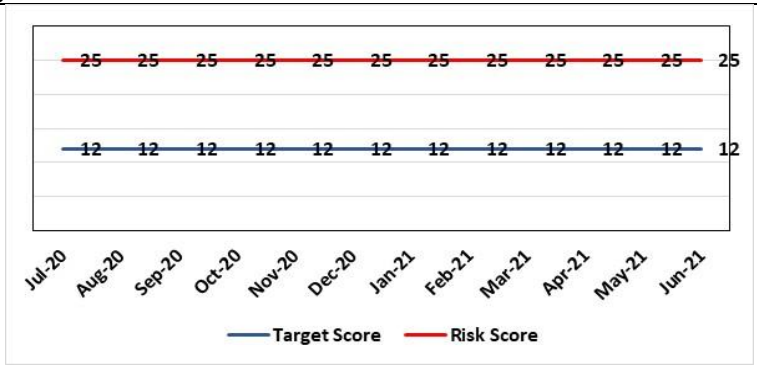
Datix ID Number: 922 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**		**HBR Ref Number: 49** **Target Date: 31st July 2021**	**Current Risk Rating** **4 x 3 = 12**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Richard Evans, Medical Director **Assuring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

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

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Reduction in waiting times for TAVI. Executive Medical Director Oversight of improvement plans. Development of Quality and Safety Dashboard. Oversight and scrutiny by Quality and Safety Committee	

Additional Comments

Reports now received from RCP on (1) initial casenote review (2) site visit in July 2019 (3) second cohort casenote review; action plans implemented in response
Improvement activity continues to have oversight of the Executive Medical Director at fortnightly Gold Command meetings. Regular briefings and reports are provided to key stakeholders including WHSSC, Welsh Government and Hywel Dda UHB.
WHSSC have de-escalated the TAVI service from its current Stage 3 to Stage 2, in recognition of significant improvement in the service.
Recommend reduction in risk score from 16 to 12.

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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Tight management processes to manage each individual case on the unscheduled care (USC) Pathway. • Initiatives to protect surgical capacity to support USC pathways have been put in place in RGH and PCH to protect core activity. • Additional investment in MDT consideration, with 5 cancer trackers appointed in April 2021. • Prioritised pathway in place to fast track USC patients. • Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. • Weekly cancer performance meetings are held at both Singleton and Morriston Delivery Units. • The tumour sites of concern is in development. One of the areas is Lower GI where clinic capacity has increased by 4 times in April. • Endoscopy contract has been extended.	Phased and sustainable solution for the required uplift in endoscopy capacity that will be key to supporting both the Urgent Suspected Cancer backlog and future cancer diagnostic demand on Endoscopy Services. Harm review process to be implemented.	Service Group Manager	1st November 2021
	To explore the possibility of offering SBAR RT for high risk lung cancer patients in SWWCC	Service Manager Surgical Services	30th September 2021

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
General improvement (sustained) trajectory. Need to continue improvement actions and close monitoring. Early diagnosis pathway launched and impact being closely monitored.	Clear current funding gap.

Additional Comments

The need to deliver sustained performance.
Whilst every effort is being made to maintain cancer treatment, surgical cancer activity in particular is being impacted upon by both the reduction in elective theatre capacity and availability in critical care beds due to the COVID-19 outbreak.
Covid screening is in place for all patients starting their 1st cycle of SACT and for all Lung RT patients.

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

Datix ID Number: 1759 **Health & Care Standard: Staff & Resources 7.1 Workforce**		**HBR Ref Number: 51** **Target Date: 31st March 2022**	**Current Risk Rating** **5 x 4 = 20**
Objective: Excellent Staff		**Director Lead:** Christine Williams, Interim Director of Nursing **Assuring Committee:** Workforce and OD Committee	
Risk: Non Compliance with Nurse Staffing Levels Act (2016)		**Date last reviewed:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 4 = 20 Target: 4 x 2 = 8		**Rationale for current score:** • Improved risk as COVID position improves. Risk remains high due to registered nursing vacancies • Service groups (Morriston, Singleton and Neath Port Talbot) remain high with a score of 20	
Level of Control = 80%		**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.	
Date added to the HB risk register November 2018			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
The Health board has put the following controls in place: • Workforce Plans have been developed by Unit Nurse Directors & Each Delivery Group to agree staffing in light of escalation to surge & super surge due to COVID-19, with consideration of all reasonable steps • Approved Registered Staff who have retired from the Nursing Midwifery Council Register in the last three years have been contacted with a view to return to practice and into the Health Board workforce. • Delivery Units have appropriately deployed of ward nurses to key areas. And also administration staff utilised to release nurses into providing care. • Student nurses have returned to clinical practice which has been supported corporately. • 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 & Patient Experience and reports to NMB and Workforce & Organisational Development Committee • Health Board representation at the All-Wales Nurse Staffing Group and its sub groups • Bi-annual calculations undertaken across all acute Service Delivery Units for calculating and reporting nurse staffing requirements • Three yearly caveated Welsh Government paper and Annual Assurance paper presented a Health Board in May 2021 • Health Board continues with workforce planning & redesign, training and development. recruitment and retention - Transformation • Scrutiny panels are held for each SDU following the submission of acuity templates • Impact assessment work is being undertaken to prepare for further roll out of the Act, extension of the Act to Paediatrics	**Action**	**Lead**	**Deadline**
	The Ward Sister / Charge Nurse and Senior Nurse should continuously assess the situation and keep the designated person formally appraised.	Director of Nursing & Patient Experience	30th June 2021 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.	Director of Nursing & Patient Experience	30th July 2021
	The responsibility for decisions relating to the maintenance of the nurse staffing level rests with the Health Board should be based on evidence provided by and the professional opinions of the Executive Directors with the portfolios of Nursing, Finance, Workforce, and Operations.	Director of Nursing & Patient Experience	30th July 2021
	Risk register to be reviewed monthly to ensure compliance	Director of Nursing & Patient Experience	1st July 2021 Monthly ongoing

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
• 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. • Accurate reporting of Acuity data and governance around sign off. • Agreed establishments to be funded. • E-Rostering implemented and roster scrutiny undertaken, ensuring effective staff allocation • All Wales Templates are visible informing patients of planned roster. • At least Yearly Board reports outlining compliance and any key risks.	Issue raised regarding Information Technology barriers around the capture of data required for the Act on an All- Wales and Health Board basis.

Additional Comments

7.5.21 - Discussed in Nurse Staffing Act Meeting formally agreed to maintain score of 20 based on evidence provided from Delivery Groups
Morriston Singleton & NPT Risk Score remains at 20 - Roster Scrutiny Panels operate to ensure the rostering Policy and Standards are fully implemented and are being reviewed to encompass triangulation with key quality indicators. Overseas recruitment remains a key priority.
Action Complete - Daily Staffing Tool has been agreed across the Delivery Groups to maintain a consistent approach.

Datix ID Number: 1763 **Health & Care Standard: Staff & Resources 7.1 Workforce**		**HBR Ref Number: 52** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 3 = 12**
Objective: Partnerships for Care – Effective Governance		**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee:** Performance and Finance Committee	
Risk: The Health Board does not have sufficient resource in place to undertake engagement & impact assessment in line with strategic service change		**Date last reviewed:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 = 12 Target: 4 x 2 = 8		**Rationale for current score:** • Current lack of sustainable funding source to secure capacity	
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?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Band 6 recruited to provide engagement support. • Band 8b Head of Engagement & Partnerships appointed to provide additional support for engagement. • Robust policies and processes to be in place for Impact Assessment going forward. • EIA responsibilities incorporated into planning roles going forward. • Consideration being given to temporary support.	Appoint to agreed Planning posts	Interim Assistant Director of Strategy	30th June 2021
Assurances (How do we know if the things we are doing are having an impact?) Equality Impact specialist advice and support to be considered as part of resourcing for engagement.	**Gaps in assurance** **(What additional assurances should we seek?)** Permanent additional resources not yet available		
Additional Comments As at 19.5.21 there has been no progress to create a IIA post.			

Datix ID Number: 1762 **Health & Care Standard: Staff & Resources 7.1 Workforce**		**HBR Ref Number: 53** **Target Date: 31st March 2022**	**Current Risk Rating** **5 x 3 = 15**
Objective: Partnerships for Care		**Director Lead**: Pam Wenger, 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:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 3 = 15 Target: 3 x 3 = 9		**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.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Recruitment of a Welsh Language Officer (WLO)	Head of Compliance	31st August 2021
Review and update the Welsh Language Standards Action Plan. In doing so, reflect the findings of the independent assessment	Head of Compliance	30th November 2021
Reinstate quarterly meetings of the Welsh Language Delivery Group.	Head of Compliance	31st January 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?)
Meetings of the Welsh Language Standards Delivery Group, which is charged with 'overseeing compliance with the Welsh Language Standards and reporting on such to the Executive Board and the Board' need to be reinstated once the Welsh Language Officer has taken up her post.

Additional Comments

The resignation of the Welsh Language Officer in December 2020 has adversely impacted upon our ability to progress mitigating actions, notably the reinstatement of the Welsh Language Delivery Group meetings. These actions will now be progressed following the recruitment of the new WLO.

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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Emergency Preparedness resilience and response, (EPRR) work programme in relation to the 6 statutory duties is monitored via the EPRR Strategy Group; this includes emergency planning, risk assessment, collaboration, sharing of information, warning and informing and business continuity. • The Health Board continues to respond to the C-19 pandemic and has been in response since 31.01.21. In addition, there have been a number of concurrencies that the Health Board has responded to; emphasising the need for a continued cycle of EPRR. There is an EPRR risk register as well as a Brexit specific risk register and full risk assessment process, as well updated business continuity plans. There is national oversight of Procurement specifically for Brexit and continued HB engagement. • Welsh Government has put in place national communication and co-ordination arrangements for Brexit and most are now in dormancy. The Local Resilience Forum meets monthly to discuss Brexit specific risks • EPRR Work programme monitored via EPRR Strategy Group.	Plans were exercised during 2018 for a no deal Brexit. Continued planning remained in place and a constant review of risk assessments. In addition, the Health Board has invoked its business continuity arrangements a few times whilst responding to the pandemic and the most was in relation to disruption to supplies of blood science products. The learning from this incident is being taken forward to ensure critical stocks and supplies of just in time products is more robust.	Head of Emergency Preparedness, Resilience & Response	Monthly EPRR meetings occur for continued monitoring

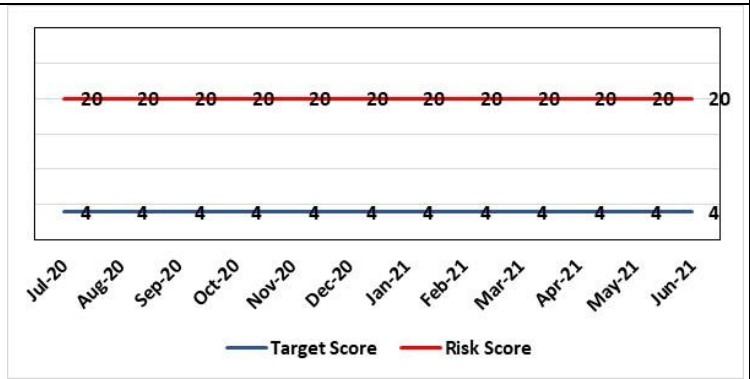
Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
• Work programme in place and monitored via EPRR Strategy Group • All services have up to date business continuity plans • Robust risk management system in place • Preparedness and response assurance procedure specifically for Brexit • Horizon scanning process in place for issues that may arise later during 2021	None

Additional Comments
None

Datix ID Number: 1799 **Health & Care Standard: Controlled Drug 2.6 Medicines Management**	**HBR Ref Number: 57** **Target Date: 31st December 2021**	**Current Risk Rating** **4 x 4 = 16**
Objective: Best Value Outcomes of High Quality Care	**Director Lead**: Richard Evans, Executive Medical Director **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 re future service change compliance.	**Date last reviewed:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 2 = 8 **Level of Control** = 40% **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. 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?)	**Mitigating actions (What more should we do?)**		
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.	**Action**	**Lead**	**Deadline**
	HB to discuss and agree a policy position on the requirements for HO CD Licenses with the HO.	CD Pharmacy	1st Sept 2021
	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	1st Sept 2021
	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	1st Sept 2021
	Apply for a HO CD License for HMP Swansea.	CD Lead, PCT	1st Sept 2021

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 None.	

Datix ID Number: 146 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**		**CRR Ref Number: 58** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Excellent Patient Outcomes		**Director Lead**: Rab McEwan, Chief Operating Officer **Assuring Committee**: Quality and Safety Committee	
Risk: Failure to provide adequate clinic capacity for follow-up patients **Ophthalmology** results in a delay in treatment and potential risk of sight loss.		**Date last reviewed:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 5 = 20 Target: 4 x 1 = 4		**Rationale for current score:** Risk rating increased to 20 in July 2020 due to Covid-19 pandemic backlog has continued to grow.	
Level of Control = 40%		**Rationale for target score:** Mitigation plan via outsourcing will reduce the backlog to pre-covid levels.	
Date added to the HB risk register December 2014			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• All patients are categorised by condition in order to quantify issue. • Additional IS capacity secured to increase activity from July 2021, implementation plan under development. Welsh government funding secured for 2021.	An overall Regional Sustainability Plan to be delivered	Service Group Manager Surgical Specialties	31st March 2021 (Monthly ongoing)

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
• Deputy COO in regular liaison with IS on contract progress.	Regular liaison with patients on extended waiting list/times and validation.

Additional Comments

Routine appointments were suspended since the advent of the Covid-19 outbreak the following essential Eye services have been maintained during Covid 19.

- AMD treatments
- Retina services
- Rapid Access Eye clinic (RACE - Eye Casualty)

Some clinically urgent Cataract operations have also been undertaken.

14.04.21 - Additional glaucoma clinic capacity now available in Wellbeing Centre, Swansea University. Work ongoing with Hywel Dda HB on regional solutions commence in July 2021.

Datix ID Number: 2003 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**		**HBR Ref Number: 60** **Target Date: 31st March 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:** Prepared for Management Board – July 2021	
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** The level of cyber security incidents is higher than it has ever been and recently the Ireland Health Service were subjected to a ransomware attack (May 2021). The increase in users and devices increases the threat landscape. Mandatory training not adopted to date.	
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			

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. • 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.	Adopt mandatory Cyber training across SBUHB, or identify alternative options.	Cyber Security Manager	1st August 2021
	Undertake Cyber Assessment as part of annual NIS compliance work with Cyber Resilience Unit in DHCW	Cyber Security Manager	1st August 2021

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.	Cyber Security Training is not mandatory and the biggest risk is our staff's awareness to identify phishing/scam emails and malicious websites.

Additional Comments

Papers on the progress of Cyber Security are being sent annually to the Senior Leadership Team, Audit committee and Health Board meetings.
A paper will be sent to the Management Board in July 2021 to gain approval to make cyber security training mandatory.

Datix ID Number: 1587 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 61** **Target Date: 31st March 2022**	**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:** Rab McEwan, 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:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 4 x 4 = 16 Target: 4 x 2 = 8		**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	
Level of Control = 60%		**Rationale for target score:** Relocation of the paediatric GA service [provided by Parkway Clinic] to a hospital site being treated as a priority	
Date added to the HB risk register 4th July 2018			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• 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	Transfer of services from Parkway.	Interim Head of Primary Care	31st May 2021

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

Task & Finish Group continue to progress transfer of service to Morriston.

Action moved to May 2021 due to Covid pressures. However, PWC have now given the Health Board notice that they wish to terminate the contract at the end of January 2021. Transfer of this service to Morriston is not feasible by the end of January and given the limitations on staffing and theatre capacity is not achievable by May 2021 therefore T&F Group are looking at the other options available to deliver the service which, includes extending the contract with PWC through to March 2022 or transferring the service the NPTH. A paper setting the options will be

presented the Senior Leadership on 18 November 2020. Risk remains - for review in November following meeting with Senior Leadership on 18th November 2020. Task and Finish Group re-established first meeting on 1st December to progress transfer to Morriston Hospital by 31st May 2021. The limited theatre capacity available due to Covid restrictions has resulted in an extension of the contract with Parkway until June 2022 being negotiated.

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

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

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
Audit of compliance with guidance being undertaken, detection rates of babies born below the 10th centile is being monitored via Datix and audited by the service. Ultrasound are assisting with finding capacity wherever possible in order to meet standards for screening and complying with Gap & grow recommendations.	

Additional Comments

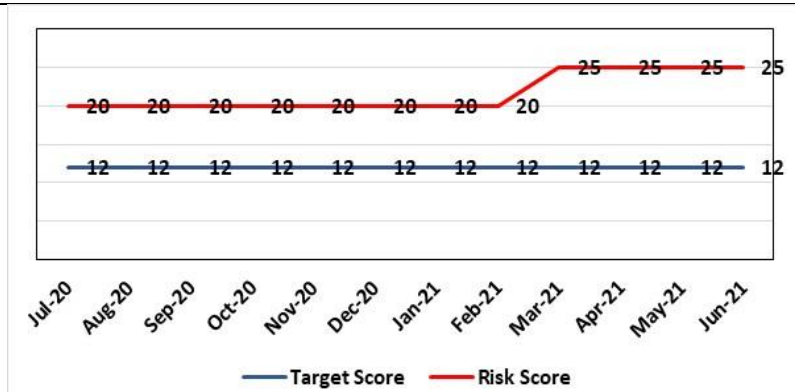
Training currently being provided by appropriately trained obstetrician and the two trainee midwife sonographers are making good progress in their university course and practical skills training. Trainer role currently on Trac (2 year fixed term). 2 current trainee sonographers progressing well through training.
Ensure SBAR for recruitment for two further trainee sonographers is completed and presented to NPTSSG group for approval.

Datix ID Number: 2159 Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety	HBR Ref Number: 64 Target Date: 31st March 2022	Current Risk Rating 5 X 5 = 25
Objective: Best Value Outcomes	**Director Lead:** Christine Williams, Interim Director of Nursing and Patient Experience **Assuring Committee:** Health and Safety Committee	
Risk: Insufficient resource and capacity of the Health, safety and fire function within SBUHB to maintain legislative and regulatory compliance for the workforce and for the sites across SBUHB. .	**Date last reviewed:** Prepared for Management Board – July 2021	

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



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

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.

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

- 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 2021to reduce the number of FRA overdue.
- Fire training in place and fire wardens in place

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Health and safety department structure to be reviewed and produce proposals, business case	Assistant Director of H&S	31st July 2021
Health and safety structure review to be presented to the H&S Committee	Assistant Director of H&S	31st July 2021

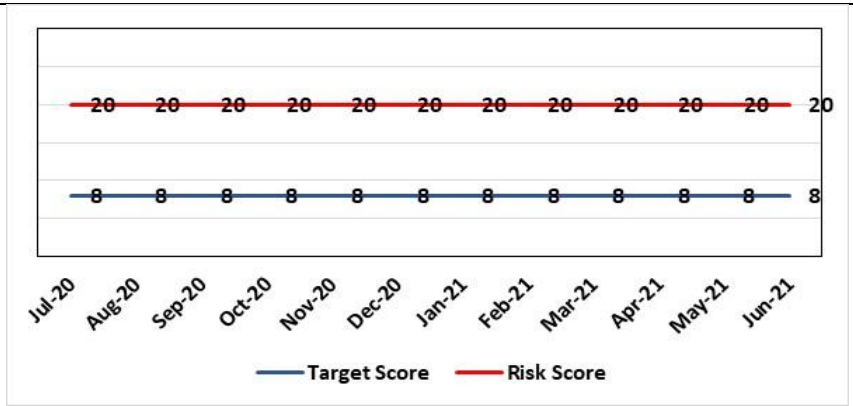
Assurances
(How do we know if the things we are doing are having an impact?)

- 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.

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

Additional Comments

The health and safety team has been allocated temporary resource to assist in addressing the overdue fire risk assessments, with a plan in place to reduce the number of overdue fire risk assessment.
Actions include completion of the health & safety team resource business case to address resource issues within the H&S team to enable the HB to address its legal obligations. The additional resources required have been included in the HB annual plan. Resources when approved will be phased in over 2021/22 and 2022/23 financial years, this will enable the risk level to be reduced when implemented. Update 28/06/2021: Business case has been submitted and awaiting confirmation on resource allocation as outlined in the business case. There is no change to the current risk score.

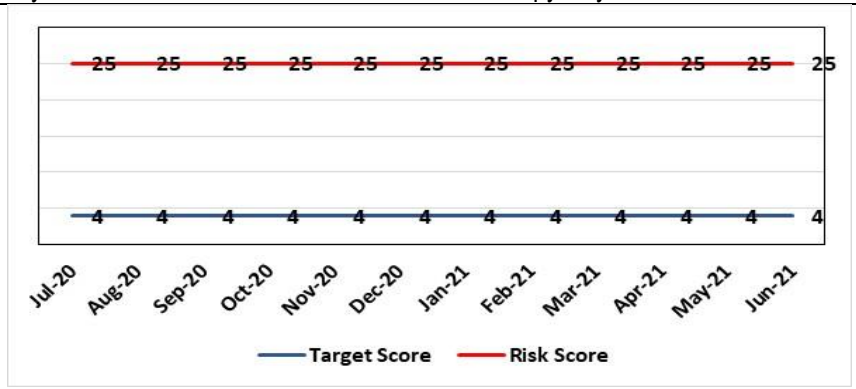
Datix ID Number: 329 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 65** **Target Date: 31st March 2022**	**Current Risk Rating** **4 X 5 = 20**
Objective: Digitally enabled Care		**Director Lead**: Christine Williams, Interim Director of Nursing and Patient Experience **Assuring Committee:** Quality & Safety Committee	
Risk: Risk associated with misinterpreting abnormal cardiotocography readings in the delivery room. A central monitoring station would enable multi-disciplinary viewing and discussion of the readings to take place, and reduce the risk of a concerning CTG trace going unidentified. Provisionally scored C4 (irrecoverable injury) x L3= 12. The central monitoring system has a facility to archive the CTG recordings: currently these tracings are only available as a paper copy, which can be lost from the maternity records. There is also a concern that the paper tracings fade over time which makes defending claims very difficult.		**Date last reviewed** Prepared for Management Board – July 2021 **Rationale for current score:** Meeting with K2, IT, finance, procurement and midwifery team on 30/09/2019. System viewed and IT needs identified. Final costing to be assessed prior to resubmission to IBG in Oct or November 2019.	
Risk Rating (consequence x likelihood): 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		**Rationale for target score:** Funding for central monitoring approved for 2021/22 Meeting to be arranged with provider and key stakeholders in SBU to commence the project toward installation and training.	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Current controls include all staff undertaking RCOG CTG training and competency assessment. Protocol in place for an hourly "fresh eyes" on 'intrapartum CTG's' and jump call procedures. CTG prompting stickers have been implemented to correctly categorise CTG recordings. Central monitoring is also expected to strengthen the HB's position in defending claims. K2 fetal monitoring system has been identified as the best option for a central monitoring system.	Business case prepared for Central monitoring system to store CTG recordings of fetal heart rate in electronic format.	Deputy Head of Midwifery	31st December 2021

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
All Wales Fetal Surveillance Standards for 6hrs Fetal Surveillance Training per year	

Additional Comments

04.05.21 – Update - Awaiting final sign off for purchase of central monitoring. Walk around planned for 12th May 2021 for estates and I.T to cost up the infrastructure aspect of the bid.

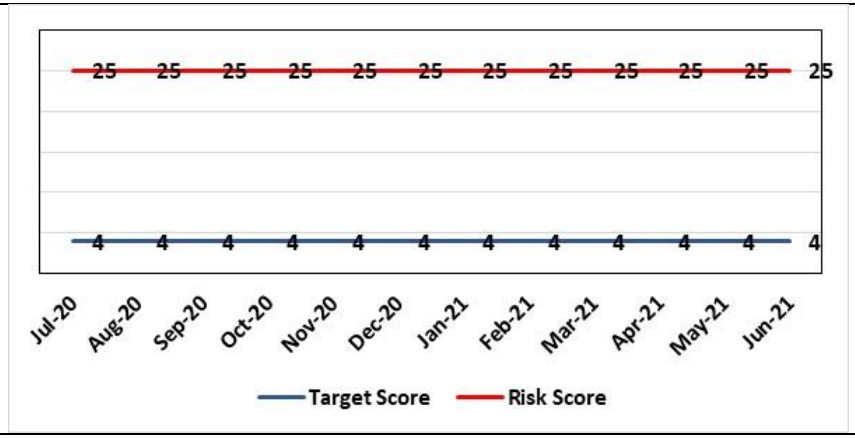
Datix ID Number: 1834 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 66** **Target Date: 31st March 2022**	**Current Risk Rating** **5 X 5 = 25**
Objective: Best values outcomes from high quality care		**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee:**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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Review of CDU by improvement science practitioner Increase nursing staff x 1 at risk, to ensure all nurses are working appropriately. Review of scheduling by staff to ensure all chairs used appropriately. Looking at options around expansion of home care delivery to free up chair capacity in CDU	Expansion of home care delivery and additional chair capacity - SACT group	Associate Service Group Director-Cancer Division	31th July 2021

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Extra nurse in place reliant on agency. Senior team meeting to review findings of service review paper. Additional funding agreed to support increase in nurse establish to appropriately run the unit during their main opening hours	

Additional Comments

Working with MSD/GE around potential partnership agreement to look at C&D mapping and best practice elsewhere.
Covid has impact on demand for chairs due to need to socially distance.
Loss of 3 Chairs (due to IPC controls for COVID) has impacted on capacity. Currently running alternate Saturdays in CDU to mitigate loss. Current wait time for SACT >21 days for the majority of patients.
Update: 23/06/2021: Paper on home care expansion has been rewritten at request of CEO awaiting final cost before being submitted for decision on next steps

Datix ID Number: 89 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 67** **Target Date: 31st March 2022**	**Current Risk Rating** **5 X 5 = 25**
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:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 5 = 25 Target: 2 x 2 = 4		**Rationale for current score:** Waiting times deteriorating for elective delays patients, particularly prostates discussed in Oncology business meeting.	
Level of Control =			
Date added to the HB risk register 30/11/2019		**Rationale for target score:**	

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

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

Additional Comments

27.04.21 Update - Risk remains 25 due to limited CT and LINAC capacity. Wait time for RT >28 days for the majority of patients.
Exploration of further opportunities to (a) increase hyperfractionation for other diseases (b) opportunity to outsource.
New CT due to be operational mid-May 2021. If on schedule and additional capacity (hyperfractionation and outsourcing) is confirmed, risk should reduce to 16.
16.06.21 Update – Started sourcing for prostate RT – 70 pts over 6 months. Hypo fractionation case for prostate with CEO for consideration.

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

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

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

Additional Comments

Mitigation as follows to identify and reduce risks of spread of infection:
Pandemic plans invoked
Command, Control and Coordination arrangements in place with Strategic, Tactical and bronze Groups in place to ensure Health Board wide engagement and instigate required planning including:

- Patient flow pathway scenarios for unwell patients and well patients that may self-present in both acute and Primary and Community Care
- Appropriate PPE kit and training
- Appropriate support service pathways for cleaning, decontamination, waste and linen management
- Multi-agency engagement
- Community Testing arrangements
- Workforce review
- Identified isolation facilities.

Pandemic was declared. Health Board stood up 3CF structures and response on 31 January 2020. System wide response in place. Lockdown established 23rd March. Current levels of demand are containable within existing capacity. Expectations that initial peak of infections has been managed within capacity.
08.03.21 – Current score reduced as per e-mail EMD

Datix ID Number: 1418 **Health & Care Standard: 5.1 Timely Access**		**HBR Ref Number: 69** **Target Date: 31st March 2022**	**Current Risk Rating** **5 X 4 = 20**
Objective: Best values outcomes from high quality care		**Director Lead**: Rab McEwan, Chief Operating Officer/Christine Williams, Interim Director of Nursing and Patient Experience **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:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 2 x 3 = 6 Current:5 x 4 = 20 Target: 2 x 3 = 6		**Rationale for current score:** Risk score increased to 20.	
Level of Control =			
Date added to the HB risk register 27/02/2020		**Rationale for target score:**	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Safeguarding Training for Staff, Joint protocol with Cwm Taf LHB [CAMHS] currently subject to review, Local SBUHB policy on providing care to young people in this environment. This includes the requirement for all such patients on admission to be subject to Level 3 Safe and Supportive observations.	Long Length of Stay reduction programme in Mental Health	Service Director	31st July 2021
Assurances (How do we know if the things we are doing are having an impact?) Individual Rooms with ensuite facilities, joint working with CAMHS, monitoring of staff training, monitoring of admissions by the MH & LD DU Legislative Committee of the HB.	**Gaps in assurance** **(What additional assurances should we seek?)**		

Additional Comments

09.06.21 Update - The risk remains at 20 as while the provision is not ideal no other alternative has been identified. Welsh Government Mental Health Improvement monies have been bid for to extend CAMHS crisis and hospital liaison services to be 24/7, which if successful should enhance the support available in such circumstances.

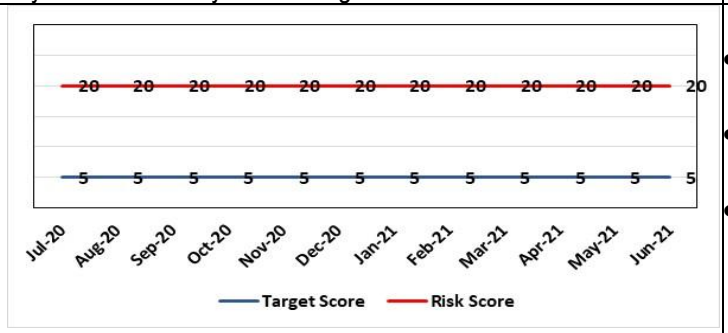
Datix ID Number: 2245 **Health & Care Standard: 3.1 Clinically Effective Care**		**HBR Ref Number: 70** **Target Date: 31st March 2022**	**Current Risk Rating** **4 X 5 = 20**
Objective: Digitally enabled care		**Director Lead**: Matt John, Director of Digital **Assuring Committee:** Audit Committee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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• SBU Representation at IMB and NSMB to hold DHCW to account for service provision • Digital Services Representation at EPRR for escalation and Digital Service Management Group to report progress. • The impact of outages is partly mitigated by the Business Continuity plans that are in place within the Service Delivery Units to allow operational services to continue during a data centre service outage	**Action**	**Lead**	**Deadline**
	Implementation of the new National data centre by DHCW	Head of ICT Operations	31st July 2021 Monthly ongoing
	Monitoring availability of national services through IMB, NSMB and DSMG. On stable operations agree to address this risk in DSMG.	Head of ICT Operations	On quarterly reviews
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

NWIS have a Programme of works to upgrade out of date equipment. The network upgrade Programme was completed this year at 2 national data centres i.e. Newport (NDC) and Blaenavon (BDC).

The final report on the BDC outage has been received and recommendations put in place to increase maintenance levels and monitoring and monitoring in the BDC and replace equipment. In addition, it is recommended that serious consideration should be given to identifying and funding an alternative Tier 3+ facility (in line with the NDC) to host these critical systems which is agreed and migration will complete this year to Church Village Data Centre (CDC).
WLIMS was upgraded in December 2020 which consists of new hardware and software and monitoring availability is ongoing.

Datix ID Number: 2450 **Health & Care Standard: 2.1.1 Managing Financial Risk**		**HBR Ref Number: 73** **Target Date: 31st March 2022**	**Current Risk Rating** **5 x 4 = 20**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Darren Griffiths. Director of Finance (interim) **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:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 5 x 1 = 5		**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 • As the Health Board moves out of direct COVID response and into COVID recovery there remains a real risk that some additionality cost and some service change cost could be part of the run rate of the Health Board and this could be exposed when additional funding ceases.	
Level of Control = 25%			
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?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
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 in place for 2021/22 • Review all of KPMG pipeline savings opportunities to test whether these can be accelerated in the light of COVID-19 impact. • System of internal control proposed and will be implemented in quarter 1 2021/22	Impact of reset and recovery to be assessed through QIA process to ensure clear understanding of impact on underlying cost base.	COO	30th September 2021 Monthly ongoing
Assurances **(How do we know if the things we are doing are having an impact?)** 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	**Gaps in assurance** **(What additional assurances should we seek?)** Reporting on savings opportunities and service change impacts to be developed.		
Additional Comments None.			

Datix ID Number: 2595 **Health & Care Standard: 3.1 Safe and Clinically Effective Care** NEW RISK		**HBR Ref Number: 74** **Target Date: 31st March 2022**	**Current Risk Rating** **5 X 4 = 20**
Objective: Best Value Outcomes from High Quality Care		**Director Lead**: Christine Williams, Interim Director of Nursing and Patient Experience **Assuring Committee:** Quality and Safety Committee	
Risk: Delay in Induction of Labour (IOL) or augmentation of Labour Swansea BAY UHB have developed a local guideline for the management of IOL based on NICE guidance. Women are booked for IOL by a senior obstetrician either for clinical reasons (which may be for fetal or maternal factors) and for prolonged pregnancy at 41+6 when spontaneous labour has not occurred.		**Date last reviewed:** June 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 4 = 20 Target: 2 x 3 = 6		**Rationale for current score:** 15 linked records since January 2021 where IOL was placed on hold. No significant poor outcomes resulted from the cases identified in the linked records. The IOL is booked and it is anticipated this should take place as planned within the standards set. However, for reasons of acuity in either maternity services or neonatal services, admission for IOL, continuation of IOL that has commenced or augmentation of labour is not possible.	
Level of Control = 60%		**Rationale for target score:**	
Date added to the HB risk register 30th April 2021			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Diary is maintained for booking of IOL with agreed numbers of IOL per day. Daily obstetric consultant ward round to review all women undergoing IOL. Ongoing/regular monitoring by cardiotocograph for fetal wellbeing. 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. If IOL's/ Augmentation of labour are put on hold/delayed the women are reviewed by the MDT to assess for any potential risk to mother or baby. The MDT (Obstetric, Neonatal and Midwifery) discuss and consider the impact of delay for each woman. Escalation to the appropriate senior staff takes place and the Escalation Policy is implemented. 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. The senior midwife will review staffing across all areas and deploy staff if possible including the specialist midwives and the community midwifery on call team. Neighbouring maternity units are contacted to ask if they are able to support by accepting the transfer of women.	Ongoing review of risk	Head of Midwifery	30th June 2021

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Review of midwifery staffing on ward 19 (antenatal ward), during recent birthrate plus assessment. This will ensure women receive effective midwifery support and reassurance of fetal wellbeing.	

Additional Comments

Datix reporting of breach in standards set. 28.06.21 Update - An electronic diary is being prepared for booking IOL. This will allow all staff easy access to the diary to prevent overbooking and will improve waiting times in antenatal clinic. The updated BR+ assessment has been received into the HB and the review of Ward 19 staffing is incorporated for an additional midwife to support the IOL clinical area to reduce delays.

Datix ID Number: 2522 **Health & Care Standard: 5.1 Timely Care NEW RISK**		**HBR Ref Number: 75** **Target Date: 31st March 2022**	**Current Risk Rating** **5 x 4 = 20**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Rab McEwan. 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:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 5 x 1 = 5		**Rationale for current score:**	
Level of Control = 25%		**Rationale for target score:** .	
Date added to the HB risk register May 2021			

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• Sites have business continuity plans, however, there is a need to review the impact of one site being overwhelmed by COVID demand. In particular, the impact of a closure of one or more hospital front doors may require additional BC plans to be developed. Operational Silver will review BC arrangements.	Business Continuity plans in place to be reviewed by operational silver command.	Singleton Group Director/Morriston Service Director	31st March 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?)**
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Additional Comments

Discussion at Gold 12.04.2021: No alteration to post-MA risk score required currently. Deb Lewis and JW to consider review of score. This is now less related to COVID as the immediate risk has stabilized, however, a long term plan is required.

Discussion at Gold 20.04.21: No alteration to post-MA risk score required currently: Procedure being developed. This is complex. The risk was agreed to be more of a general business risk, rather than a COVID-specific one. Consideration to be made of whether this can be moved to the Service Group risk register and/or the corporate risk register.

Datix ID Number: 2377 **Health & Care Standard: Staff & Resources 7.1 Workforce NEW RISK**		**HBR Ref Number: 76** **Target Date: 31st March 2022**	**Current Risk Rating** **5 x 4 = 20**
Objective: Partnerships for Care		**Director Lead:** Kathryn Jones. Director of W&OD (interim) **Assuring Committee:** Workforce & OD Committee, Health & Safety Committee	
Risk: Partnership Working There are growing tensions between the Health Board and some trade union partners within SBUHB particularly in response to the supply of PPE which has the potential to create unrest in the workforce and hamper an effective response to COVID-19.		**Date last reviewed:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 4 = 20 Target: 5 x 1 = 5		**Rationale for current score:** From the beginning of the Covid outbreak staff side including the BMA have been extremely critical of the HB position and demanded that the HB operate outside of national guidance. Demanding widespread us of higher levels of PPE than the all Wales position allows. They have engaged with external media and voiced their concerns in very direct and critical terms, threatening to involve the Minister. Their position has not changed and this issue is raised at every LPF meeting. The risk score has reduced in line with the prevalence of Covid and thus the likely actions of staff although staff side have recently been involved in a local campaign actively encouraging their members to raise retrospective Datix incident for any staff who had a position Covid test. This has generated circa 1600 Datix entries.	
Level of Control = 25%		**Rationale for target score:** Ideally staff side would support the HB position re PPE in line with PHW guidance. In doing so they would reassure staff and reduce their levels of general concern and anxiety regarding Covid Protection. .	
Date added to the HB risk register May 2021			

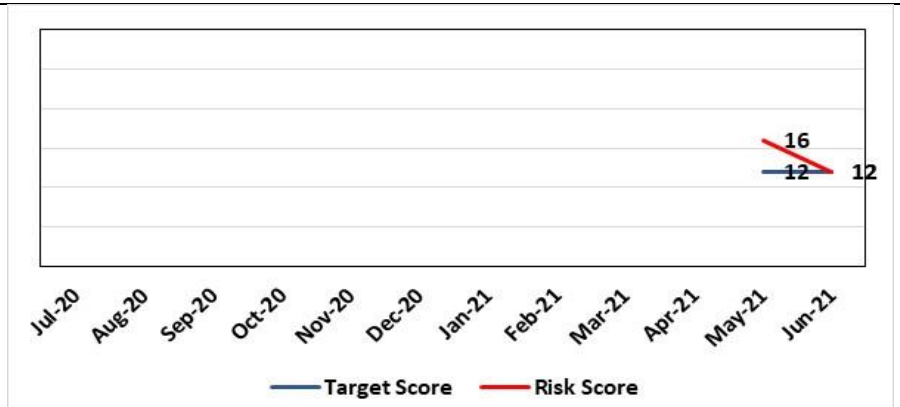
Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Frequent meetings will continue to take place, supplemented by local discussions when required. • Employees will be encouraged to raise concerns via existing mechanisms and directly to the Chief Executive. • We will continue to utilise the daily briefings to be transparent about issues such as PPE to improve confidence in the supply and availability. • Chief Executive and other Executive Directors will attend HB Partnership Forum on a regular basis. Partnership principles and ways of working will be emphasised as the most effective approach to secure progress. • The Health Board will continue to develop an effective working relationship with all trade union partners and collectively via the agreed HB Partnership Forum. Frequent meetings will continue to take place, supplemented by local discussions when required. Employees will be encouraged to raise concerns via existing mechanisms and directly to the Chief Executive. We will continue to utilise the daily briefings to be transparent about issues such as PPE to improve confidence in the supply and availability. Chief Executive and other Executive Directors will attend HB Partnership	The Health Board will continue to develop an effective working relationship with all trade union partners and collectively via the agreed HB Partnership Forum.	Director of Workforce & OD	31st March 2022

Forum on a regular basis. Partnership principles and ways of working will be emphasised as the most effective approach to secure progress. • Despite extensive discussions at PF staff side formally raised a number of issues in writing indicating they have not accepted the information provided.			
Assurances **(How do we know if the things we are doing are having an impact?)** • Monitored through range of contact points with staff side organisation mainly LPF and other routine meetings interaction with staff side. Reduction in direct action by staff side and the issue of PPE not being consistently raised through formal channels media etc.	**Gaps in assurance** **(What additional assurances should we seek?)** N/A		
Additional Comments. Group discussed consistently high position of risk score leaving no room for further escalation should situations worsen. Noted that sufficiently robust mitigating actions required if the score is to remain this high. JRQ reluctant to support reduction of the score in light of recent difficulty in relations with TUs, who have been threatening instigating Ministerial action. JRQ to discuss this with KJ Discussion at Gold 12.04.21: No alteration to post-MA risk score required currently. KJ to review and see if downgrade to score of 20 is possible. Discussion at Gold 20.04.21 JRQ noted that this risk should have been reduced to 20 and cannot be reduced any further currently due to a number of ongoing issues. Risk score reduced to reflect immediate impact only. Significant tensions remain. Access to all Wales support to help reduce concerns under consideration.			

Datix ID Number: 2569 **Health & Care Standard: Staff & Resources 7.1 Workforce NEW RISK**		**HBR Ref Number: 77** **Target Date: 31st March 2022**	**Current Risk Rating** **5 x 5 = 25**
Objective: Excellent Staff		**Director Lead:** Kathryn Jones. Director of W&OD (interim) **Assuring Committee:** Workforce & OD Committee	
Risk: Workforce Resilience (added 16/12/20) Culmination of the pressure and impact on staff wellbeing - both physical and mental relating to Covid Pandemic. Local prevalence of Covid infections increasing positive testing and the debilitating effect of the second wave impacting staff. Impact direct in terms of covid / related sickness (symptomatic Absence) and self-isolation (Asymptomatic). Increased staff absence impact on the pressures for those still in work.		**Date last reviewed:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 5 = 25 Target: 5 x 2 = 10		**Rationale for current score:** Whilst direct Covid related absence has reduced in recent months the HB still has a significant number of staff who either caught Covid or were directly impacted either due to self-isolation and or the impact of being Clinically Extremely Vulnerable (CEV). Some 350 staff are still not yet back into a substantive role. Although sick absence levels have reduced the proportion of that % relating to stress has increased. It is still too early to be sure that long term impacts of the pandemic will have already manifested itself. The health board has a number of staff with long covid whose return to work is not certain and whose sick pay protection will end later this year.	
Level of Control = 25%		**Rationale for target score:** All organisations would wish for their staff to be resilient to the impact of working within their organisation. The significant ongoing impact of Covid would never be zero but through a range of interventions in place we would hope to minimise the impact on staff to an acceptable level. .	
Date added to the HB risk register May 2021			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Additional Wellbeing support facilitated by limited L&D Coaches and Wellbeing team. – the model developed aims to increase awareness of the staff wellbeing service and National support offer a 'listening ear' approach with interventions to support and increase resilience of line-managers. Commitment from Nurse Directors and MGH Matron's to increase line-manager presence physically rather than virtually on wards and to utilise staff unable to work on wards to deliver, 'Taking Care Giving Care' rounds to colleagues. • Staff Psychological Wellbeing Cell established – partnership working with MH Psychology, Chaplaincy, Comms and L&D. • Staff WB and OH – 7 day services to support staff. • 30 staff deployed to OH and resource to support WB service. • Trained 140+ 'Taking Care Giving Care' facilitators to support team wellbeing. • 240+ TRiM 'React MH' LM's to support staff MH & trauma. • Trauma/bereavement pathways for staff developed. • OH Long Covid service developed. • Supporting HB wide Wellbeing/Resilience days with Senior Nursing colleagues.	Additional Wellbeing support facilitated by limited L&D Coaches and Wellbeing team.	Director of Workforce & OD	31st March 2022
	Occupational Health open over the bank holidays to support staff testing, urgent advice giving and contact tracing.	Director of Workforce & OD	31st March 2022

• 400+ Wellbeing Champions supporting teams and services. • ESF funded 'In Work Support' team supported local SME employee's/teams. • SBU 'double winners' in UK OH&WB Awards for Covid response.			
Assurances (How do we know if the things we are doing are having an impact?) Monitoring of Sick absence (long, short term and Covid related), staff impacted by CEV and the numbers of staff seeking to access the supporting mechanisms already in place.	**Gaps in assurance (What additional assurances should we seek?)** **N/A**		
Additional Comments Risk added to Gold Command 16 December 2020 Discussion at Gold 20.04.2021: No alteration to post-MA risk score required currently. Further discussions required regarding impact and liability – update under consideration. Post Covid Well Being Strategy established and presented to WF&ODC. Whilst there are no signs of an underlying increase in risk absence there are indications that stress related absence % has increased in some areas. There remains risk that impact will only emerge over time.			

Datix ID Number: 2521 NEW RISK **Health & Care Standard: 2.4 Infection Prevention and Control (IPC) and Decontamination**		**HBR Ref Number: 78** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 3 = 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:** Prepared for Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 3 = 12 Target: 3 x 4 = 12		**Rationale for current score:** Outbreak remains in Morriston Service Group and evidence has shown that sustainability of IPC processes are challenging. Delta variant is reported to be 40% more transmissible and therefore a risk to all Health Board sites. Visiting has re started (outside of Morriston) and has increased footfall within wards (IPC Control Measures in place) 25/06/21: No outbreaks in the health board. Risk reduced to 12.	
Level of Control = 40%		**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.	
Date added to the HB risk register May 2021			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Nosocomial transmission Silver established to report to Gold. 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.	Nosocomial transmission Silver established to report to Gold. A nosocomial framework has been developed to focus on: (a) prevention and (b) response.	Executive Medical Director & Deputy Director Transformation	Weekly 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	Weekly ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Monitor Outbreaks throughout the HB / Review Nosocomial Deaths and lessons learnt	Audit compliance of sustainable IPC practices and training compliance Implement lessons learnt from outbreaks and death reviews.

Additional Comments

Discussion at Gold 17.05.21: Reviewed and updated in the log. Risk reduced to 16. Request by PW, Director of Corporate Governance for this risk to remain on C-19 risk register but also to be included as a risk on the Corporate risk register- SCORE REDUCED FROM 20 TO 16
25/06/21: Risk reduced to 12 – see Rationale.

Datix ID Number: 2739 **Health & Care Standard: 2.1.1 Managing Financial Risk**		**HBR Ref Number: 79** **Target Date: 31st March 2022**	**Current Risk Rating** **5 x 3 = 15**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Darren Griffiths. Director of Finance (interim) **Assuring Committee:** Performance and Finance Committee	
Risk: The COVID-19 pandemic has 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.		**Date last reviewed:** Prepared for Management Board – July 2021	
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		**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. • The Health Board has submitted bids against a first tranche of funding available from Welsh Government but this is not yet allocated • 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:** Securing resources to meet the ambition of the Health Board in terms of access recovery will recue this risk which is an affordability, rather than a service delivery risk.	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
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 • Working with Welsh Government to access additional funding based on the modelling carried out to date • 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.	Develop a final annual plan setting out recovery plans	Director of Finance and Director of Strategy	30th June 2021
	Prioritise limited Health Board internal capacity and resource in a risk assessed way.	COO	31st March 2021 Monthly ongoing

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 None.	

Datix ID Number: 1832 **Health & Care Standard: : 3.1 Safe and Clinically Effective Care** NEW RISK		**HBR Ref Number: 80** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Rab McEwan, Chief Operating Officer **Assuring Committee:** Quality & Safety Committee	
Risk: There are high numbers of medically fit patients who are unable to be discharged from a medicine bed due to various issues/delays. The number is now returning to pre-COVID level of +50.		**Date last reviewed:** Prepared for Management Board – July 2021	
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		**Rationale for current score:** • Sustained levels of medically fit patients 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. **Rationale for target score:**	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Medically fit 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.	**Action**	**Lead**	**Deadline**
	To be agreed		

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
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Additional Comments
None.

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