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

HEALTH BOARD RISK REGISTER
February 2022

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

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

HEALTH BOARD RISK REGISTER
DASHBOARD OF ASSESSED RISKS – February 2022

Impact/Consequences						
5			**53:** Compliance with Welsh Language Standards **67:** Access to Cancer Services – Radiotherapy **76:** Partnership Working **79**: Finance Recovery of Access Times	**16:** Access to Planned Care **51:** Compliance with Nurse Staffing Levels (Wales) Act 2016 **Reduced from 25** **60:** Cyber Security **66:** Access to Cancer Services – SACT **69:** Adolescents being admitted to Adult MH wards **73:** There is potential for a residual cost base increase post COVID-19 as a result of changes to service delivery models and ways of working. **74:** Induction of Labour (IOL) **75:** Whole Service Closure **77:** Workforce Resilience **82:** Risk of closure of Burns service **Reduced from 25** **83:** Release of Bed Capacity Savings	**01:** Access to Unscheduled Care Service **50:** Access to Cancer Services **64:** H&S Infrastructure
4			**13:** Environment of Health Board Premises **27:** Digital Transformation to Deliver Sustainable Clinical Services **37:** Operational and strategic decisions are not data informed **52**: Engagement & Impact Assessment Requirements	**36:** Electronic Patient Record **39:** IMTP Statutory Responsibility **41:** Fire Safety Regulation Compliance **43:** DOLS/LPS 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~~ **Closed** **70:** Data Centre outages **72:** CRL & Capital Plan **78:** Nosocomial Transmission **80:** Inability to Transfer Patients **81:** Critical Staffing Levels: Midwifery
3		~~**54:** No Deal Brexit~~ **Closed**				
2						
1						
C X L	**1**	**2**	**3**	**4**	**5**	
	Likelihood					

Risk Register Dashboard

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
Best Value Outcomes from High Quality Care	1 (738)	**Access to Unscheduled Care Service** If we fail to provide timely access to Unscheduled Care then this will have an impact on quality & safety of patient care as well as patient and family experience and achievement of targets. There are challenges with capacity/staffing across the Health and Social care sectors.	20	25	➔	➔	February 2022	Performance & 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	➔	➔	February 2022	Quality & Safety Committee
	13 (841)	**H&S Compliance: Environment of Premises** Risk of failure to meet statutory health and safety requirements.	16	12	➔	➔	February 2022	Health & Safety Committee
	16 (840)	**Access to Planned Care** There is a risk of harm to patients if we fail to diagnose and treat them in a timely way.	16	20	➓	➔	February 2022	Performance & Finance Committee
	37 (1217)	**Information Led Decisions** Risk that operational and strategic decisions are not data informed.	16	12	➔	➔	February 2022	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	➔	➔	February 2022	Performance & Finance Committee
	41 (1567)	**Fire Safety Compliance** Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations.	15	16	➔	➔	February 2022	Health & Safety Committee

[1] This trend reflects the change since the HBRR that was received by the Board in November 2021.

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	43 (1514)	**DoLS** Due to a lack of Best Interest Assessor resource, there is a risk of failure to complete and authorise the assessments associated with Deprivation of Liberty/Liberty Protection Safeguards within the legally required timescales, exposing the health board to potential legal challenge and reputational damage.	16	16	➔	➔	February 2022	Quality & Safety Committee
	48 (1563)	**CAMHS** Failure to sustain Child and Adolescent Mental Health Services (CAMHS).	16	16	➔	➔	February 2022	Performance & Finance Committee
	50 (1761)	**Access to Cancer Services** There is a risk of delay in diagnosing patients with cancer, and consequent delay in commencement of treatment, which could lead to poor patient outcomes and failure to achieve targets.	20	25	↑	➔	February 2022	Performance & Finance Committee
	57 (1799)	**Controlled Drugs** Non-compliance with Home Office Controlled Drug Licensing requirements.	20	16	➔	➔	February 2022	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	➔	➔	February 2022	Quality & Safety Committee
	64 (2159)	**Health and Safety Infrastructure** Insufficient resource and capacity of the health, safety and fire function to maintain legislative and regulatory compliance.	20	25	➔	➔	February 2022	Health & Safety Committee
	66 (1834)	**Access to Cancer Services (SACT)** Delays in access to SACT treatment in Chemotherapy Day Unit	25	20	➔	➔	February 2022	Quality & Safety Committee
	67 (89)	**Risk target breaches – Radiotherapy** Clinical risk – Target breeches of radical radiotherapy treatment	16	15	➔	➔	February 2022	Quality & Safety Committee

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	69 (1418)	**Safeguarding** Adolescents are being admitted to adult mental health wards	20	20	➔	➔	February 2022	Quality & Safety Committee
	72 (2449)	**CRL & Capital Plan** The impact of Covid-19 pandemic on the health board capital resource limit and capital plan	20	20	New	New	February 2022	Performance & Finance Committee
	73 (2450)	**Finance** There is a potential for a residual cost base increase post COVID-19 as a result of changes to service delivery models and ways of working.	20	20	➔	➔	February 2022	Performance & Finance Committee
	74 (2595)	**Induction of Labour (IOL)** Delay in IOL or augmentation of Labour	20	20	➔	➔	February 2022	Quality & 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.	20	20	➔	➔	February 2022	Performance & Finance Committee
	78 (2521)	**Nosocomial Transmission** Nosocomial transmission in hospitals could cause patient harm; increase staff absence and create wider system pressures (and potential for further harm) due to measures that will be required to control outbreaks.	20	20	↑	➔	February 2022	Quality & Safety Committee
	79 (2739)	**Finance - Recovery of Access Times** Potential risk that resource available is below the ambition of the board to provide improved access.	15	15	➔	➔	February 2022	Performance & Finance Committee
	80 (1832)	**Inability to Transfer Patients** If the health board is unable to discharge clinically optimised patients there is a risk of harm to those patients as they will decompensate, and to those patients waiting for admission.	20	20	➔	➔	February 2022	Quality & Safety Committee

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	81 (2788)	**81: Critical Staffing Levels: Midwifery** Unplanned absence resulting from Covid-19 related sickness, shielding and isolation, alongside other current absences, has resulted in critical staffing levels, further reductions in which could result in unsafe service provision, poor patient outcomes and/or experience. In turn, poor service quality or reduction in services could impact on organisational reputation.	25	20	↓	→	February 2022	Quality & Safety Committee
	82 (2554)	**Risk of closure of Burns service if Burns Anaesthetic Consultant cover not sustained Reduced from 25** There is a risk that adequate Burns Consultant Anaesthetist cover will not be sustained, resulting in closure to this regional service and the associated reputational damage. This is caused by: • Decreasing consultant numbers due to retirement • Anaesthetists not gaining CCT with appropriate ICM and Burns experience	12	20	↓	→	February 2022	Performance & Finance Committee
	83	**Release of Bed Capacity Savings** There is a risk that the health board will not be able to release sufficient bed capacity to meet the requirements of savings schemes predicated on bed release.	20	20	→	→	February 2022	Performance & Finance Committee
Excellent Staff	3 (843)	**Workforce Recruitment** Risk of failure to recruit medical & dental staff	20	20	→	→	February 2022	Workforce & OD Committee
	51 (1759)	**Nurse Staffing (Wales) Act Reduced from 25** Risk of Non Compliance with the Nurse Staffing (Wales) Act	16	20	↓	→	February 2022	Workforce & 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. (From Covid-19 Register)	25	15	→	→	February 2022	Workforce & OD Committee

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	77 (2569)	**Workforce Resilience** Culmination of the pressure and impact on staff wellbeing - both physical and mental relating to Covid Pandemic. (From Covid-19 Register)	25	20	➔	➔	February 2022	Workforce & OD Committee
Digitally Enabled Care	27 (1035)	**Digital Transformation to Deliver Sustainable Clinical Services** Inability to deliver sustainable clinical services due to lack of digital transformation.	16	12	➔	➔	February 2022	Audit Committee
	36 (1043)	**Storage of Paper Records** Failure to provide adequate storage facilities for paper records then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if there is poor records management in some wards.	20	16	➔	➔	February 2022	Audit Committee
	60 (2003)	**Cyber Security – High level risk** The level of cyber security incidents is at an unprecedented level and health is a known target.	20	20	➔	➔	February 2022	Audit Committee
	65 (329)	**CTG Monitoring on Labour Wards** Risk associated with misinterpreting abnormal CTG readings in delivery rooms.	16	20	➔	➔	February 2022	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	➔	➔	February 2022	Audit Committee
Partnerships for Improving Health and Wellbeing	58 (146)	**Ophthalmology - Excellent Patient Outcomes** Risk of failure to provide adequate clinic capacity to support follow-up patients within the Ophthalmology specialty.	12	20	➔	➔	February 2022	Quality & Safety Committee
	61 (1587)	**Paediatric Dental GA Service – Parkway** Safety risk of general anaesthetic procedures performed on children outside of an acute hospital setting.	15	16	➔	➔	February 2022	Quality & Safety Committee

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	68 (2299)	**Pandemic Framework Closed and Removed from Register** ~~Risk of declared pandemic due to Coronavirus Infectious Disease outbreak 2020.~~	20	20	➔	➔	February 2022	Quality & Safety Committee
Partnerships for Care	52 (1763)	**Statutory Compliance: Engagement & Impact Assessment** The Health Board does not have sufficient resource in place to undertake engagement & impact assess in line with Statutory Duties	16	12	➔	➔	February 2022	Performance & Finance Committee
	53 (1762)	**Welsh Language Standards** Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.	15	15	➔	➔	February 2022	Health Board (Welsh Language Group)
	54 (1724)	**Brexit Closed & Removed from Register** ~~Failure to maintain services as a result of the potential no deal Brexit~~	20	6	➔	➔	February 2022	Health Board (Emergency Preparedness Resilience and Response Group)

Risk Schedules

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

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

Level of Control
= 50%

Date added to the HB risk register
26.01.16

Rationale for current score:
Post wave 2 of COVID 19 Morriston and Singleton have experienced a steady increase in emergency demand to pre-covid levels. Capacity is limited due to covid response and therefore remains a high risk. Current score raised due to increasing pressures

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.

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

- Programme management office in place to improve Unscheduled Care.
- Daily Health Board wide conference calls/ escalation process in place.
- Regular reporting to Executive and Health Board/Quality and Safety Committee.
- Increased reporting as a result of escalation to targeted intervention status.
- Targeted unscheduled care investment of £8.5m in the annual plan, including a new Acute Medical Model focused on increasing ambulatory care.
- Development of a Phone First for ED model in conjunction with 111 to reduce demand.
- 24/7 ambulance triage nurse in place

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Re-establish short stay unit on ward D at Morriston	SGD (Morriston)	31/03/2022
Increase SDEC working hours and throughput of patients.	SGD (Morriston)	31/03/2022
Third phase of procurement to be undertaken to commission additional care home beds.	SGD (PCT)	31/03/2022

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

- New Urgent & Emergency Care Board to meet monthly

Gaps in assurance (What additional assurances should we seek?)
The need to deliver sustained service.

Additional Comments

Zero tolerance target of 4 hours agreed. SOP in place. Currently not achieving due to Omicron surge and increased pressures at Morriston.
Patient pathways that can bypass ED have been identified, but the EMD is working with WAST and SBU clinicians to maximise the number of patients receiving SDEC (Same Day Emergency Care).
Acute hub relocated to TAWE as planned in December. Estates works have commenced in Enfys ward.
Update 11.02.22 Action closed - Business case to take virtual wards up to 8 have been submitted to Management Board.

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:** Debbie Eyitayo, Director of Workforce and OD **Assuring Committee:** Workforce and OD Committee	
Risk: Workforce recruitment of medical & dental staff	**Date last reviewed:** February 2022	

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

Level of Control
= 70%

Date added to the HB risk register
April 2012

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

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

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

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

- Regular monitoring of recruitment position with reports to Executive Team and Board via Medical Director and Medical Workforce Board.
- Specialty based local workforce boards established to monitor and control specific issues. The new HB Workforce & OD Committee will seek assurance of medical workforce plans to maintain services.
- Engagement of the Deanery about recruitment position.
- Weekly workforce delivery meetings with CEO to review progress against critical medical and clinical posts
- Working with specialist agency and head hunters to improve chances to fill hard to recruit posts
- Plan to work with a marketing agency to develop a branding and attraction campaign for the health board.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Medical training initiatives pursued in a number of specialties to ease junior doctor recruitment	Director W&OD.	31st March 2022
The Medical Workforce Board continues to monitor recruitment and junior doctor's rotas.	Director W&OD.	31st March 2022
Continue to recruit internationally.	Director W&OD.	31st March 2022
Continue to work with head hunters	Director W&OD	31st March 2022

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

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

Gaps in assurance (What additional assurances should we seek?)
Locum cover
Adequate supply of doctors who can work in this country
Ability to flexibly deploy doctors in training.

Additional Comments
16/12/2021: Introducing best practice into the recruitment process to reduce delay and to streamline. We will continue to work with specialist agencies and head hunters. We will consider feasibility of introducing golden handcuff on any other initiatives to support recruitment.

17/01/2022: We have over established locum posts in specialties such as medicine, ITU and Anaesthetics in anticipation of trainee gaps and turnover. We have adopted a more pastoral approach to International medical recruitment as part of onboarding but we need to focus on measures to support retention. We have signed a contract with SBW to improve the HBs branding and attraction SBW will also support individual campaigns.

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:** Gareth Howells, Executive Director of Nursing **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:** February 2022	

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

Level of Control
= 40%

Date added to the HB risk register
January 2016

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 and antimicrobial stewardship 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.

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

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

- Policies, procedures, protocols and guidelines supplement the National Infection Control Manual.
- 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.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Drive improvements in prudent antimicrobial prescribing	Cons. Antimicrobial Pharmacist	31/03/22
Develop ward to board Dashboard on key Tier 1 infections	HoN IP&C & Digital Intelligence	31/03/22
Achieve compliance with IPC mandatory training	Service Group Triumvirates	31/03/22

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

- Clear Corporate and Service Group IPC Assurance Framework in place.

Gaps in assurance
(What additional assurances should we seek?)
Review single room capacity. Poor condition of hospital estate requires investment. High activity limits access for planned preventative maintenance and necessary HTM

• Ongoing monitoring of infection control rates, with weekly feedback corporately & to Service Groups. • Infection Control Committee and Quality Priority Sub-groups receive assurance reports, monitor infection rates, and identify key actions to drive improvement. Quality Priority Sub-groups of ICC review progress of improvement actions. • Training compliance. • IPC, antimicrobial, decontamination and cleaning audit programmes. • Compliance and validation systems for water safety, ventilation systems and decontamination.	validation/compliance checks. Seek improved Corporate and Service Group 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

20/01/22 - the incidence of key Tier 1 infections remains amongst the highest in Wales, with year-on-year increases across the five key infections.
COVID-19 infections in inpatient settings has highlighted the natural ventilation in the majority of inpatient areas is not adequate for preventing transmission of infections spread by the airborne route.
Progress has been made towards progressing many of the actions identified and included within the HCAI Quality Priorities.
There has been a temporary suspension to the IP&C 7-day service due to high level of vacancies within the service.
Three actions closed – 1. Define governance structures to support the HCAI Quality Priority. 2. Recruitment to support strengthening governance of decontamination processes. 3. Recruitment of key personnel to support improvements in antimicrobial prescribing.

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:** Inese Robotham, 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:** February 2022	

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

Level of Control
= 90%

Date added to the HB risk register
April 2012

Rationale for current score:
The accommodation is varied in age, tired and in need of upgrading/refurbishment to enable improved condition and compliance to regulations and WHBN/WHTMs.

Rationale for target score:
Risk assessments of premises.

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
The Health Boards 'Change for the Future' which is about improving access to services, will include a review of the whole estate and its suitability	Assistant Director of Operations (Est) & Assistant Director of Strategy (Capital)	31/03/2022
There is a 6 facet survey scheduled to be completed by 31/03/22 covering the occupancy and utilisation of the various sites	Assistant Director of Operations (Est)	31/03/2022
A review is currently taking place of current PCST structures and governance arrangements for estates and H&S to cover key compliances and escalation processes, with a draft report targeted for 31/12/21	Service Group Director (PCT) & Assistant Director of Health & Safety	31/03/2022
Work is being progressed to understand the detail in each of the leased properties to ensure appropriate levels of responsibility are identified for the landlord and the tenant/occupier	Service Group Director (PCT) supported by ADoOperations (Est), ADoStrategy (Capital) and ADoH&S	31/03/2022

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

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

Additional Comments

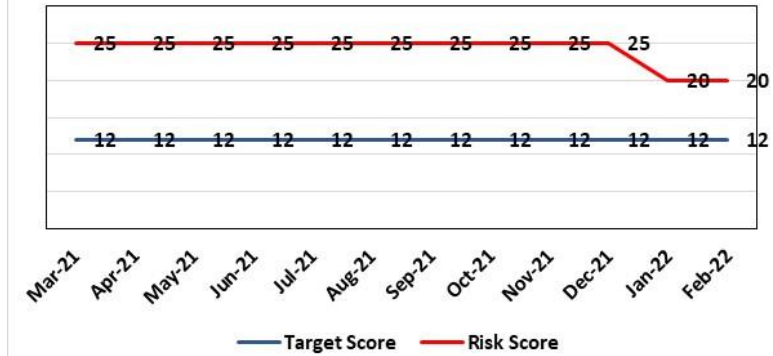
Update 21/01/22: Target date for action revised. Out of date, historical text removed.

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 4 = 20
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Inese Robotham, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee **For information:** Quality & Safety Committee	
Risk: Access and Planned Care. There is a risk of harm to patients if we fail to diagnose and treat them in a timely way.	**Date last reviewed:** February 2022	

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

Level of Control
= 90%

Date added to the HB risk register
January 2013



Rationale for current score:
All non-urgent activity was cancelled due to response to the Covid-19 pandemic and has increased the backlog of planned care cases across the organisation. Whilst mitigating measures such as virtual clinics have been put in place new referrals are still being accepted which is adding to the outpatient backlog particularly in Ophthalmology and Orthopaedics. The significant reduction in theatre activity during the pandemic increased the number of patients now breaching 36 and 52 week thresholds.

Rationale for target score:
There is scope to reduce the likelihood score to reduce the overall risk to an acceptable level

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

- Post Covid 19 the focus is on minimising harm by ensuring that the patients with the high clinical priority are treatment first. The Health Board is following the Royal College of Surgeons guidance for all surgical procedures and patients on the waiting list have been categorised accordingly.
- There is a bi-weekly recovery meeting for assurance on the recovery of our elective programme.
- Specialty level capacity and demand models set out the baseline capacity and identify solutions to bridge the gap. Non-recurring pump – prime funding is available to support initial recovery measures. Fortnightly performance reviews track progress against delivery.
- A focused intervention is in train to support to the 10 specialties with the longest waits.
- Long waiting patients are being outsourced to the Independent Sector
- Additional internal activity is being delivered on weekends (via insourcing)

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Implement demand management initiatives between primary and secondary care to reduce the number of new patients awaiting outpatient appointments.	Service Directors	31/03/2022
Implement a full range of interventions to support patients to be kept active and well whilst on a waiting list. The focus will be on cancer patients awaiting surgery and long waiting orthopaedic patients.	Service Group Directors	31/03/2022
Develop robust demand and capacity plans for delivery in 2022/23	Service Group Directors/ Deputy COO	31/03/2022

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

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

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

Additional Comments

27/01/22: An additional ophthalmology day case theatre in Singleton will also be operational early in 2022/23.
23/02/22 – Work has commenced in cardiology, ENT, dermatology and colorectal surgery. Other areas are being developed.

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 3 = 12
Objective: Digitally enabled care	**Director Lead:** Matt John, Director of Digital **Assuring Committee:** Audit Committee	
Risk: Digital Transformation Inability to deliver sustainable clinical services due to lack of Digital Transformation. There are insufficient resources to: • invest in the delivery of the ABMU Digital strategy, • support the growth in utilisation of existing and new digital solutions • replace existing technology infrastructure and the end of its useful life.	**Date last reviewed:** February 2022	

Risk Rating
(consequence x likelihood):
Initial: 4 x 4 = 16
Current: 4 x 3 = 12
Target: 5 x 2 =10

Level of Control
= 50%

Date added to the HB risk register
2012

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.

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.

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Establish 5year financial plan for Digital including the risks of the termination of the CTM SLA.	Assistant Director of Digital: Business Management and Information Governance	31st March 2022

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

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

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

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

Additional Comments

Update 16/2/2022 - Reviewed by the Digital Services Risk Management Group on the 8th February and no further updates required for the Executive Risk Management for this month.

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:** February 2022	

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

Level of Control
= 70%

Date added to the HB risk register
June 2016

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

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

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Develop Business Case for improved storage solution for both paper and digital records.	Head of Health Records & Clinical Coding	31st March 2022

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

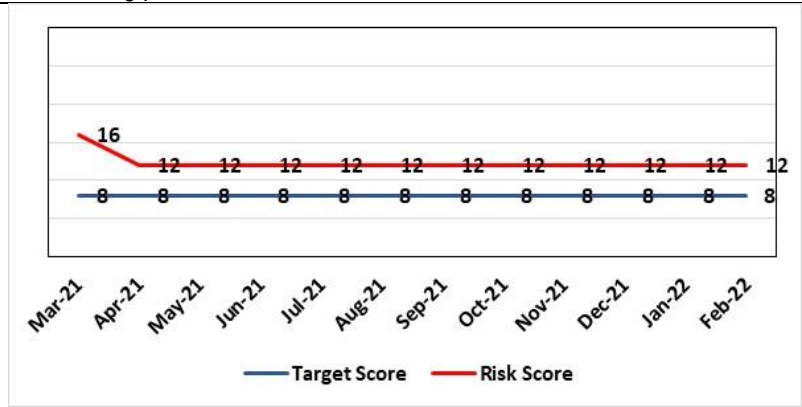
- RFID has been implemented for the acute record improving the management and storage of records
- Health Records performance reports developed in line with RFID technology
- Attainment of the Tier 1 Health Board target for clinical coding completeness which relies on the timely availability and quality of the Paper record and electronic sources
- Monitoring complaints and incident reporting.
- Electronic record is being implemented in accordance with the plan eg implementation of WNCR, ETR, HEPMA etc.

Gaps in assurance (What additional assurances should we seek?)
Investment required supporting the delivery and operational costs of the Digital strategy.
Reliance on NWIS for delivery of the solution for a fully electronic patient record.
Impact of the Infected Blood Enquiry on the Health Boards ability to destroy notes.
Process for ensuring clinical adoption of electronic ways of working and cessation of adding information to the paper record that is already available electronically needs to be agreed and enforced by the Health Board.

	Impact of the infected Blood Inquiry on the health boards ability to destroy notes has considerably increased the pressure on storage capacity and negating some of the mitigating actions that are in place.
Additional Notes Update 17.11.21 – Action completed - Complete convergence with WCP (replace ABMU Clinical Portal with Welsh Clinical Portal at all inpatient locations) 16.02.22 – No further update for February 2022.	

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:** February 2022	

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%

Date added to the HB risk register
June 2016

Rationale for target score:
C- will remain the same or increase due to increased reliance in information
L- Investment in BI will lead to more information be available and used. The higher the use of information at operational level will lead to better quality data.

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
In line with the BI Strategy & Implementation Plan a new data warehouse server will be brought on line and all existing data will be migrated onto it ready for further work to be undertaken to increase our levels of Business Intelligence maturity and the delivery of the Ambitions set out within the strategy.	Assistant Director of Digital Intelligence	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?)

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 Update 15.11.21 – Investment and implementation of system to record patient outcome measures (Completed). Funding secured by the Head of Values Based Healthcare for a pilot solution for PROMS delivery. Action completed - Investment and implementation of system to record patient outcome measures. 15.02.2022 – Action complete - The BI Strategy was presented to the Management Board at the end of January 2022, and this was very well received. 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:** February 2022	

Risk Rating (consequence x likelihood):		**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 has been submitted to WG on 30.06.21 and includes a balanced financial plan.
Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 4 x 2 = 8		
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.

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

- Welsh Government written statement published on the 7 October 2020 advising that SBUHB been de-escalated from targeted intervention status to 'enhanced monitoring' status.
- A draft Annual Plan within 3 year context was considered by the Board In Committee in March 2021 and submitted to WG.
- The final Annual Plan was approved by the Board on 23 June 2021 and submitted to WG on 30 June 2021.
- The Health Board is developing a 3 – 5 Recovery and Sustainability Plan which will provide the foundation to deliver an agreed IMTP for 2022/23.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Development of draft Recovery and Sustainability Plan for approval by the Board	Dir of Strategy & Dir of Finance	31st March 2022

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

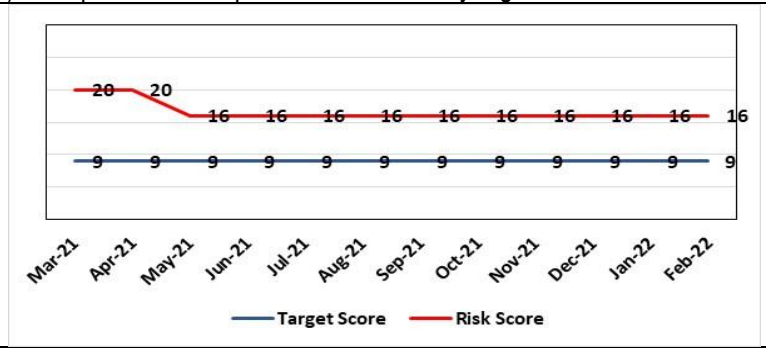
Recovery and Sustainability Working Group has been established, chaired by CEO with independent members and Executive leads. The existing IMTP Executive Steering Group will provide oversight of the R&S Plan, Performance and Finance Plans assured by P&F Committee. W&OD Committee reviews the workforce plan, Q&S Committee the Q&S elements. JET meetings with WG. Robust programme arrangements have been put in place to execute the 21/22 Annual Plan. An update on Annual plan progress at Q2 was reviewed by Board Nov 2021 and adjustments to off track actions approved in Dec Special Board.

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

Additional Comments

22.02.2022 – Timescales for completion of IMTPs have been changed by Welsh Government – now changed to 31/03/22. Board has been kept updated at each meeting and at briefing sessions since December. Accountable Officer letter to be submitted to WG on ability to submit a balanced IMTP by 28/02/22 following Board.

Datix ID Number: 1567 Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety	HBR Ref Number: 41 Target Date: February 2024	Current Risk Rating 4 x 4 = 16
Objective: Best Value Outcomes	**Director Lead:** Darren Griffiths, Director of Finance & Performance **Assuring Committee:** Health and Safety Committee	
Risk: Fire Regulation Compliance Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations.	**Date last reviewed:** February 2022	

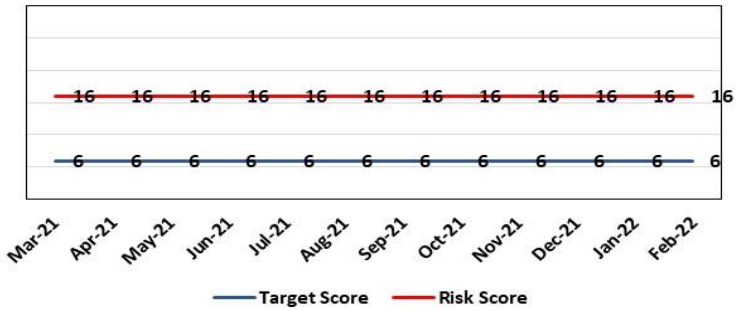
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 4 x 4 = 16 Target: 3 x 3 = 9		**Rationale for current score:** Cladding applied to Singleton Hospital front flank is not compliant with fire regulations. General compliance with fire regulations and WHTM/WHBN requirements. Risk reduced 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?)		
	Action	**Lead**	**Deadline**
• 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.	Change in fire evacuation plans and alarm and detection cause and effect	Head of Health & Safety	28th February 2024
	Replacing the existing cladding and insulation with alternative specifications and inserting 30 minute fire cavity barriers where appropriate	Service Improvement Manager	28th February 2024

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

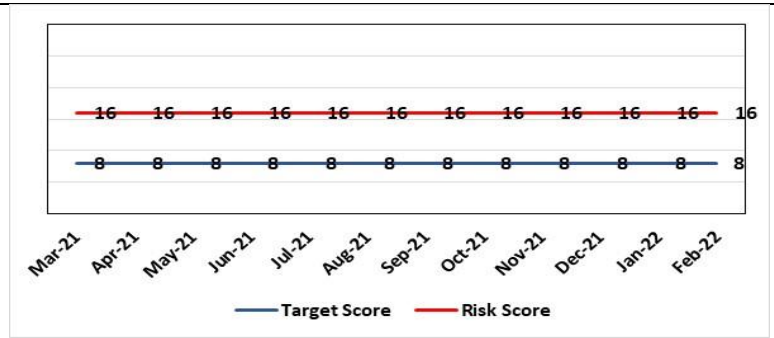
17.01.22: Cladding project board met on 14.01.22 for an update on the progress of the cladding project, due to a number of reasons (Asbestos removal - Expert witness investigations). The latest expected completion date is March 2024. The cladding replacement works (fire integrity) is not now expected to be completed until March 2024, therefore, this will impact on the ability to reduce the risk rating at present and will be continually reviewed.

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

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
Additional supervisory body signatories in place BIA rota now implemented but limited uptake due to inability to release staff. BIA Training undertaken for 9 nursing staff (7 within the Long Term Care Team). Able to undertake assessments utilising additional monies from WG. 1 x substantive BIA in post and additional admin post in place. DoLS database updated and DoLS dashboard in place, monitoring applications and breaches via dedicated BIAs and Admin. Delivery of DOLS Action plan reviewed monthly Regular reporting to Mental Health and Legislative Committee (MHLC) (Nov 21) New legislation changes regarding Liberty Protection Safeguards (LPS) was expected in April 2022. Confirmation received from UK government December 2021 that this is to be delayed. Waiting for draft Code of Practice and LPS Guidance to be published for consultation January 2022. Additional funding received from WG to manage the backlog of DoLS assessments and implementation of LPS. A different service model is required to meet existing and future requirements for LPS. Additional funds from WG will allow for a business plan to be completed to help meet this new service need.	**Action**	**Lead**	**Deadline**
	Business case for revised service model	GND Primary and Community	31/03/2022
	Agency commissioned to support backlog of assessments	GND Primary and Community	31/03/2022
	Overtime agreed to fund sign off from nurse assessor team to process the backlog assessments	GND Primary and Community	31/03/2022
Assurances (How do we know if the things we are doing are having an impact?) Regular scrutiny at Service Group and Safeguarding Committee and by DoLS Internal Audit; monitoring via DoLS Dashboard this will provide real-time accurate data. Update report to MHLC, impact of backlog of DoLS breaches and new LPS implementation	**Gaps in assurance (What additional assurances should we seek?)**		
Additional Comments			

This risk has been linked to MHLD Operational Risk Register risk 2294 on Court of Protection Cases (current operational risk score within service group of 20) reflecting claims received. WG have delayed implementation of LPS but confirmed it will go ahead. Current DoLS process and role of BIA's reviewed, interim model required to allow consideration of future model in along with wider MCA capacity and consent issues to support transition to LPS. Business case to support interim model to support current service. Health board-wide training and awareness of mental capacity required in preparation for LPS. Training and education plan using WG funding being developed. Ongoing work strategically in the HB and regionally with LA partners to agree model required and where this work sits within the HB long term.

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 **For information:** Quality & Safety Committee	
Risk: Failure to sustain Child and Adolescent Mental Health Services	**Date last reviewed:** February 2022	

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?)

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Additional investment expected - from Welsh Government. Additional investment received in 2021/22, however no additional investment is expected	CAMHS network	31st March 2022
Staffing of service being strengthened & supplemented by agency staff	CAMHS network	31st December 2021
Improvement plan has been shared by CTM and is monitored monthly. Action to mitigate the risk to young people waiting is being taken including utilisation of the third sector for support. Update is scheduled to the performance & finance committee in March	Assistant Director of Strategy	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?)

Additional Comments

28/01/22: Risk reviewed – no change to score.
17/02/22: New action added.
Update 22.02.2022 - Potential for repatriation of CAMHS service from Cwm Taf Morgannwg HB being considered through commissioning additional external support to review

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**: Inese Robotham, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee **For information:** Quality & Safety Committee	
Risk: Access to Cancer Services A backlog of patients now presenting with suspected cancer has accumulated during the pandemic, creating an increase in referrals into the health board which is greater than the current capacity for prompt diagnosis and treatment. Because of this there is a risk of delay in diagnosing patients with cancer, and consequent delay in commencement of treatment, which could lead to poor patient outcomes and failure to achieve targets.	**Date last reviewed:** February 2022	

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

Level of Control
= 70%

Date added to the HB risk register
April 2014

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

Rationale for target score:
Target score reflects the challenge this area of work present the Board and where small numbers of patients impact on the potential to breach target.

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

- Tight management processes to manage each individual case on the Urgent Suspected Cancer Pathway. Enhanced monitoring & weekly monitoring of action plans for top 6 tumour sites.
- Initiatives to protect surgical capacity to support USC pathways have been put in place
- Additional investment in MDT coordinators, with cancer trackers appointed in April 2021.
- Prioritised pathway in place to fast track USC patients.
- Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. This will form part of the remit of the Cancer Performance Group.
- Weekly cancer performance meetings are held for both NPTS and Morriston Service Groups by specialty.
- The top 6 tumour sites of concern have developed cancer improvement plans.
- Additional work being undertaken as part of diagnostic recovery and theatre recovery workstreams.
- Endoscopy contract has been extended for insourcing.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Phased and sustainable solution for the required uplift in endoscopy capacity that will be key to supporting both the Urgent Suspected Cancer backlog and future cancer diagnostic demand on Endoscopy Services.	Service Group Manager	31 Mar 22
Implement a process for clinical harm review (Waiting on all Wales decision of patient pathway reviews & framework).	Cancer Quality & Standards Manager	28 Feb 22
Cancer Programme Board to be established	Cancer Quality & Standards Manager	28 Feb 22

Assurances (How do we know if the things we are doing are having an impact?)
Backlog trajectory accepted at Management Board on 15th September and trajectory will be monitored in weekly enhanced monitoring meetings. Cancer Performance Group being established to support execution of the services delivery plans for improvements.

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

Additional Comments

18.11.21 In September, the HB reported 62% compliance, meeting the trajectory of 62%. Total waits at all stages pre-treatment show a level of stability through September, showing a small decline through October but remain considerably higher than at any other point since the start of 2020 and 44% higher than January 2021.
We are still experiencing the impact and restrictions of COVID-19 on our services and our cancer pathways. The number of COVID patients being admitted into our hospitals has increased significantly through July and August. End of October Backlog remains off trajectory by+61
Actions updated to more accurately reflect actions directly related to this risk including the new established Cancer Performance Group. Risk score updated based on being off trajectory for SCP and Backlog. Controls updated to accurately reflect work being undertaken.
12.01.21: Weekly operational tumour site meetings continue with top 7 sites. Challenge and review of data done by CIT and Cancer Associate Service Group Director for Cancer Division. Cancer Improvement Group has now been stood down, new Cancer Programme Board to be established and chaired by Medical Director. PMO office to be engaged to support set up of programme and programme board. Draft TOR for this new Cancer Programme Board (PBD) have been complete and were approved in last CIG.
The newly established Cancer Programme Group chaired by Deputy COO will report into this Cancer Programme Board.
28.01.22 - Deputy COO at request from CEO is reviewing current improvement plans. New Revised pathway is being implemented around FIT, which will appropriately remove patients off SCP pathway. Additional WLI plans are in place across Breast and Gynae for February. Additional capacity has come on line in NPT to support inpatient diagnostic capacity for Urology. New amended plans are being revised due to deterioration in backlog as part of Cancer Perf Group.
07.02.22 - A health board Cancer Performance Group has been established in November 2021. A work programme for the group has been established

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:** Gareth Howells, Executive Director of Nursing **Assuring Committee:** Workforce and OD Committee	
Risk: Non Compliance with Nurse Staffing Levels Act (2016)	**Date last reviewed:** February 2022	

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

Rationale for current score:

- Risk is high due to COVID related sickness and high (although improving) level of registered nursing vacancies
- Service groups remain high with scores ranging from 16 to 20 (Morriston = 16, Singleton and Neath Port Talbot = 20), high vacancies and sickness cited as reasons for scores. Corporate score has been decreased to 20 to reflect Service Groups position.

Level of Control
= 80%

Date added to the HB risk register
November 2018

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.

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

The Health board has put the following controls in place:

- Workforce Plans have been developed by service group 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.
- Designated person confirmed as Director of Nursing & Patient Experience.
- The Ward Sister / Charge Nurse and Senior Nurse should continuously assess the situation and keep the designated person formally appraised.
- 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 and reports to NMB and Workforce & Organisational Development Committee
- Health Board has representation at the All-Wales Nurse Staffing Group and its sub groups
- Bi-annual calculations undertaken across all acute Service Delivery Units for calculating and reporting nurse staffing requirements
- Following June 2021 acuity data collection and submission of acuity templates, scrutiny panels took place in September and agreed templates for all Section 25B wards. A further scrutiny panel

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Student Streamlining and Overseas recruitment	Executive Director of Nursing	01/09/2022 Monthly ongoing
The Board should ensure a system is in place that allows the recording, review and reporting of every occasion when the number of nurses deployed varies from the planned roster. Implementation of Safecare, commenced 1st February, roll out plan is 32 weeks.	Executive Director of Nursing	01/10/2022
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.	Executive Director of Nursing	01/09/2022 Monthly ongoing
Risk register to be reviewed monthly to ensure compliance	Executive Director of Nursing	01/09/2022 Monthly ongoing

undertaken for all section 25A templates for NPTSSG, January Bi-annual acuity completed awaiting visualisers from HEIW. Scrutiny panels arranged for corporate scrutiny in March, visualisers and timescales from HEIW circulated. • Extension of 'the Act' into paediatric inpatient areas commenced on 1st October 2021 • Mandatory Assurance Report submitted to November Board, May Assurance Board Paper currently being prepared, for draft submission to March Nurse Staffing Group • Workforce planning & redesign, training and development. recruitment and retention continues. Weekly Workforce meeting for each Service Group, on a rotation basis, re-instated w/c 15th November 2021, every fifth week all Service groups to attend for Transformation work. Weekly workforce meeting re-instated w/c 10.01.2022, stood down from 24th January 2022, will re0instate as appropriate. • Robust roster scrutiny is undertaken to optimise nursing workforce • Implementation of SafeCare underway. Roll out to first 5 wards in MHSG commenced 1st February 2022. All Wales SOP has been supported by All Wales NSA Group and remains a working document as implementation of Safecare continues and understanding evolves. • Service groups continue daily staffing huddles and daily staffing tool and escalate as appropriate			
Assurances (How do we know if the things we are doing are having an impact?) • Ongoing robust recruitment and retention plans in place to reduce vacancies in key clinical areas, which is in line with the Health Board recruitment plan. • 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/visitors of planned roster. • At least Yearly Board reports outlining compliance and any key risks. • Mandatory Assurance report to Board in May. • Monitoring arrangements • HB NSA and NMB • Patient Information available on all Section 25B wards	**Gaps in assurance (What additional assurances should we seek?)** • Issue raised regarding Information Technology barriers around the capture of data required for the Act on an All- Wales and Health Board basis. • Implementation of SafeCare end of this year potential to cause additional work at ward level, particularly around the bi-annual acuity data collection, planned support from corporate nursing team to reduce impact as much as possible. • Ongoing work across Wales to ensure IT systems are compatible with each other for operational and reporting purposes.		

Additional Comments

01.02.2022 - Nurse staffing risk scores continue to be updated and discussed monthly in HB NSA Steering group. Service groups and Corporate team share good practice and review scores monthly. Clear escalation process is in place should/when situation changes. Weekly Staffing meeting re-commenced in December and stood down in January, then re-instated in January due to ongoing pressures mainly COVID related.

Weekly meeting allows for clear discussion and mitigation/limiting of risk across HB. Throughout, Sept to December risk scores remained at 20, increase in maternity services reported which was mitigated by stopping home birth service for a short time. Welsh Government aware, plan to re-start service in place.

In January HB NSA Steering group, SHNPT SG reported increase in risk score to 25, based on wards in hospitals and pressure within maternity and neonatal services. This risk score increase was reflected in the Corporate risk score increasing to 25. Weekly staffing meeting continue to support. Daily staffing huddle and tool completed by service groups, allows for seamless escalation of risk. Pressure felt to be mainly COVID related as community spread increased. Enhanced overtime rates have continued. Use of Bank and pool bank remains. All non-essential meetings cancelled. Vacancy rate shows slight improvement following student streamlining, Recruitment, including overseas nurses, remains a high priority. Support for new nurses to the HB has been raised as a concern, work towards venue and ability to support these nurses that are new to the HB continues. Wellbeing of staff is considered and support provided as necessary.

January bi-annual acuity audit undertaken, plans for scrutiny panels in March. Section 25A wards in NPTSH SG re-calculated in November 2021, using triangulated methodology. Extension of 'the Act' into paediatric inpatient areas commenced 1st October 2021. Preparation of Mays Board paper underway, review and scrutiny of all NSA quality indicators being undertaken. **15.02.2022 –** Following HB NSA Steering Group, corporate risk has been decreased to 20. Reflecting Risk scores in Service groups; MHSG 16, NPTSHSG Adults 20, NICU 20, Paediatric acute wards 15, Maternity 20, District nursing 20, Health Visiting 20, Mental Health 15.

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:** February 2022	

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

Level of Control
= 50%

Date added to the HB risk register
November 2018

Rationale for current score:
- Current lack of sustainable funding source to secure capacity

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.

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Review of the current process for developing Equality Impact Assessments around service change, engagement and consultation.	Interim Assistant Director of Strategy	30th April 2022
Robust policies and processes to be in place for Impact Assessment going forward.	Interim Assistant Director of Strategy	31st July 2022
Conclude work on exec equalities portfolios	Interim Assistant Director of Strategy	31st December 2022

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

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

Datix ID Number: 1762 Health & Care Standard: Staff & Resources 7.1 Workforce	HBR Ref Number: 53 Target Date: 31st March 2022	Current Risk Rating 5 x 3 = 15
Objective: Partnerships for Care	**Director Lead**: Hazel Lloyd, Interim Director of Corporate Governance **Assuring Committee:** Health Board (Welsh Language Group)	
Risk: Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.	**Date last reviewed:** February 2022	

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

Level of Control
= 60%

Date added to the HB risk register
November 2018

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.

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.

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
Ensure the Board is fully sighted on the UHB's position through regular reporting to the Health Board.	Head of Compliance	30/06/2022
Review and update the Welsh Language Standards Action Plan. In doing so, reflect the findings of the independent assessment	Head of Compliance	31/03/2022
Reinstate quarterly meetings of the Welsh Language Delivery Group.	Head of Compliance	31/03/2022

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

Update Jan 2022: Timescales refreshed.

Datix ID Number: 1724 *Risk Closed* Health & Care Standard: Safe Care 2.1 Managing Risk & Health & Safety	HBR Ref Number: 54 Target Date: 31st December 2022	Current Risk Rating 3 x 2 = 6
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:** January 2022	

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

Level of Control
= 70%

Date added to the HB risk register
November 2018

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.

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.

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

- Emergency Preparedness resilience and response, (EPRR) work programme in relation to the 6 statutory duties is monitored via the EPRR Strategy Group; this includes emergency planning, risk assessment, collaboration, sharing of information, warning and informing and business continuity.
- The Health Board continues to respond to the C-19 pandemic and has been in response since 31.01.21. In addition, there have been a number of concurrencies that the Health Board has responded to; emphasising the need for a continued cycle of 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.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
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?)

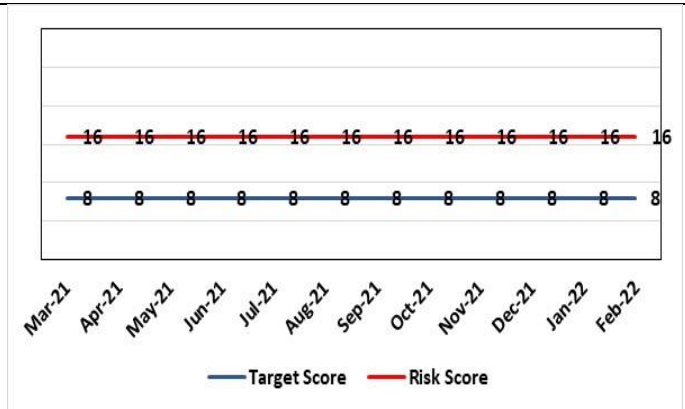
- Work programme in place and monitored via EPRR Strategy Group
- All services have up to date business continuity plans
- Robust risk management system in place
- Preparedness and response assurance procedure specifically for Brexit
- Horizon scanning process in place for issues that may arise later during 2021

Gaps in assurance (What additional assurances should we seek?)
None

Additional Comments

~~BREXIT has now occurred with a "deal". There were requirements for data adequacy arrangements for the UK to be approved by end of June 2021, and for the settled status scheme to be implemented. Both of these are now complete. There is one further requirement due for resolution in Dec 2022, and it is therefore proposed to reduce the risk to 3 x 2 = 6 until this is closed.~~
28/01/2022: It is proposed to close this risk

Datix ID Number: 1799 Health & Care Standard: Controlled Drug 2.6 Medicines Management	HBR Ref Number: 57 Target Date: 01/03/2022	Current Risk Rating 4 x 4 = 16
Objective: Best Value Outcomes of High Quality Care	**Director Lead**: Richard Evans, Executive Medical Director (tb reviewed) **Assuring Committee**: Audit Committee	
Risk: Non-compliance with Home Office (HO) CD Licensing requirements. The Health Board (HB) currently has limited assurance regarding compliance with HO CD Licensing requirements, nor does it have processes in place re future service change compliance.	**Date last reviewed:** February 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 2 = 8	**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.	
Level of Control = 40%		
Date added to the HB risk register January 2019	**Rationale for target score:** Following either the HO agreeing with the content of the HB 'Policy to determine the requirement for HO CD Licenses,' or a position of compromise being agreed there will be a training session held with all Service Groups supported at Executive level.	



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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
HB to discuss and agree a policy position on the requirements for HO CD Licenses with the HO.	CD Pharmacy	1st March 2022
Upon agreement of policy with the HO: HB to undertake baseline assessment of current CD management (including any HO CD licenses currently held) in line with agreed policy on requirements for HO CD licenses	CD Pharmacy	1st March 2022
Upon agreement of policy with the HO: HB to develop and implement a control system to ensure compliance with agreed policy on HO license requirements.	CD Pharmacy	1st March 2022
Apply for a HO CD License for HMP Swansea.	CD Lead, PCT	1st March 2022

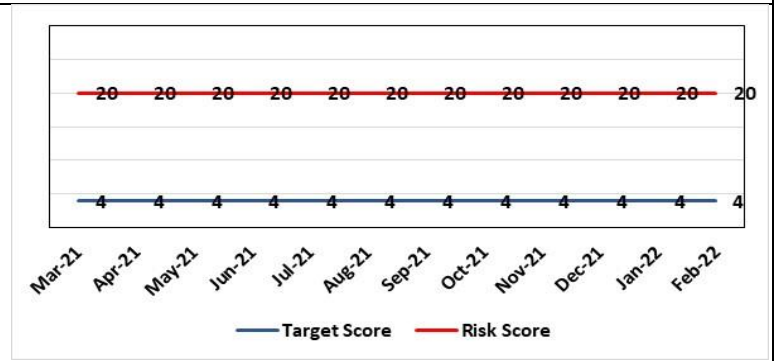
Assurances (How do we know if the things we are doing are having an impact?)
The HB policy on HO CD licenses is referred to when issues are raised in order to provide consistency in arrangements.

Gaps in assurance (What additional assurances should we seek?)
The HB will develop a license compliance register, this is expected to be maintained by the Corporate Governance Team thus ensuring there is sufficient segregation of duty.

Additional Comments

We are awaiting advice from the Home Office. The intention is review this risk following receipt of that advice with a view to de-escalating if appropriate.
27/01/22: The risk remains unchanged so has not been de-escalated yet.
Update 22.02.2022 - No change to current score - Executive Medical Director.

Datix ID Number: 146 Health & Care Standard: Effective Care 3.1 Clinically Effective Care	HBR Ref Number: 58 Target Date: 31st March 2022	Current Risk Rating 4 x 5 = 20
Objective: Excellent Patient Outcomes	**Director Lead**: Inese Robotham, Chief Operating Officer **Assuring Committee**: Quality and Safety Committee	
Risk: Failure to provide adequate clinic capacity for follow-up patients **Ophthalmology** results in a delay in treatment and potential risk of sight loss.	**Date last reviewed:** February 2022	

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?)**		
• All patients are categorised by condition in order to quantify issue. • Community optometry scheme successfully implemented to reduce number of diabetic retinopathy patients on follow up list. • Scheme developed for assessment of glaucoma patients by community optometrists for virtual review by consultant ophthalmologists to reduce follow up backlog. • Outsourcing of cataract activity to reduce overall service pressures.	**Action**	**Lead**	**Deadline**
	An overall Regional Sustainability Plan to be delivered	Service Group Manager Surgical Specialties	31st March 2022 (Bi-weekly ongoing)
Assurances **(How do we know if the things we are doing are having an impact?)** • Deputy COO holds Gold Command meetings on a monthly basis to monitor progress.	**Gaps in assurance** **(What additional assurances should we seek?)** Regular liaison with patients on extended waiting list/times and validation.		

Additional Comments

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:** February 2022	

Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 5 x 3 = 15		**Rationale for current score: C and L** 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.	Assistant Director of Digital Technology	31st March 2022
	Complete subsequent Cyber Security Assessment as part of annual NIS compliance work with Cyber Resilience Unit in DHCW	Assistant Director of Digital Technology	31st March 2022
	Complete an Improvement Plan based on the Assurance Report from the Cyber Security Resilience Unit	Cyber Security Manager	30th April 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?)**
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.
Update 13.10.21 – Action completed - Undertake Cyber Assessment as part of annual NIS compliance work with Cyber Resilience Unit in DHCW. One new action added.
Update 15.11.21 – A paper is being submitted to the next IGG, to explore the options for making Cyber Security Training mandatory.

Update 16/2/2022 - Indications at a national level regarding the procurement of a Training Package to combine Cyber Security & IG training are underway. At this stage no agreement has been made.

Datix ID Number: 1587 Health & Care Standard: 3.1 Safe and Clinically Effective Care	HBR Ref Number: 61 Target Date: 1st June 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:** Inese Robotham, Chief Operating Officer **Assuring Committee:** Quality and Safety Committee/Strategy Planning and Commissioning Committee	
Risk: Paediatric dental GA/Sedation services provided under contract from Parkway Clinic, Swansea. Medical Safety risk GAs performed on children outside of an acute hospital setting.	**Date last reviewed:** February 2022	

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

Level of Control
= 60%

Date added to the HB risk register
4th July 2018

Rationale for current score:
There is no immediate access to crash team/ICU facilities in in Parkway Clinic – the client group are undergoing G/A/sedation. Paediatric GA/Sedation services provided under contract from Parkway Clinic, Swansea continue due to lack of capacity for these patients to be accommodated in Secondary Care

Rationale for target score:
Relocation of the paediatric GA service [provided by Parkway Clinic] to a hospital site being treated as a priority

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Transfer of services from Parkway.	Interim Head of Primary Care	31st May 2022

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

- RMC collate referral and treatment outcome data for review by Paediatric Specialist
- Regular clinical meeting arranged with Parkway to discuss individual cases/concerns
- Regular clinical/ management meeting for CDS/primary care management team to discuss service pathway /concerns/issues arising
- Roll out of new pathway to encompass urgent referrals

Gaps in assurance
(What additional assurances should we seek?)
ToR for the task and finish group should continue to include consideration of the pressures on the POW special care dental GA list and this service is considered alongside any plans for the Parkway contract.

Additional Comments

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**: Gareth Howells, Executive Director of Nursing **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:** February 2022	

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

Level of Control
= 60%

Date added to the HB risk register
1st August 2019

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.

Rationale for target score:
Compliance with Gap & Grow requirements.

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

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.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Adherence to Gap/Grow Standards	Deputy Head of Midwifery	30/03/2022

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

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

Additional Comments

UWE course now anticipated to be completed for 2 midwifes by early 2022. Business case for 2nd cohort to be completed.
28.10.21 This risk additionally going to be added to the Radiology Risk Register to acknowledge the issues identified. ML to email AS for an update as to whether we can return to pre-covid scanning.
19.11.21 Expressions of interest requested from midwives to attend January 2022 sonographer training at UWE. Training places funded by HEIW. Business case required to backfill for trainees. Further capacity issues identified due to the introduction of 30 minute fetal anomaly scans in line with ASW standards. Increased capacity gap assessed to be 20 scans per week.
14.01.22: Two midwives have commenced ultrasound training at UWE. Two midwives currently on preceptor program with an aim to achieve service delivery lists in April 2022. Resignation received from midwife sonographer trainer. Options being explored for covering 15 hours training.

20.01.2022: Meeting with USS lead trainer and lead obstetric consultant. Concern raised of the impact of one USS machine on bot service development and training. Suggestion for all issues to be set out using a risk assessment form which will be passed to divisional manager and cc Chair of HB ultrasound group convened for development of midwife sonographer third trimester screening clinics

Datix ID Number: 2159 Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety	HBR Ref Number: 64 Target Date: 31st August 2023	Current Risk Rating 5 X 5 = 25
Objective: Best Value Outcomes	**Director Lead:** Darren Griffiths, Director of Finance & Performance **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:** February 2022	

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 reviewed and proposals & business case produced. Discussion ongoing to determine funding.	Assistant Director of H&S	31st March 2022
The two fire safety posts will be advertised W/C 15/11/21, with interviews scheduled for December 21, with posts being filled between January - March 2022.	Assistant Director of H&S	31st March 2022
Health and safety structure review to be presented to the H&S Committee when funding has been agreed. The Target date has been adjusted to reflect this.	Assistant Director of H&S	31st March 2022

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?)
Agreement of funding for resources identified in business case to implement structure in business case by Q2/3 2022/23 financial year.

Additional Comments

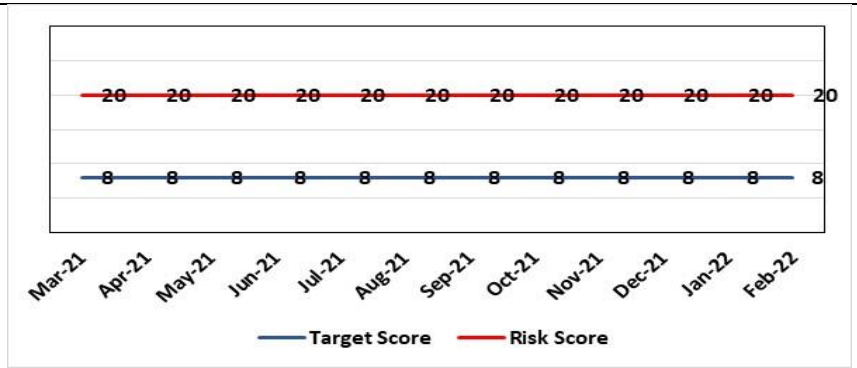
17.01.22: Two fire advisors were successfully appointed in December 2021, with expected commencement in February 2022.This will increase the number of FSA to 3 FT, further posts covering health & safety, manual handling, violence and aggression awaiting a decision on funding to implement during 2022/23 financial year. It is not anticipated that a reduction in risk score and will be continuously reviewed.

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**: Gareth Howells, Executive Director of Nursing **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:** February 2022 **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



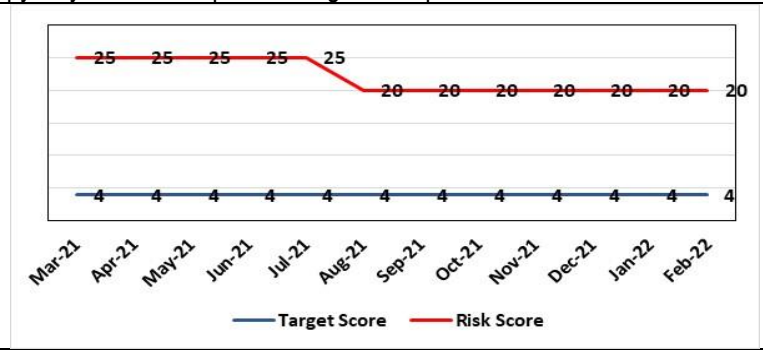
Rationale for target score:
Funding for central monitoring approved for 2021/22
Meeting to be arranged with provider and key stakeholders in SBU to commence the project toward installation and training.

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
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.	**Action**	**Lead**	**Deadline**
	Business case prepared for Central monitoring system to store CTG recordings of fetal heart rate in electronic format.	Deputy Head of Midwifery	31/03/2022
Assurances (How do we know if the things we are doing are having an impact?) All Wales Fetal Surveillance Standards for 6hrs Fetal Surveillance Training per year	**Gaps in assurance (What additional assurances should we seek?)**		

Additional Comments

25.10.21 – Update – Business case completed. Awaiting update from K2 regarding when the monitoring system can be delivered as funds available through slippage funding.
Update 05.11.21 – Meeting to agree costings - On completion and agreement of the action a project Board Steering Group will be set up to manage installation and training on the system
14.01.22 Central monitoring system approved at BCAG - project board being developed.

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 4 = 20
Objective: Best values outcomes from high quality care	**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee:** Quality and Safety Committee	
Risk: The demand & complexity of planned treatment regimes for cancer patients requiring chemotherapy currently exceed the available chair capacity, risking unacceptable delays in access to SACT treatment in Chemotherapy Day Unit with impact on targets and patient outcomes.	**Date last reviewed:** February 2022	

Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 4 = 20 Target: 2 x 2 = 4		**Rationale for current score:** Reduced risk to 20 as plan agreed for homecare service and plan for increasing chairs going forward.
Level of Control =		
Date added to the HB risk register 30/11/2019		**Rationale for target score:** Reduced delays in treatment will reduce risk of harm.

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. A daily scrutinizing process in progress to micro manage individual cases, deferrals etc.	Business case endorsed by CEO for shift of capacity to home care to be considered by the Management Board.	Service Director Lead for Cancer	30th March 2022
	A second business case is being developed to propose relocation of CDU to a vacant ward area, which would increase chair capacity.	Service Director Lead for Cancer	28th March 2022
	Subject to approval of the above relocation will progress with aim of completion by April 2022.	Service Director Lead for Cancer	1st April 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?)**
Following completion of the Medical move to Morriston from Singleton following population engagement, assurance reports on activity and improved chair waiting times will be monitored through monthly Cancer Improvement Group	Capital & Revenue assumptions & resources for second business case for increasing chair capacity in 2022/23 to meet increased demand.

Additional Comments

Update 21.10.21 – Change of risk owner to Matron who will report and monitor progress via SACT.

Update 18.11.21 - from discussions in SACT meeting: Staffing levels are not a contributory factor for the increased waiting times. CDU waiting times are having an impact on the inpatient ward since an increased number of patients are being booked into inpatient beds. A 6 quick fix solution list has been shared with RJ yet on review the majority of the solutions have already been implemented with the remaining ones being deemed not currently feasible. Scope to access Rutherford for some treatments. There is a reduction in the number of pre-prepared drugs which is impacting on PTS. A request for clinicians to briefly annotate intent to treat to speed up manufacturing process. Plan to maximize 7 day blood tests for immunotherapy regimes. PTS is lacking staff resource to optimize all equipment. There are vacancies and training requirements. Therefore, only 2 out of 3 capacitors are in operation at one time. The need for trial

patients to be reviewed on the day of treatment is impacting on manufacturing times. Homecare projects ongoing and planned for next year. Plan to look at switch with Zometa for Denosumab. While this is deemed costly, it may be cheaper than paying Rutherford for treatments – will free up alternative Saturday space to accommodate immunotherapy regimes thus creating increased capacity during the week for cytotoxic regimes. Update 10.02.2022 - 2 options appraisals have been submitted for consideration of uplifting staffing numbers to deliver treatments outside CDU or CDU current working hours, this will release capacity in CDU to enable more timely access for high risk SACT. Update 22.02.2022 - No change to risk score currently - EMD.

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 3 = 15
Objective: Best values outcomes from high quality care	**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee:** Quality and Safety Committee	
Risk: Clinical risk-target breeches in the provision of radical radiotherapy treatment. Due to capacity and demand issues the department is experiencing target breaches in the provision of radical radiotherapy treatment to patients.	**Date last reviewed:** February 2022	

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

Level of Control
=

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

Rationale for current score:
Waiting times deteriorating for elective delays patients, particularly prostates discussed in Oncology business meeting. Current Risk reduced to 15. At present 70 patients to be outsourced which increases capacity. New Linac building work underway, which will increase capacity in near future

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

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Hypofractionated Prostate - Business plan submitted for additional resources required to implement hypofractionated technique.	Service Manager Cancer Services	31st March 2022
Explore the possibility of undertaking SABR treatment for lung cancer patients at SWWCC. Awaiting confirmation from WHSSC on whether they will commission SABR from SBUHB.	Executive Medical Director	30th March 2022
New Linac required – Linac case agreed with WG	Service Manager Cancer Services	1st July 2022

Assurances
(How do we know if the things we are doing are having an impact?)
Performance and activity data is being monitored and monthly data shared with radiotherapy management meeting and cancer board. It is also now included in scorecard.

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

Additional Comments

02/12/21: New Linac approved to replace Lin 4. SGRT retrofit underway on Lin 1. Reassess scoring at next RTMM.
29/12/21: SGRT lin 2 out of action from 23/12/21; CRAD fitting to be completed w/c 10.01.22.
20/01/22: LIN1 SGRT upgrade completed; Lin C Replacement delivered.
01/02/22: LinC Replacement fitted - acceptance and commissioning to take place; Lin D Replacement funding secured.
Update 22.02.2022 - No change to current score EMD.

Datix ID Number: 2299 Risk Closed 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	**Director Lead**: Keith Reid, Director of Public Health **Assuring Committee:** Quality and Safety Committee	
Risk: Risk of declared pandemic due to Coronavirus Infectious Disease outbreak 2020 leading to disruption to Health Board activities.	**Date last reviewed:** January 2022	

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?)

- 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.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
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?)

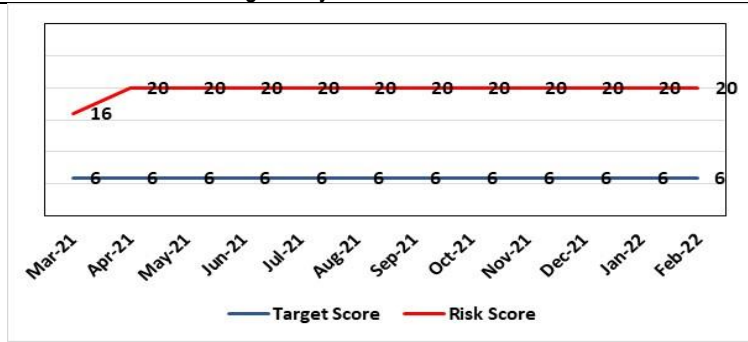
- Community testing arrangements are active - Early detection.
- PPE training and procurement centrally co-ordinated.
- Command and control structures are monitoring effectiveness of corporate response.
- Engagement with All wales co-ordinating groups - alignment of local and national responses.
- Activation of local resilience forum arrangements.

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

Visibility and scrutiny of local plans at Executive/Board level.

Additional Comments

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**: Inese Robotham, Chief Operating Officer / Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality & Safety Committee	
Risk: Risk issues related to **adolescent patients being admitted to Adult MH inpatient wards**- Inappropriate settings resulting in 'Safeguarding Issues' The WG has requested that HBs identify Secondary Care in -patient facilities for the care of adolescents- in Swansea Bay University Health Board Ward F NPT hospital is the dedicated receiving facility with one bed identified.	**Date last reviewed:** February 2022	

Risk Rating (consequence x likelihood): Initial: 2 x 3 = 6 Current:5 x 4 = 20 Target: 2 x 3 = 6		**Rationale for current score:** Every health board is required to have an admission facility for adolescent MH patients. Whilst ward F has been identified as the single point of access in SBU and a dedicated bed is ring-fenced for adolescent admissions it is a mixed sex adult ward. Therefore the facilities are less than ideal for young patients in crisis.
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?)		
Safeguarding Training for Staff, Joint protocol with Cwm Taf LHB [CAMHS] currently subject to review, Local SBUHB policy on providing care to young people in this environment. This includes the requirement for all such patients on admission to be subject to Level 3 Safe and Supportive observations. Only Adolescents within 16-18 age range are admitted to the adult ward. The health board works with CAMHS to make sure that the length of stay is as short as possible.	**Action**	**Lead**	**Deadline**
	The service group will review the effectiveness of current controls.	MH&LD Head of Operations & Clinical Directors	End March 2022
Assurances (How do we know if the things we are doing are having an impact?) Individual Rooms with en Suite Facilities, Joint working with CAMHS, Monitoring of staff training, Monitoring of admissions by the MH & LD SG legislative Committee of the HB. The ongoing issues with the risks presented by the use of this has recently been raised at an all Wales level with Welsh Government and a formal review is anticipated. The Service Group continues to flag the risk particularly in light of Ward F being identified as the SPOA for AMH in the HB which has resulted in an increase in acuity and a greater concentration of individuals who are experiencing the early crisis of admission - this has served to increase the already identified risks for young people in the environment.	**Gaps in assurance (What additional assurances should we seek?)**		

Additional Comments

01/02/2022: Risk reviewed and score remains 20. Controls are in place to mitigate this risk as far as possible. The only alternative to the current arrangement of the emergency bed for CAMHS in each Board would be to open up the tertiary centre (Ty Lydiard) for these admissions. This would require agreement across all health boards and the assessment of demand to justify costs.

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:** February 2022	

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

Level of Control
=

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

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.

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?)

- 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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Monitoring availability of national services through IMB, NSMB and DSMG. On stable operations agree to address this risk in DSMG.	Assistant Director of Digital Technology	On quarterly reviews

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

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

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.	

Additional Comments

Update 15.11.21 - The Data centre transition to Cloud Centres Data Centre was completed on the 3rd October 2021.
SBU Digital Services Team will continue to monitor the national service performance closely over the next 3 months, and will hopefully be in a position to reduce the National Data Centre risk score during Q4 21/22.
Update 16/2/2022 - This risk was discussed at DSMG with the recommendation that the risk needs re-scoring on the basis of higher levels of availability with WLIMS following the hardware and software upgrades and the migration of services from Blaenavon to CloudCentres Data Centre (CDC).
The Digital Risk Management Group members were also in agreement that this risk should be downgraded, lowering the likelihood score from 5 to 3 bringing the overall score down to from 20 to 12.
It was also proposed that the risk should be de-escalated from the HB Risk Register and managed on the DS Risk Register.
Final Approval is being sought from the Director of Digital during the Digital Services Business Meeting scheduled for the 28th February 2022.

Datix ID Number: 2449 *NEW RISK* (Re-opened) Health & Care Standard: 2.1.1 Managing Financial Risk	HBR Ref Number: 72 Target Date: 31st March 2022	Current Risk Rating 4 X 5 = 20
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Darren Griffiths. Director of Finance **Assuring Committee:** Performance and Finance Committee	
Risk: Impact of COVID-19 pandemic on the Health Board Capital Resource Limit and Capital Plan for 2021-22	**Date last reviewed:** February 2022	

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

Rationale for current score:

- The Health Board has been advised that its discretionary capital allocation for 2022/23 as been reduced from £11.1m to £8.5m.
- There is a risk that funding available within the Capital Resource Limit (CRL) will not meet the demands for capital investment. Discretionary capital is deployed to replace ageing medical devices & equipment; to address backlog maintenance of premises; and to support small scale, non-National service improvements with capital investments
- The current Health Board assessment of the carry forward and previously agreed commitments for inclusion in the 2022/23 capital plan currently suggests a requirement for an additional £7.5m to balance the plan.
- It is likely that due to slippage on capital schemes, this over-commitment will reduce.
- There is potential for further capital requirements arising from service model changes which will need to be managed.
- Potential consequences of this risk are the inability to achieve the ambitions set out within health board plans; the potential failure of ageing equipment leading to service disruption; the exposure to potential environmental health & safety risks.

Level of Control
= 25%

Date added to the risk register
January 2022 (re-opened)

Rationale for target score:
The target score expresses the aspiration of the health board for addressing this risk. The target date indicated above reflects the point which the current actions are anticipated to reduce the risk, though knowledge of the actual funding available is required to reduce it further and this is not available until some months into the financial year.

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

The Health Board is doing the following: -

- Regular dialogue with Welsh Government regarding capital requirements.
- Clear communication and reporting of the capital position, the risks and limitations.
- Close management of all schemes to ensure slippage is understood along with the impact on service.
- Clear prioritisation of any new requirements recognising the current constraints

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Formal review of existing capital plan to revise schemes and scheduling of schemes to move to balance.	Head of Capital Finance	Management Board 9th February 2022
Appraise Welsh Government of content of revised capital plan to consider possibilities of support for key areas.	Director of Finance & Performance	Review with Welsh Government 3rd February 2022

• Routine assessment of local demands for discretionary capital spend through internal capital prioritization group which meets monthly.			
Assurances (How do we know if the things we are doing are having an impact?) The Health Board capital position is reviewed and monitored through: • Monthly capital prioritisation group • Performance and Finance Committee • Monthly Monitoring Returns to Welsh Government.	**Gaps in assurance (What additional assurances should we seek?)** Reporting on impact of constraints to the capital programme on service delivery.		
Additional Comments			

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 **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:** February 2022	

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

Level of Control
= 25%

Rationale for current score:

- There is a potential for a residual cost base increase post COVID-19 as a result of changes to service delivery models and ways of working - Risk Rated 20
- The residual cost base risk remains difficult to assess as the Health Board continues to respond to the impact of the pandemic (a formal review is being undertaken in February 20-22 of all costs and their ability to be managed out)
- As the Health Board moves out of direct COVID response and into COVID recovery there remains a real risk that some additional cost and some service change cost could be part of the run rate of the Health Board and this could be exposed when additional funding ceases.
- Welsh Government has indicated that the funding available for COIVD response in 2020/21 and 2021/22 will be restricted only to vaccination, TTP and PPE for 2022/23 thereby rendering any cost remaining within the Health Board a matter for the Health Board to address.

Date added to the HB risk register
July 2020

Rationale for target score:
Mitigating actions around delivering efficiency opportunities and service changes will reduce likelihood of the risk emerging alongside improved systems of control.

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

The Health Board is doing the following: -

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Critical review of all costs related to COVID response to be undertaken in February 2022	DoPH, COO	February 2022
Appraise Welsh Government of content of revised revenue plan to consider possibilities of support for key areas.	DoF&P	Review with Welsh Government 3rd February 2022
All Wales work through Directors of Finance to benchmark costs and work with WG on solutions.	DoF&P	February and March 2022

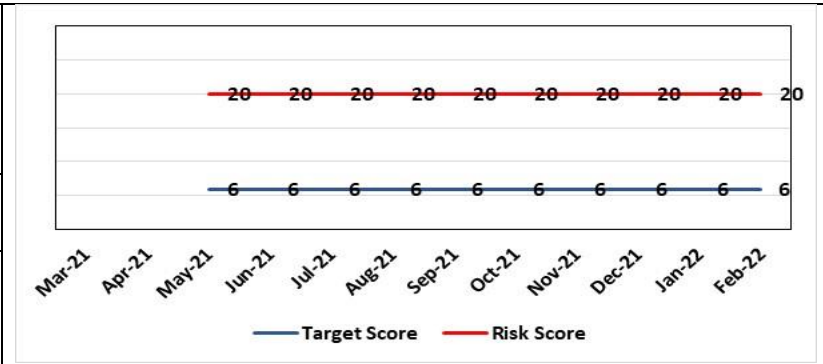
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
The Health Board financial performance is reviewed and monitored through: • Monthly financial recovery meetings • Performance and Finance Committee • Routine reporting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

Datix ID Number: 2595 Health & Care Standard: 3.1 Safe and Clinically Effective Care	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**: Gareth Howells, Executive Director of Nursing **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:** February 2022	

Risk Rating
(consequence x likelihood):
Initial: 4 x 4 = 16
Current: 5 x 4 = 20
Target: 2 x 3 = 6

Level of Control
= 60%

Date added to the HB risk register
30th April 2021



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.

Rationale for target score:

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

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.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Ongoing review of risk	Head of Midwifery	30th March 2022

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

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

Additional Comments
28.10.21 Update - This was reviewed on 27.10.21 with NT & CW. If any delays for transfer to LW this is incident reported and reviewed. 19.11.21 Critical midwifery staffing levels have had a severe impact on the ability of the team to transfer women to labour ward in a timely manner. See Critical Staffing Risk (ID 2788) for mitigation. 14.01.22 No change

Datix ID Number: 2522 **Health & Care Standard: 5.1 Timely Care**	**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:** Inese Robotham, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee	
Risk: Whole-Service Closure Risk that services or facilities may not be able to function if there is a major incident or a rising tide that renders current service models unable to operate	**Date last reviewed:** February 2022	

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

Level of Control
= 25%

Date added to the HB risk register
May 2021

Rationale for current score:
Unpredictability of Covid pandemic and different waves of covid variants leaves health board service vulnerable to scenarios that couldn't be accurately predicted.

Rationale for target score:
Through the framework of Silver and Gold command the health board is both implementing latest guidance and embedding lessons learned. The strategy of moving towards living with Covid will eventually lower the risk level to target.

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

- Sites have business continuity plans, 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.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
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?)
Monitored via Operational Silver and Gold – reviewed local choices framework and managed retreat plans.

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

Additional Comments

Datix ID Number: 2377 Health & Care Standard: Staff & Resources 7.1 Workforce	HBR Ref Number: 76 Target Date: 31st March 2022	Current Risk Rating 5 x 3 = 15
Objective: Partnerships for Care	**Director Lead:** Debbie Eyitayo, Director of Workforce & OD **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:** February 2022	

Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 3 = 15 Target: 5 x 1 = 5		**Rationale for current score:** Work is underway to improve the management /staff side partnership relationship. Facilitated workshops took place in October 2021, from which an action plan to continue to build on improving the relationship will be developed. Both parties have agreed a reset.
Level of Control = 25%		**Rationale for target score:** Mutual trust and respect. High quality relationships with staff contribution to decision making which would support service improvement and efficiency. .
Date added to the HB risk register May 2021		

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

- 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.
- 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. Facilitated Partnership workshops took place in October 2021 where all parties agreed to draw the line around historical issues and move forward. A number of measures have been introduced to close this risk including an agreed action plan which was produced from agreed actions from the workshop.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
The Health Board will continue to develop an effective working relationship with all trade union partners and collectively via the agreed HB Partnership Forum.	Assistant Director of Workforce & OD	31st March 2022

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.
Dec 2021 update: Joint action plan to be presented at HBPF in January 22. Health Board to facilitate Staff Side chair attending Management Board meeting.

Datix ID Number: 2569 Health & Care Standard: Staff & Resources 7.1 Workforce	HBR Ref Number: 77 Target Date: 31st March 2022	Current Risk Rating 5 x 4 = 20
Objective: Excellent Staff	**Director Lead:** Debbie Eyitayo, Director of Workforce & OD **Assuring Committee:** Workforce & OD Committee	
Risk: Workforce Resilience Risk covers two issues: Part 1 The present direct impact (wave 3) in terms of Covid / related sickness including Long Covid (symptomatic Absence) and self-isolation (Asymptomatic), and risks associated with CEV staff. Then how those levels of absence impact on the pressures for those still in work. Part 2 Culmination of the pressure and impact on staff wellbeing in terms of both physical and mental stress linked to the Covid Pandemic. How that stress may have a delayed significance and longer term impact on some staff.	**Date last reviewed:** February 2022	

Risk Rating
(consequence x likelihood):
Initial: 5 x 5 = 25
Current: 5 x 4 = 20
Target: 5 x 2 = 10

Rationale for current score:
Covid related absence has increased by 50% in recent weeks, as a result of the spread of the omicron variant. Whilst there are few staff who have not returned to work in some capacity either working from home or another role a number remain away from their substantive role. Sick absence levels have increased over the last few months and 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 in Mid 2022. Enquiries to OH increasing in recent weeks due to Covid Impact.

Level of Control
= 25%

Date added to the HB risk register
May 2021

Rationale for target score:
Covid related absence is increasing as we enter wave 3.
All organisations would wish for their staff to be resilient to the impact of working within their organisation. The significant ongoing impact of Covid seen by a number of our staff would never be zero but through a range of interventions in place we would hope to minimise the impact on staff.

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

- 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.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Additional Wellbeing support facilitated by limited L&D Coaches and Wellbeing team.	Assistant Director of Workforce & OD	31st March 2022
Occupational Health open over the bank holidays to support staff testing, urgent advice giving and contact tracing.	Assistant Director of Workforce & OD	31st March 2022

• 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. • 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. • Further funding secured from Charitable funds for additional Trauma and Risk management (TRIM) support for staff (October 2021)	Occupational Health to submit Business Case for 2022/23 funding to continue enhanced OH and Wellbeing services given that Covid monies are due to end in March 2022.	Head of Occupational Health and Wellbeing	31st March 2022
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 Update 22.02.2022 – New action added.			

Datix ID Number: 2521 (& COV_Strategic_017) Health & Care Standard: 2.4 Infection Prevention and Control (IPC) and Decontamination	HBR Ref Number: 78 Target Date: 31st March 2022	Current Risk Rating 4 x 5 = 20
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:** February 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 5 = 20 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. EMD and Director of Public Health considers this should be increased again to 16 – reflecting less effective track-and-trace measures and indications that testing is not as effective on staff who have been fully vaccinated.	
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	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?)
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

Gold Command 06.12.21: Additional reviews are being undertaken with the authorised engineer to assess options of providing more localised systems to increase air flows.
Gold Command 18.01.22: Risk score revised by Executive Medical Director, in discussion with AHoR&A.
Update 22.02.2022 - No change to score currently - EMD.

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 **Assuring Committee:** Performance and Finance Committee	
Risk: The COVID-19 pandemic has affected services in many different ways, in this risk specifically the impact on access to services, such as OP, diagnostic tests, IP&DC and therapy services. The recovery of access times will require additional human, estates and financial resource to support it. There is potential for resource available is below the ambition of the board to provide improved access.	**Date last reviewed:** February 2022	

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

Level of Control
= 25%

Date added to the HB risk register
May 2021

Rationale for current score:

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

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

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

The Health Board is doing the following: -

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Develop a final annual plan setting out recovery plans	Director of Finance and Director of Strategy	31st March 2022
Ensure that overall financial plan for 2022/23 can accommodate as much clinical capacity as possible by delivering savings and taking a risk assessed approach	Director of Finance	31st March 2022
Undertake a robust prioritisation exercise with clinical leaders to identify core service areas to be funded	Chief Operating Officer & Executive Medical Director	End of February 2022

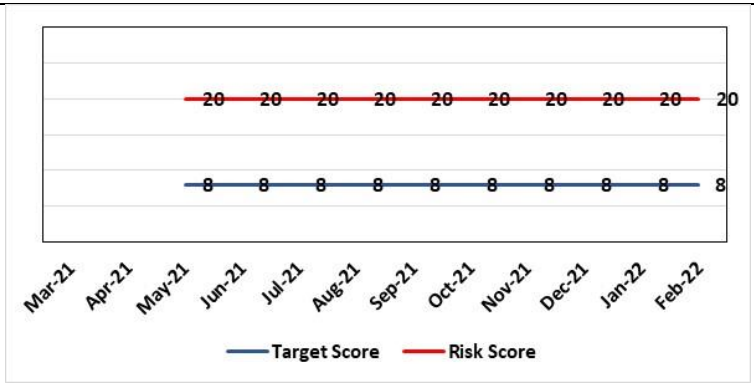
Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
The Health Board financial performance is reviewed and monitored through: • Monthly financial recovery meetings • Performance and Finance Committee • Routine reporting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

Datix ID Number: 1832 Health & Care Standard: : 3.1 Safe and Clinically Effective Care	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:** Inese Robotham, Chief Operating Officer **Assuring Committee:** Quality & Safety Committee	
Risk: If the health board is unable to discharge clinically optimised patients there is a risk of harm to those patients as they will decompensate, and to those patients waiting for admission.	**Date last reviewed:** February 2022	

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 clinically optimised 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.
- Delay in discharge for clinically optimised patients can result in deterioration of their condition.

Rationale for target score:

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

- Clinically optimised numbers are monitored and reviewed weekly by the MDU. Delays are reported and escalated to try to ensure timely progress along a patient's pathway.
- Review on a patient by patient basis – with explicit action agreed in order to progress transfer to appropriate clinical setting.
- Critical constricts in relation to access/time delays for social workers and assessment for package of care and social placement – lead times in excess of 5 weeks.
- Patient COVID-19 status has added an additional level of complexity to decision making.
- The health board has procured 63 additional care home beds to provide additional discharge capacity.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Undertake another procurement round with the aim of increasing additional care home beds to 100.	Service Group Director (PCT)	31/03/2022

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

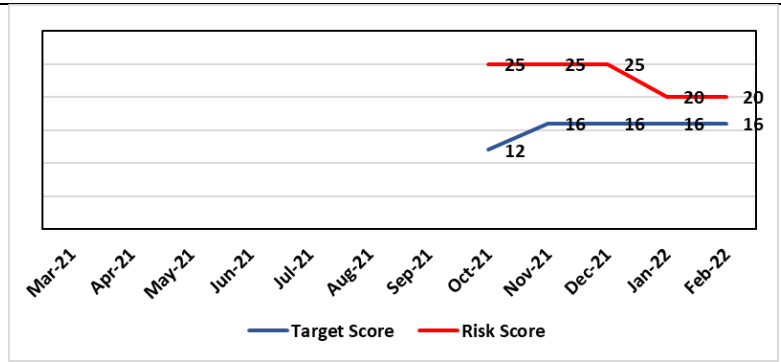
- Patient level dashboard allows breakdown by delay type
- Close management of utilization of additional care home beds

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

.

Additional Comments

Datix ID Number: 2788 Health Care Standards: 7.1 Workforce	HBR Ref Number: 81 Target Date: 31/03/2022	Current Risk Rating 4 x 5 = 20
Objective: Best value outcomes	**Director Lead:** Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality & Safety Committee **For Information:** Workforce & OD Committee	
Risk: Critical staffing levels – Midwifery: Unplanned absence resulting from Covid-19 related sickness, shielding and isolation, alongside other current absences, has resulted in critical staffing levels, further reductions in which could result in unsafe service provision, poor patient outcomes and/or experience. In turn, poor service quality or reduction in services could impact on organisational reputation.	**Date last reviewed:** February 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 4 = 16	**Rationale for current score:** Centralisation of community services has broken down continuity of carer which means women will see many midwives through pregnancy. There is evidence that shows the outcome for women is better with lower interventions when continuity of carer is maintained. This is particularly relevant for women with perinatal mental health issues and for safeguarding. Singleton Hospital working with on average 10 /11 midwives w/c 22/08/2021. The lowest staffing number being 8 instead of 13 midwives.	
Level of Control = %	**Rationale for target score:** Target score refreshed. Actions taken and planned for December are anticipated to reduce risk to a target score of 16 by the end December. The decentralization of services in Q4 may assist to reduce the risk further. A new target for additional reduction of the risk will be considered in January.	
Date added to the risk register 12/10/2021		



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

- Home births are suspended. Reduced the on call requirement for community midwives.
- All midwives are working at the hours they require up to full time.
- A small midwifery bank has been created.
- All midwives are offered additional hours. Enhanced overtime promoted, provided and accepted.
- Band 6 recruitment in training.
- Student midwives on pre-qualifying placement are supporting in the clinical areas within their student capacity.
- 11 new midwives have been employed from September- October 2021. 6 started.
- Risk assessments are currently taking place with OH and H&S leads support for matrons to return staff to clinical front facing roles where possible
- Centralisation of community services to improve staff availability
- NPT Birth Centre temporarily suspended - services relocated to The Bay Birth Centre in Singleton Hospital
- Updated early warning to WG
- Service Group Nurse Director keeping RCM updated
- Daily escalation call with the SG Service Director and Nurse Director to do 24 hour lookback on potential harm events, patient and staff experience, and 3 day look forward of staffing

Mitigating actions (What more should we do?)

Action	Lead	Deadline
On-boarding new Band 5 recruits (expected all complete by mid November)	Deputy Head of Midwifery	Mid November 2021 (onboarding complete - will require supernumerary period)
14 Band 5 graduates from 2020 – preceptorship completion plan (2 have completed, 9 due by end of December). All remaining active 2020 graduates to complete preceptorship *(3 of 4 graduates – the exception being on maternity leave)*.	Deputy Head of Midwifery	Majority Complete Remainder March 2022
Due to review suspension of the Birth Centre and Home Births	Deputy Head of Midwifery	1st February 2022 (next review)
Midwifery bank & agency SOP has been developed and will be approved this month (already in use).	Deputy Head of Midwifery	20th October 2021 *See Additional Notes*

• Briefings for families via corporate comms & online			
Assurances **(How do we know if the things we are doing are having an impact?)** Daily briefings with the senior team are taking place for updated position. Weekly meeting held with staff to update on the situation. No surprise submission to Welsh Government 9/7/2021. CHC informed. Engagement with Clinical Supervisors for midwives for staff support. Engagement with workplace representatives. On call manager for Women and Child Health available 24/7. Datix reports are submitted when appropriate.	**Gaps in assurance** **(What additional assurances should we seek?)**		

Additional Comments

In addition to controls listed above, additional measures taken include:
• Staff support and well-being information circulated, and presented to the staff
• Where able, block booking agency midwives to improve the baseline numbers in the obstetric unit.
• Enhanced overtime promoted, provided and accepted
• Liaison and working closely with the Local Authorities to utilise Jigso and Flying start midwives where possible
• Cancelled PROMPT training (being reviewed weekly)
• Linking in with Karen re getting an all Wales approach to financing/increasing our part time to full time conversion rates
• Utilising our medical teams to support where possible
• Ensuring the all Wales Midwifery and Neonatal network are aware and linking ensuring SBUHB are represented in with the weekly risk huddle
• Hywel Dda UHB are buddying up to provide support
• Ensuring RCM and RCOG COVID guidance is implemented – esp re vaccinations
• Maintaining a Maternity Helpline to answer any queries, emails received and messages from women who may be worried. We plan to continue with this (utilising staff who may be pregnant themselves)

19.11.21 Update: Recruitment of band 6 midwives completed. Employment checks underway. Working with 2020 band 5 midwives to support achievement of their preceptor passport for transition to band 6. 2021 graduates in post (1 outstanding). All band 5 midwives on temporary increase to full time hours. Workforce paper in preparation. Consider there are enough vacancies to offer 2020 graduates substantive full time hours. Awaiting sign off with finance. Obstetric unit stabilised. Community midwifery service continue to carry significant shortfalls due to staff unavailability. Centralised community midwifery service continues.

09.01.2022 Update: - 2021 Graduate midwives (Band 5) are all in post and are working full time to support during the current midwifery critical staffing levels related to Covid pandemic. Good feedback from midwives via Clinical Supervisors for Midwives (CSfM) that they have settled into the role and are well supported by the team.

- The preceptorship programmes for the 2020 graduate midwives are completing in line with expectation. 4 midwives continue with Individualised action plans and rotation to the required clinical areas for completion of the programmes. All 2020 graduate midwives will complete the preceptorship programme by March 2022 with one exception (delay due to maternity leave).
- Suspension of homebirth and NPT birth centre are ongoing. The midwifery critical staffing levels continue and are risk rated at 25 The Executive Nurse Director is updated of the position. The next review date for the recommencement of service is the 1st February 2022.
- The Bank and agency SOP is in place and working effectively. Bank and a limited number of agency midwives have been employed as appropriate to maintain safe staffing levels within the Obstetric Unit and Community Services.

14.01.22: All band 6 midwives due to commence by February 2022. Workforce planning is being progressed. Management trainee allocated to maternity services to support this work.

23.01.22: Daily acuity meeting on 19/01/2022 midwifery unavailability 28.66%

As the unavailability has remained below 30% for previous three days risk rating reduced to 20. Monitoring will continue. Plan in development for re-introduction of midwifery led intrapartum services at 1/2/2022 if unavailability remains below 30%

Datix ID Number: 2554 **Health & Care Standard:** Standard 5.1 Timely Access	**HBR Ref Number: 82** **Target Date: TBC** **Current Risk Rating** **5 x 4 = 20**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Executive Medical Director **Assuring Committee**: Performance & Finance Committee **For Information**: Workforce & OD Committee
Risk: Risk of closure of Burns service if Burns Anaesthetic Consultant cover not sustained There is a risk that adequate Burns Consultant Anaesthetist cover will not be sustained, potentially resulting in closure to this regional service and the associated reputational damage. This is caused by: • Significant reduction in Burns anaesthetic consultant numbers due to retirement and long-term sickness • Inability to recruit to substantive burns anaesthetic posts • The reliance on temporary cover by General intensive care consultants to cover while building work is completed in order to co-locate the burns service on General ITU • Reliance on capital funding from Welsh Government to support the co-location of the service	**Date last reviewed:** February 2022
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 5 x 4 = 20 Target: 3 x 1 = 3 **Level of Control** = **Date added to the HB risk register** December 2021	**Rationale for current score:** This risk has been increased due to closure of the Burns Unit due to staffing levels, and reduced from 25 to 20 having secured the agreement of the general ITU consultants to provide cross-cover while enabling capital works are completed **Rationale for target score:** This is a small clinical service with staff with highly specialised skills. While a small service may always be vulnerable to challenges (eg staff) the intention will be to operate a more resilient clinical model that is supported by other clinical groups.

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

- The general ITU consultants to support the Burns service on a temporary basis, supporting the remaining burns anaesthetic colleagues to provide critical care input for burns patients
- The agreement reached is that they will cover the current Burns Unit on Tempest ward at Morriston hospital for 6-9 months while capital work is underway on general ITU to enable co-location of the service
- The capital works will be in two phases (1) to co-locate in a smaller footprint in GITU, followed by (2) larger-scale capital work to accommodate complete co-location by mid-2023.
- WHSSC as commissioners of the service have been kept fully informed, as has the South West (UK) Regional Burns Network
- Other UK burns units have ICU co-located with Burns ICU, removing the need for dual certified consultants

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Securing the agreement of GITU consultants to cover pending completion of capital work	CEO & EMD	Completed
Submit bid for capital funding to Welsh Government for both phases of work required	Morriston Service Group	TBC

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

Effect on patients of the temporary closure of the burns service in Swansea is being mitigated by maintaining an urgent assessment/stabilisation service for patients in Wales with severe burns, with

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

onward transfer for inpatient care to another unit in the UK following the initial assessment. The service will fully reopen with the support of General ITU consultants on 14/02/2022	
Additional Comments Ongoing staff burnout combined with two substantive consultants resigning means there is no foreseeable mechanism to open the burns unit as it previously operated. Have recurrently advertised with no applicants and initial efforts for oversee recruitment not successful. November 2021: Burns service currently closed to P3 patients; P2 patients located in Wales will be assessed before transfer to another unit or downgrade to ward based patient; WG notified via NSA – November 2021. Agreement for General ITU consultants to cover will result in reopening of the service on 14/02/2022 pending completion of capital work.	

Datix ID Number: 2961 NEW RISK Health & Care Standard: 2.1.1 Managing Financial Risk	HBR Ref Number: 83 Target Date: TBC	Current Risk Rating 5 x 4 = 20
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Darren Griffiths. Director of Finance **Assuring Committee:** Performance and Finance Committee	
Risk: Release of Bed Capacity Savings There is a risk that the health board will not be able to release sufficient bed capacity to meet the requirements of savings schemes predicated on bed release. The main causes of this are: length of stay above benchmark; the unavailability of beds in the community to support discharge; the impact of COVID patients on the overall bed plan; clear ambition of the health Board to reduce exceptionally high occupancy which affects flow The potential consequence is that savings plans will not be achieved, increasing the risk of failure to achieve overall financial outturn target.	**Date last reviewed:** February 2022	

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

Rationale for current score:

- A reduction in bed day consumption was identified as part of the benefits realisation for the Health Board's investment plan in 2021/22
- The bed day release was aggregated and a financial assessment of the budget that could be saved as a result of this release was made. This saving then features in the saving plans for the Board spread across service groups
- The bed release has not been possible to date as a result of slower implementation of plans than was anticipated, the move of the AMSR plan into 2022/23, COVID pressures and workforce pressures
- The Health Board's savings plan for 2021/22 requires recurrently delivery and failure to release the bed savings would reduce the recurrent delivery by circa £6m

Level of Control
=

Date added to the risk register
January 2022

Rationale for target score:
The consequence is very significant given the financial settlement for 2022/23 and beyond. At present there is no safe service plan which would allow the bed reduction making likelihood very high. There is a significant amount of mitigation work underway to reduce likelihood but this is yet to formulate into a plan

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

- Extensive bed modelling and benefits realisation checks being carried out in February 2022
- Change in front door model at Morriston to reduce admissions
- Escalation of length of stay improvement via performance framework
- Monitoring COVID patient numbers and cohorting of patients to reduce surge requirements
- Commissioning additional care home beds

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Focus on front door redesign to manage patients away for admission to alternative services	COO	TBC
Agree occupancy level to support the modelling	COO	March 2022
Delivery AMSR	COO	September 2022
Delivery of Virtual Ward model across all	COO	April 2022

	clusters		
Assurances (How do we know if the things we are doing are having an impact?) • Length of stay reduction • Fewer admissions • Reduced COVID patients in beds • Reduction in surge bed numbers	**Gaps in assurance (What additional assurances should we seek?)** • Signed off plan of beds to be decommissioned		
Additional Comments			

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