Meeting Date	26 November 2020	Agenda Item	2.2
Report Title	Health Board Risk Register (HBRR) Report		
Report Author	Hazel Lloyd, Head of Patient Experience, Risk & Legal Services		
Report Sponsor	Pam Wenger, Director of Corporate Governance		
Presented by	Pam Wenger, Director of Corporate Governance		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to provide an update on the Health Board Risk Register (HBRR) and the Covid-19 Risk Register.		
Key Issues	**The Executive Team previously updated the following risks:** • **Risk Ref 1:** Access to Unscheduled Care risk reduced from 25 to 16. • **Risk Ref 16:** Access to Planned Care increased from 20 to 25. • **Risk Ref 50:** Access to Cancer Services increased from 20 to 25. • **Risk Ref 51:** Compliance with Nurse Staffing Levels (Wales) Act 2016 – risk increased from 16 to 20. • **Risk Ref 58:** Access to Ophthalmology Services increased from 12 to 16. • **Risk Ref 68 Covid-19 Pandemic** increased from 15 to 25. Further updates have been made following the Executive Team meeting on 11th November which are summarised on page 8 in Table 3. **New risks have been included in the HBRR:** • **Risk Ref 71:** The total quantum for funding for addressing COVID-19 across Wales remains fluid and uncertain. • **Risk Ref 72:** Impact of COVID-19 pandemic on the Health Board Capital Resource Limit and Capital Plan for 2020-21. • **Risk Ref 73:** 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. **Covid Risk Register:** • Health Board has recognised the pandemic as an issue and as such a Covid 19 Risk Register has		

	been created which is managed through the Gold Command Executive led meeting. The highest risks relate to: - Care homes - Delivery of Essential Care - Nosocomial transmission - Risk of Emergency Department closure **New risks added to the Covid risk register at a high level:** • R_COV_017 Nosocomial Transmission • R_COV_018 Risk of Closure of the Emergency Department and impact on the service. Both these risks were considered at the Health Boards Risk Management Group in November 2020. **Risk Appetite:** • The Board considered the risk appetite and tolerance levels in April 2020 and increased the high level risk from 16 to 20, recognising the current risk level the Health Board is managing in relation to the pandemic and re-establishing essential services. **Risk Management Group** The Group met in October and: • Reviewed the HBRR and high level Covid Risk Register; • Considered the updated Risk Management Policy, which has been updated and attached as appendix 3; • Considered and updated the Groups Terms of Reference; and • Received an update on the Board Assurance Framework. • The Director of Corporate Governance has requested Executive Directors/Service Directors review their existing operational risks on the Datix Risk Module (taking into account the positive /negative impacts that Covid-19 may have had on them). To ensure effective governance the interim Assistant Head of Risk and Assurance is supporting the Executive Directors/Service Directors to review and manage their risks. Ensuring regular reporting of the updates to the Executive Team, the Audit Committee and the Board for review.

Specific Action Required *(please choose one only)*	Information	Discussion	Assurance	Approval
	☐	☐	☒	☐
Recommendations	Members are asked to: • **NOTE** the updates to the Health Board Risk Register and Covid-19 Gold Command Risk Register and the further changes being made in recognition of the changing risks facing the Health Board and the uncertainty in terms of modelling required as a result of the current 2nd wave of Covid-19, and the risk of a potential 3rd wave, • **NOTE** the updates approved, by the Executive Team and reported to the Audit Committee in November 2020, to the Health Board Risk Register (HBRR), • **AGREE** the tolerance level to risks, currently 20 with a review in 3 months; • **NOTE** the updates to the Risk Management Policy, Risk Management Group Terms of Reference and Terms of Reference for the risk scrutiny panel.			

HEALTH BOARD RISK REGISTER (HBRR) REPORT

1. INTRODUCTION

The purpose of this report is to provide an update on the Health Board Risk Register (HBRR) and the Covid-19 Risk Register.

2. BACKGROUND

2.1 Health Board Risk Register (HBRR)

Swansea Bay University Health Board (SBUHB) is committed to providing safe and effective, high quality healthcare. We mandate a culture and environment, which minimises and actively seeks to reduce risk and promotes the health, safety and well-being of patients, staff, visitors and the general public.

All staff have a responsibility for promoting risk management, adhering to SBUHB policies and have a personal responsibility for patients' safety as well as their own and colleague's health and safety. SBUHB encourages staff to take ownership of their responsibilities through a two-way communication process, with appropriate training and support, to identify and manage risk.

The Health Board Risk Register (HBRR) is intended to summarise the key 'live' extreme risks facing the Health Board and the actions being taken to mitigate them.

Each Health Board risk has a lead Executive Director who is responsible for ensuring there are mechanisms in place for identifying, managing and alerting the Board to significant risks within their areas of responsibility through regular, timely and accurate reports to the Senior Leadership Team/Executive Team, relevant Board Committees and the Board.

2.2 Covid 19 Risk Register

The Covid-19 pandemic, also known as the coronavirus pandemic, is an ongoing pandemic of coronavirus disease 2019 (Covid-19) caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The Covid-19 outbreak has had a huge impact on core NHS services. In order to free up enough capacity to deal with the initial peak of the pandemic, the NHS was forced to shut down or significantly reduce many areas of non-COVID care during April, May and June 2020. This, combined with fewer patients seeking care during lockdown, means that there has been a significant drop in elective procedures, urgent cancer referrals, first cancer treatments and outpatient appointments.

The Health Board is in unprecedented times, and the evolving Covid-19 situation poses some practical challenges in terms of board governance, transaction execution and statutory compliance commitments. As they focus on business continuity and crisis management, directors must be in a position to make effective and swift boardroom decisions. Boards remain accountable at times of national crisis and it is important they are seen to be doing the right thing[1] (Good Governance Institute, 2020) and the rationale behind key decisions is transparent. In the context of Covid-19 the strategic governance of the organisation has to be agile. There also needs to be clarity on 'changed' roles and responsibilities, decision making, communication and record keeping. Whilst substantial amounts of management time will be focussed on ensuring that the Health Boards response is coordinated and effective, there is a risk that quality

[1] https://www.good-governance.org.uk/blog-post/boards-remain-accountable/

governance and oversight may not be as robust as the resource/capacity of our staff is stretched in an unprecedented way which is changing on a daily basis.

In addition, the Minister of Health and Social Services announced on 13th March 2020, a framework of actions, within which local health and social care providers could make decisions to ensure that preparations could be made in a planned and measured way for managing Covid-19 and included:

- Suspending non-urgent outpatient appointments and ensure urgent appoints are prioritised;
- Suspending non-urgent surgical admissions and procedures (whilst ensuring access for emergency and urgent surgery);
- Prioritising the use of Non-Emergency Patient Transport Service to focus on hospital discharge and ambulance emergency response;
- Expediting discharge of vulnerable patients from acute and community hospitals;
- Relaxing targets and monitoring arrangements across the health and care system;
- Minimising regulation requirements for health and care settings;
- Fast tracking placements to care homes by suspending the current protocol which give to right to a choice of home;
- Permission to cancel internal and professional events, including study leave, to free up staff for preparations;
- Relaxation of contract and monitoring arrangements for GPs and primary care practitioners; and
- Suspending NHS emergency service and health volunteer support to mass gatherings and events.

The focus is now on re-establishing essential services in line with the NHS Wales Covid-19 Operating Framework. Covid-19 business decisions are made against the backdrop of quickly-changing circumstances on the ground, and the Covid-19 risk register offers an essential framework for informing those choices. The risk register accomplishes this by keeping the spotlight on operational changes and offering a structured method to identify and mitigate the derivative risks.

3. MANAGEMENT OF HEALTH BOARD RISK REGISTER (HBRR)

The HBRR is agreed by the Executive Team and is scrutinised by the Board level Committees on a quarterly basis in terms of the risks aligned to each sub committee of the Board with the Audit Committee overseeing the complete HBRR on behalf of the Board. The HBRR is presented at ***Appendix 1*** for information.

3.1 New risks for the HBRR

Three new risks have been added to the HBRR by the Director of Finance in relation to:

- **Risk Ref 71:** The total quantum for funding for addressing COVID-19 across Wales remains fluid and uncertain.

- **Risk Ref 72:** Impact of COVID-19 pandemic on the Health Board Capital Resource Limit and Capital Plan for 2020-21.

- **Risk Ref 73:** 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.

3.2 Health Board Risk Register (HBRR) Dashboard

There are a total of 35 risks on the HBRR and a summary of the risks is outlined in the tables below:

Table 1 – Summary of Risk Score

Risk Analysis	No of Risks
High Risk: Risk Score of 20 – 25 (Red)	**20**
High Risk: Risk Score of 16 (Red)	**6**
Moderate Risk: Risk Score 9 – 15 (Amber)	**9**
Manageable Risk: Risk Score of 5 – 9 (Yellow)	**0**
Acceptable Risk: Risk Score of 1 – 4 (Green)	**0**

Table 2 - Dashboard of HBRR Risks – November 2020

Impact/Consequences	5			71: The total quantum for funding for addressing COVID-19 across Wales remains fluid and uncertain.	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 69: Adolescents being admitted to Adult MH wards 70: Data Centre outages	16: Access to Planned Care Services 50: Access to Cancer Services 51: Compliance with Nurse Staffing Levels (Wales) Act 2016 66: SACT Treatment 67: Target breaches to Radical Radiotherapy Treatment 68: Coronavirus Pandemic
	4				37: Operational and strategic decisions are not data informed 43: DOLS Authorisation and Compliance with Legislation 48: Child & Adolescence Mental Health Services 49: TAVI Service 57: Non-compliance with Home Office Controlled Drug Licensing requirements 61: Paediatric Dental GA Service – Parkway	01: Access to Unscheduled Care Service 39: IMTP Statutory Responsibility 60: Cyber Security 62: Sustainable Corporate Services 64: H&S Infrastructure 72: Impact of COVID-19 pandemic on the Health Board Capital Resource Limit and Capital Plan for 2020-21. 73: 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.
	3				13: Environment of Health Board Premises 27: Sustainable Clinical Services for Digital Transformation 36: Electronic Patient Record 41: Fire Safety Regulation Compliance 52: Engagement & Impact Assessment Requirements	15: Population Health Improvement 53: Compliance with Welsh Language Standards 54: No Deal Brexit
	2					
	1					
C X L		1	2	3	4	5
		Likelihood				

3.3 Updates to the Health Board Risk Register (HBRR)

In October 2020 each Executive Director was requested to provide an update on the risks assigned to them, and the risk schedules and the Datix software system have been updated to reflect the changes. A summary of the updates is outlined in Table 3 below, and the Executive team approved the changes to risk status:

Table 3 – Summary of Executive HBRR Updates approved in November 2020

Executive Director	Risks	Notable Updates - October 2020
Director of Finance	**71, 72 & 73**	**71 -** The allocation of £48.2m revenue to the Health Board specifically assigned for COVID costs and the impact of COVID on savings delivery has had a positive impact on risk 71. Further, the operating framework sets out national funding streams and assumptions around expectations of Swansea Bay's share of this have also been made in the financial forecast. **It is therefore proposed that risk 71 be reduced to a score of 15** with the consequence remaining at 5 and the likelihood reducing to 3 to reflect the confirmation of the £48.2m but the remaining uncertainty around the national funding allocations at this point.
		72 -The capital plan remains balanced and unchanged at this point and will remain at 20. Further dialogue is ongoing with Welsh Government and this risk will be revised in light of this.
		73 - The residual cost base risk remains unchanged and whilst the Health Board is working hard to control underlying run rate and to seek out savings opportunities wherever possible, there is currently understandable uncertainty as to the resource arrangements for 2021/22.
Director of Strategy	**39, 48,52, 54**	**Minor updates to all risks.** **39 -** Development of Annual Plan within 3-year context to be considered. Welsh Government written statement published on the 7 October 2020 advising that SBUHB had been de-escalated from targeted intervention status to 'enhanced monitoring' status. **54 BREXIT** risks are being considered by the Emergency Preparedness Resilience and Response Group shortly after 20th November 2020 which is the deadline for all responses for services. A separate Strategic Brexit register is being developed to support the HBRR entry and services who have identified red risks are completing a RAID log to note the actions to mitigate the risks. Following this the HBRR entry will be further reviewed and updated.
Director of WODS	**3, 62,**	**3** – Deadline for mitigating actions has changed to March 2021, and Recruitment remains a challenge but is also a national problem. The problem persists but the restriction on overseas travel is not the same as in the first phase. We are still recruiting staff from overseas but have had to provide hotel accommodation for them to quarantine for 14 days before they can commence work. Supply issues to the COVID areas however have been mitigated by using doctors from other specialties where demand is currently low and we are looking to over establish locum posts in medicine, ITU and Anaesthetics.

Director of Nursing & Patient Experience	**4, 41, 43, 51, 63, 64, 65**	**4 –** updated to reflect the Minister for Health & Social Services written statement, 7 October 2020 concerning SBUHB being deescalated to "enhanced monitoring". **41 –** Date deadline change for cladding to 2023, and provisional review of health & safety team undertaken, including fire resources. **43 –** Controls and mitigating actions updated to reflect assurance reporting to MHLC and a business case for revised services model. **51** – R**<u>isk score is increased from 20 to 25</u>** due to opening of surge capacity. Additional Controls re-instated in October 2020 include • Workforce Plans have been developed by Unit Nurse Directors & Each Delivery Group to agree staffing in light of escalation to surge & super surge due to COVID-19, with consideration of all reasonable steps • A Nurse Staffing & Workforce meeting has been set up chaired by the Interim Director of Nursing & Patient Experience. Weekly meetings initially re-instated & have now increased to 3 times weekly with the potential to be increased to daily. The meetings will include a discussion around staffing hotspots, all reasonable steps associated with nurse staffing, deployment of staff, repurposed wards and surge plan, roster scrutiny • Corporate Nursing Staffing 7 day a week rota reintroduced. • Health Board wide overview of commissioning of new wards. • Review of Education Hub & training needs in line with COVID plan. A Daily Staffing Tool has been agreed across the Delivery Groups to maintain a consistent approach. **64** – Mitigating actions date change from November 2020 to March 2021. Initial structural review undertaken and an early draft is currently having costs drawn up for the draft options to be submitted to Execs. COVID-19 has had an impact of the progression of this and will be presented on Q4. **65 –** Mitigating action date change to December 2020.
Chief Operating Officer	**1, 13, 16, 37, 50, 27, 36, 58, 60, 61,69,70**	**1** – Mitigating actions have been updated including, Mobile unit to allowing cohorting of patients at entrance of Morriston ED to release ambulance crews. due to be delivered end of November and in place early December, business case for ambulatory care element of service redesign submitted WG and a group has been established to focus on a reduction in the number of Medically Fit for

		Discharge (MFFD) patients with Local Authority. **The level of risk has been increased to 20.** **58**- Advert for substantive Glaucoma consultant as part of regional development with Hywel Dda UHB to be placed in November, and the Glaucoma clinic has now been secured in the NPT Resource Centre. **61** – The contractor for delivery of dental paediatric GA services has given given the Health Board notice that they wish to terminate the contract at the end of January 2021. Transfer of this service to Morriston is not feasible by the end of January and given the limitations on staffing, and theatre capacity, is not achievable by May 2021 therefore the task and finish group are looking at the other options available to deliver the service which, includes extending the existing contract through to March 2022, or transferring the service to the NPTH. A paper setting out the options will be presented the Senior Leadership on 18 November 2020.
Director of Corporate Governance	**53**	**53 –** Risk Updated to reflect that a new Welsh Language Officer (WLO) commenced employment in 2020, and that assurances on compliance are being sought from a self-assessment against the requirement of the "More Than Just Words" framework, and the production of a Welsh Language annual report.

Executive Directors are required to provide monthly updates, or a NIL return, to provide assurance to the Board and its sub-committees on how risks are being managed effectively. The Risk & Assurance team will provide flexible support to the Executive team to undertake this task.

As the Health Board is maturing in the way it is reporting and managing risks, the individual sub committees have been requested by the chair of the Audit Committee to ensure the Chairs of the sub committees plan their agenda's to ensure the high risks are reported and discussed in the Committees focusing on:

- Current level of risk and how that has changed over the past 6 – 12 months;
- Explanation as to why a risk has remained the same risk score even though a number of actions have been completed;
- Controls in place to manage the risk and assurance level of the controls;
- Actions planned to reduce the level of risk;
- Timescales in terms of when the risk will be reduced and a check to see if the actions have reduced the level of risk.

The Chair of a sub Committee may require a deep dive report into how a high level risk is being managed and will expect the above to be included in the report. The HBRR reports provide a summary of the risk and actions and aim to help provide transparency in terms of the high risks the Health Board is managing linked to the Health Boards objectives.

3.4 Covid-19 Gold Risk Register

In recognition that Covid-19 is an "issue" which the Health Board is managing a separate Risk Register, presented at ***Appendix 2*** for information**,** which has been

established in the Datix system which is overseen by the Covid-19 Gold meetings with the risks being reviewed and updated on a weekly basis.

The register was last reviewed by the Covid 19 Gold Command group on the 22 October 2020, and the 30 October 2020 respectively. There are currently eighteen risks on the Covid-19 Gold Risk Register, two new risks were added on the 22 October 2020 in relation to nosocomial transmission and sustainable services.

At the 22 October 2020 meeting risk R_COV_ 009 concerning workforce recruitment was deescalated from 25 to 15 as both Medical and Nursing students were now deployed within the HB.

At the 29 October 2020 meeting it was suggested that covid 19 risk R_COV_004 relating to workforce shortages-self-isolation be escalated, this is being considered by the Deputy Director of Workforce & OD.

The dashboard outlined in Table 4 below provides a summary of the risks on the Covid-19 Gold risk register:

Table 4 - Dashboard of Covid-19 GOLD Command Risk Register – October 2020

Impact/Consequences	5					**R_COV_17:** Nosocomial Transmission **R_COV_18:** Sustainable Services
	4				**R_COV_008:** Capacity **R_COV_012:** Partnership Working	**R_COV_005:** Care Homes **R_COV_010:** Delivery of Essential Care **R_COV_015:** Mass Vaccination
	3				**R_COV_016:** Bed Spacing	**R_COV_001:** Shortage of Critical Care drugs **R_COV_002:** Shortage of Palliative Care drugs **R_COV_003:** Inadequate supply of PPE **R_COV_009:** Workforce – Field Hospitals **R_COV_013:** Test, Trace and Protect **R_COV_014:** Keyworker Support from Schools - CLOSED
	2					**R_COV_004:** Workforce Shortages – Self Isolation **R_COV_006:** Equipment Shortages - CLOSED **R_COV_007:** Oxygen Provision - CLOSED **R_COV_011:** BAME Workforce Risks
	1					
C X L		**1**	**2**	**3**	**4**	**5**
		Likelihood				

3.5 Management of Operational Risks

Executive Directors (Corporate functions) and Unit Service Directors supported by Unit Nurse and Unit Medical Directors remain responsible for risks outside of the Covid-19 Risk Register linked to the HBRR entry Risk Ref 68. Self-governance, transparency and management of these risks is crucial at a time when external scrutiny is at its lowest i.e. Healthcare Inspectorate Wales (HIW), Health & Safety Executive (HSE), Internal and External Audit are providing an unprecedented reduction in activity.

Managers have been asked to consider whether they have the capability (available resources and skills) to implement their planned actions, and maintain the effectiveness of their existing controls.

The Director of Corporate Governance has requested that Executive Directors/Unit Directors review their existing operational risks on the Datix Risk Module (taking into account the positive /negative impacts that Covid-19 may have had on them) and to:

- Agree the risks that remain a priority to manage and mitigate during the Covid-19 pandemic;
- Agree (archive) the risks that do not present a significant risk during the Covid-19 pandemic (however they must ensure that existing controls are in place and remain effective otherwise risk could increase); and
- Consider new and emerging risks to their service as a result of the Covid-19 pandemic (including potential risks in respect of returning to normal business)

To ensure effective governance the interim Assistant Head of Risk and Assurance is supporting the Executive Directors/Unit Directors to review and manage their risks. Once the Unit/Directorate registers are updated, the HBRR will be updated and presented to the Executive Team, the Audit Committee and the Board for review.

4. GOVERNANCE & RISK

4.1 Risk Appetite & Tolerance Levels

The Board reviewed its Risk Appetite and Tolerance levels and set new levels for the staff to follow during the Covid-19 pandemic. Previously, the Board's risk appetite was that risks of 16 and above are considered high risks and risks which the Board considered actions should be taken as a priority to mitigate the risk and there is a low threshold to taking risk where it will have a high impact on the quality and safety of care being delivered to patients. Risk appetite and tolerance acts as a guidance as to the risk boundaries that are acceptable and how risk and reward are to be balanced, as well as providing clarification on the level of risk the Board is prepared to accept.

Members of the Board agreed that the risk appetite, whilst dealing with Covid-19, would increase to **20** and above for 3 months. Given the second wave and the continual level of risk it is proposed that the risk appetite remains at **20** for the next three months. These arrangements will be reviewed regularly by the Executive Team, Audit Committee and the Board.

4.2 Escalation & Intervention Arrangements

The Welsh Government written statement published on the 7 October 2020 advised that SBUHB been de-escalated from targeted intervention status to 'enhanced monitoring' status[2], as it had demonstrated that it had a clearer understanding of its finances and the required actions, there has been a clearer approach to performance, and an improvement in some of the measures under consideration, including cancer and infections. Whilst this, is indicative of positive progress, the written statement also stated that concerns remained that unscheduled care and waiting times needed to see sustained improvement in performance.

Therefore, in October 2020 each Executive Director was requested to review the risk score in light of the new escalation and intervention arrangements balanced with the significant ongoing risks relating to the second, and potentially third wave of the covid 19 pandemic.

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[2] Written Statement: Escalation and Intervention Arrangements, 7 October 2020 https://gov.wales/written-statement-escalation-and-intervention-arrangements-2

The updated risk register will be presented to the Board on the 26 November 2020, the Senior Leadership Team (SLT) and the Executive Team in December 2020, and the updated HBRR will be presented to the Audit Committee in January 2021.

4.3 Updated Risk Management Policy & Terms of Reference

4.3.1 Risk Management Policy

To ensure effective governance the Risk Management policy has been updated to incorporate the internal audit recommendations made in April 2020. The updates include:

- Reference to the responsibility of the Senior Leadership Team (SLT),
- consistent language and terminology between the body of the policy (6.5.5.) and Appendix 2, in terms of arrangements for the escalation of risk,
- updated membership list, to include the attendance of two representatives from the Service Delivery Units (SDU's),
- a process for reporting "nil returns",
- include specific terms of reference for the risk scrutiny panel,
- makes a clearer reference to the Board Assurance Framework (BAF),
- reference to the "Simple Guide to Risk Management".

The updated Risk Management Policy was endorsed by the Risk Management Group meeting 21 October 2020, and is approved by the Executive Team in November 2020.

4.3.2 Risk Management Group Terms of Reference (TOR)

For completeness the Risk Management Group's (RMGs) terms of reference (TOR) have also been reviewed in tandem with the risk management policy. The updates include:

- Reference to the responsibility of the Senior Leadership Team (SLT);
- a process for reporting "nil returns",
- a description of the relationship between the RMG and the Risk Scrutiny panel,
- Specific terms of reference for the risk scrutiny panel, including role and delivery of the panel, the membership of the panel comprising of internal and external members and reference to devising an annual forward plan of business.

The updated TOR were endorsed by the Risk Management Group meeting 21 October 2020, and approved by the Executive Team in November 2020.

5. FINANCIAL IMPLICATIONS

There are financial implications to minimising the risks entered on the HBRR in relation to significant revenue implication around strengthening resources in the Health Board, Units and in Departments. Capital monies will also be required in relation to supporting the improvements required to improve and further detail is provided in the individual entry on the HBRR.

6. RECOMMENDATION

Members are asked to:

- **NOTE** the updates to the Health Board Risk Register and Covid-19 Gold Command Risk Register and the further changes being made in recognition of the changing risks facing the Health Board and the uncertainty in terms of

modelling required as a result of the current 2nd wave of Covid-19, and the risk of a potential 3rd wave,

- **NOTE** the updates approved, by the Executive Team and reported to the Audit Committee in November 2020, to the Health Board Risk Register (HBRR),
- **AGREE** the tolerance level to risks, currently 20 with a review in 3 months;
- **NOTE** the updates to the Risk Management Policy, Risk Management Group Terms of Reference and Terms of Reference for the risk scrutiny panel.

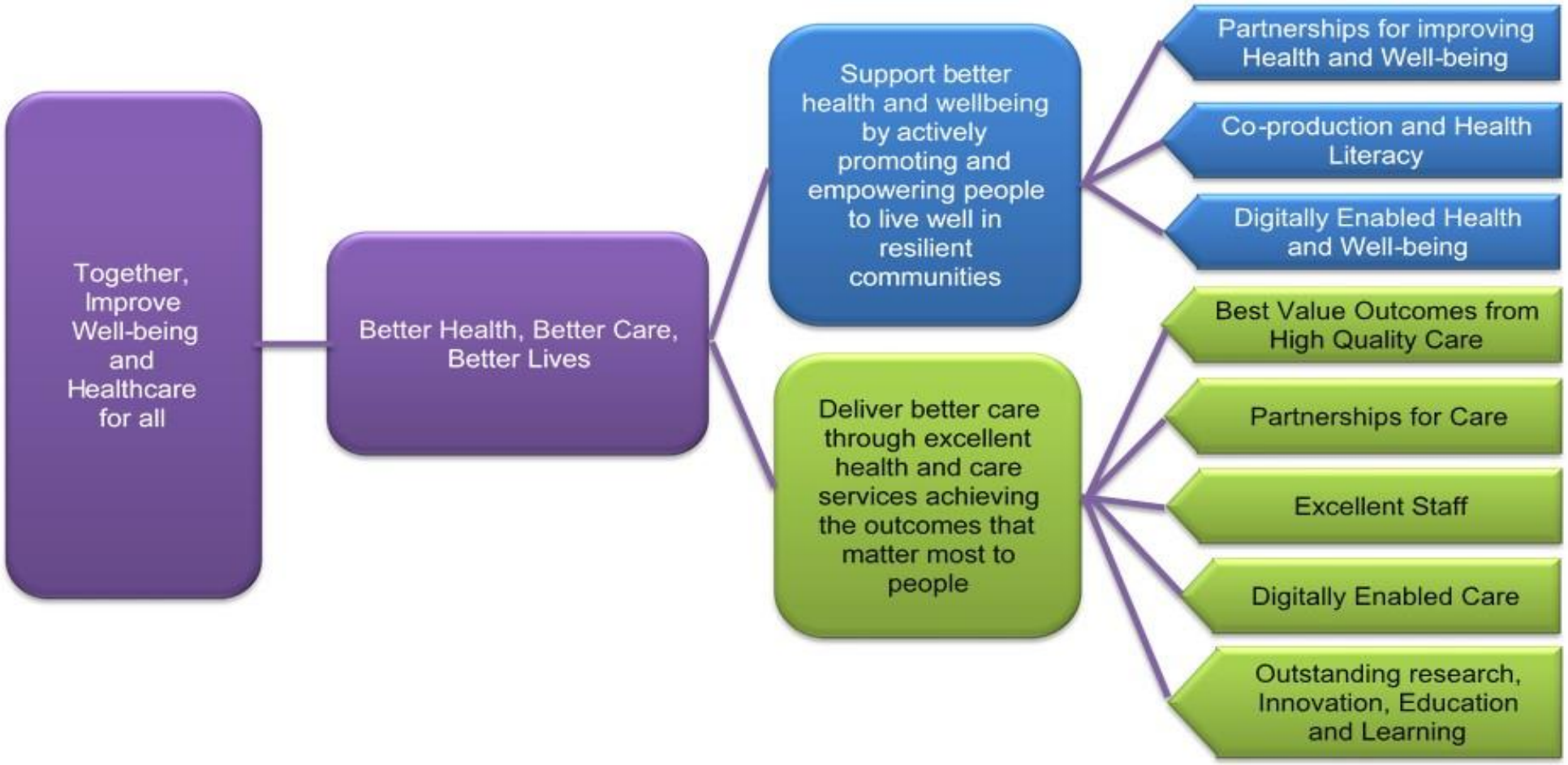
Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
Quality, Safety and Patient Experience		
Ensuring the organisation has robust risk management arrangements in place that ensure organisational risks are captured, assessed and mitigating actions are taken, is a key requisite to ensuring the quality, safety & experience of patients receiving care and staff working in the UHB.		
Financial Implications		
The risks outlined within this report have resource implications which are being addressed by the respective Executive Director leads and taken into consideration as part of the Board's IMTP processes.		
Legal Implications (including equality and diversity assessment)		
It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks faced by the organisation, as failure to do so could have legal implications for the UHB.		
Staffing Implications		
All staff have a responsibility for promoting risk management, adhering to SBUHB policies and have a personal responsibility for patients' safety as well as their own and colleague's health and safety. Executive Directors/Service Group Directors are requested to review their existing operational risks on Datix Risk Module to ensure SBUHB has an accurate and up to date risk profile.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
The HBRR and the Covid 19 risk register sets out the framework for how SBUHB will make an assessment of existing and future emerging risks, and how it will plan to manage and prepare for those risks.		
Report History	• 21 October 2020 - Risk Management Group • November 2020 - Executive Team • November 2020 - Audit Committee	
Appendices	• Appendix 1 – Health Board Risk Register; and • Appendix 2 - Covid-19 High level Risk Register.	

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

HEALTH BOARD RISK REGISTER
November 2020

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 – November 2020

Impact/Consequences						
5			**71:** The total quantum for funding for addressing		**03:** Workforce Recruitment of Medical and Dental Staff **04:** Infection Control **51:** Compliance with Nurse Staffing Levels (Wales) Act 2016 **58:** Ophthalmology Clinic Capacity **63:** Screening for Fetal Growth Assessment in line with Gap-Grow (G&G) **65:** CTG Monitoring in Labour Wards **69:** Adolescents being admitted to Adult MH wards **70:** Data Centre outages
4				**37:** Operational and strategic decisions are not data informed **43:** DOLS Authorisation and Compliance with Legislation **48:** Child & Adolescence Mental Health Services **49:** TAVI Service **57:** Non-compliance with Home Office Controlled Drug Licensing requirements **61:** Paediatric Dental GA Service – Parkway	**01: Access to Unscheduled Care Service** **39:** IMTP Statutory Responsibility **60:** Cyber Security **62:** Sustainable Corporate Services **64:** H&S Infrastructure COVID-19 across Wales remains fluid and uncertain. **72:** Impact of COVID-19 pandemic on the Health Board Capital Resource Limit and Capital Plan for 2020-21. **73:** 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.
3				**13:** Environment of Health Board Premises **27:** Sustainable Clinical Services for Digital Transformation **36:** Electronic Patient Record **41:** Fire Safety Regulation Compliance **52**: Engagement & Impact Assessment Requirements	**15:** Population Health Improvement **53:** Compliance with Welsh Language Standards **54:** No Deal Brexit
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	Controls	Last Reviewed	Scrutiny Committee
Best Value Outcomes from High Quality Care	1 (738)	**Access to Unscheduled Care Service** Failure to comply with Tier 1 target for Unscheduled Care could impact on patient and family experience of care.	20	20	↑	↓	November 2020	Performance and Finance Committee
	4 (739)	**Infection Control** Failure to achieve infection control targets set by Welsh Government could impact on patient and family experience of care.	20	20	→	→	November 2020	Quality and Safety Committee
	13 (841)	**Environment of HB Premises** Failure to meet statutory health and safety requirements.	16	12	↓	↑	November 2020	Health and Safety Committee
	64 (2159)	**Health and Safety Infrastructure** Insufficient resource and capacity of the health, safety and fire function to maintain legislative and regulatory compliance.	20	20	→	→	November 2020	Health and Safety Committee
	16 (840)	**Access to Planned Care** Failure to achieve compliance with waiting times, there is a risk that patients may come to harm. Also, financial risk not achieving targets.	16	25	↑	→	November 2020	Performance and Finance Committee
	37 (1217)	**Information Led Decisions** Operational and strategic decisions are not data informed.	12	16	→	→	November 2020	Audit Committee

39 (1297)	**Approved IMTP – Statutory Compliance** If the Health Board does not have an approved IMTP signed off by Welsh Government, primarily due to the inability to align performance and financial plans it will remain in escalation status, currently "targeted intervention".	16	20	↑	→	November 2020	Performance and Finance Committee
41 (1567)	**Fire Safety Compliance** Fire Safety notice received from the Fire Authority – MH&LD Unit. Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance.re safety regulations.	15	12	→	→	November 2020	Health and Safety Committee
43 (1514)	**DoLS** If the Health Board is unable to complete timely completion of DoLS Authorisation then the Health Board will be in breach of legislation and claims may be received in this respect.	16	16	→	→	November 2020	Quality and Safety Committee
48 (1563)	**CAMHS** Failure to sustain Child and Adolescent Mental Health Services (CAHMS).	16	16	→	→	November 2020	Performance and Finance Committee
49 (922)	**Trans-catheter Aortic Valve Implementation (TAVI)** Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI)	25	16	↓	↑	November 2020	Quality and Safety 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	→	→	November 2020	Quality and Safety Committee
	50 (1761)	**Access to Cancer Services** Failure to sustain services as currently configured to meet cancer targets could impact on patient and family experience of care.	20	25	→	↑	November 2020	Performance and Finance Committee
	57 (1799)	**Controlled Drugs** Non-compliance with Home Office Controlled Drug Licensing requirements.	20	16	↓	→	November 2020	Audit Committee
	66 (1834)	**Access to Cancer Services** Delays in access to SACT treatment in Chemotherapy Day Unit	25	25	→	→	November 2020	Quality and Safety Committee
	67 (89)	**Risk target breeches – Radiotherapy** Clinical risk – Target breeches of radical radiotherapy treatment	16	25	→	→	November 2020	Quality and Safety Committee
	69 (1418)	**Safeguarding** Adolescents being admitted to adult MH wards	6	20	→	→	November 2020	Quality & Safety Committee
	71 (2448)	**Finance** The total quantum for funding for addressing COVID-19 across Wales remains fluid and uncertain.	20	15	↓	↑	November 2020	Performance and Finance Committee
	72 (2449)	**Finance** Impact of COVID-19 pandemic on the Health Board Capital Resource Limit and Capital Plan for 2020-21	20	20	→	→	November 2020	Performance and 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	➔	➔	November 2020	Performance and Finance Committee
Excellent Staff	3 (843)	**Workforce Recruitment** Failure to recruit medical & dental staff	20	20	↓	↑	November 2020	Workforce and OD Committee
	51 (1759)	**Nurse Staffing (Wales) Act** Risk of Non Compliance with the Nurse Staffing (Wales) Act	16	25	↑	➔	November 2020	Workforce and OD Committee
	62 (2023)	**Sustainable Corporate Services** Health Board's Annual Plan and organisational strategy, and with the skills, capability, behaviours and tools to successfully deliver in support of the whole organisation, and to do so in a way which respects and promotes the health and well-being of our staff and their work-life balance.	20	20	➔	➔	November 2020	Workforce and OD Committee
Digitally Enabled Care	27 (1035)	**Sustained Clinical Services** Inability to deliver sustainable clinical services due to lack of digital transformation.	16	12	↓	➔	November 2020	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	12	↓	➔	November 2020	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	➔	➔	November 2020	Audit Committee
	65 (329)	**CTG Monitoring on Labour Wards** Risk associated with misinterpreting abnormal CTG readings in delivery rooms.	16	20	➔	➔	November 2020	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	➔	➔	November 2020	Audit Committee

Partnerships for Improving Health and Wellbeing	58 (146)	**Ophthalmology - Excellent Patient Outcomes** There is a failure to provide adequate clinic capacity to support follow-up patients within the Ophthalmology specialty.	12	20	↑	➔	November 2020	Quality and Safety Committee
	15 (737)	**Population Health Targets** Failure to achieve population health improvement targets leading to an increase in preventable disease amongst the population resulting in increased morbidity impacting on operational and financial pressures.	15	15	➔	➔	November 2020	Quality and Safety Committee
	68 (2299)	**Pandemic Framework** Risk of declared pandemic due to Coronavirus Infectious Disease outbreak 2020.	20	25	➔	↑	November 2020	Quality and Safety Committee

	61 (1587)	**Paediatric Dental GA Service – Parkway** Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morriston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies.	15	16	↑	→	November 2020	Quality and Safety Committee
Partnerships for Care	52 (1763)	**Statutory Compliance** The Health Board does not have sufficient resource in place to undertake engagement & impact assess in line with Statutory Duties	16	12	↓	↑	November 2020	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	→	→	November 2020	Health Board (Welsh Language Group)
	54 (1724)	**Brexit** Failure to maintain services as a result of the potential no deal Brexit	20	15	→	→	November 2020	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 2020**
Objective: Best Value Outcomes from High Quality Care Graph being updated	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee
Risk: If we fail to comply with Tier 1 target – **Access to Unscheduled Care** then this will have an impact on patient and family experience. Challenges with capacity /staffing across the Health and Social care sectors.	**Date last reviewed:** November 2020
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 20 Current: 4 x 4 = 16 Target: 3 x 4 =12	**Rationale for current score:** Due to current measures related to COVID 19 including the cancellation of all non-urgent activity, Emergency Department and MIU attendance have reduced by nearly 50%, red call performance is at 65% and 4hr handover for the last 3 weeks has been in excess of 75%. Both Morriston and Singleton have predominantly been at risk level 1 for the past 2 months. It is recognised that this is not likely to be maintained as we go into the winter months and therefore remains a high risk.
Level of Control = 50%	**Rationale for target score:**
Date added to the HB risk register 26.01.16	The service delivery units have been implementing models of care that reflect National priorities and there is evidence that these are starting to impact positively on patient flow, length of stay and demand management. Workforce capacity issues continue to be challenging in some key specialty areas.

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

- Programme management arrangements are in place to improve Unscheduled Care performance.
- Daily Health Board wide conference calls/ escalation process in place.
- Regular reporting to Executive Team, Executive Board and Health Board/Quality and Safety Committee.
- Increased reporting as a result of escalation to targeted intervention status.
- Targeted unscheduled care investment to support changes to front door service models/ workforce redesign/ patient flow.
- Weekly unscheduled care meeting implemented, led by COO and attended by Service Directors
- Development of new Acute Medical Services Model focused on increasing the provision of ambulatory care
- Development of a Phone First for ED model in conjunction with 111 to reduce demand

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Mobile unit to allowing cohorting of patients at entrance of Morriston ED to release ambulance crews. Mobile due to be delivered end of November and in place early December.	Chief Operating Officer	30th November 2020
Implementation of Phone First for ED as one the initiatives set out in the National Unscheduled Care Programme – six goals	Chief Operating Officer	30th November 2020
Phased implementation of the Acute Medical Services Redesign. Business case for ambulatory care element of service redesign submitted WG.	Chief Operating Officer	30th November 2020

	Group established to focus on a reduction in the number of Medically Fit for Discharge (MFFD) patients with Local Authority	Deputy COO/Deputy DNS	30th November 2020
Assurances **(How do we know if the things we are doing are having an impact?)** • Executive monitoring/support to achieve improvement plans on a weekly basis.	**Gaps in assurance** **(What additional assurances should we seek?)** The need to deliver sustained service.		
Current Risk Rating **4 x 5 = 20**	**Additional Comments** Due to current measures related to COVID 19 including the cancelled all non-urgent activity, Emergency Department and MIU attendance have reduced by nearly 50%, red call performance is at 65% and 4hr handover for the last 3 weeks has been in excess of 75%. Both Morriston and Singleton have been risk level 1 for the past 2 weeks. It is recognised that this is not likely to be maintained and therefore remains a high risk. 23.4.20		

Datix ID Number: 843 Health & Care Standard: Staff & Resources 7.1 Workforce	HBR Ref Number: 3 Target Date: 31st March 2021
Objective: Excellent Staff	**Director Lead:** Kathryn Jones, Interim Director of Workforce and Operational Development **Assuring Committee:** Workforce and OD Committee
Risk: Workforce recruitment of medical & dental staff	**Date last reviewed:** November 2020
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 5 =20 Target: 4 x 3 = 12	**Rationale for current score:** National shortages of numbers in some areas can lead to: • Unable to recruit sufficient numbers of trainees to fulfil rotas on all sites • Unable to attract non training grades to complete rotas • Unable to fill Consultant grade posts in some specialties with adverse effects on patient safety and industrial relations. Unable to recruit sufficient registered nursing staff.
Level of Control = 70%	**Rationale for target score:**
Date added to the HB risk register April 2012	This remains a challenge and is also a national problem.

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
• Regular monitoring of recruitment position with reports to Executive Team and Board via Medical Director and Medical Workforce Board. • Specialty based local workforce boards established to monitor and control specific issues. The new HB Workforce & OD Committee will seek assurance of medical workforce plans to maintain services. • Engagement of the Deanery about recruitment position.	**Action**	**Lead**	**Deadline**
	Medical training initiatives pursued in a number of specialties to ease junior doctor recruitment	Interim Director W&OD.	31st March 2021
	The Medical Workforce Board continues to monitor recruitment and junior doctor's rotas.	Interim Director W&OD.	31st March 2021
	Continue to recruit internationally.	Interim Director W&OD.	31st March 2021

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

Current Risk Rating 4 x 5 = 20	Additional Comments
	Risk covers all hospitals and multiple specialties. Participated in BAPIO in November, appointed 25 doctors. Working with Medacs to replace long term locums e.g. in Hematology and Histo pathology. Developing an Invest to Save Bid for international overseas recruitment for nursing to upscale the activity for 20/21. Recruitment remains a challenge but is also a national problem. The problem persists but the restriction on overseas travel is not the same as in the first phase. We are still recruiting staff from overseas but have had to provide hotel accommodation for them to quarantine for 14 days before they can commence work Supply issues to the COVID areas however have been mitigated by using doctors from other specialties where demand is currently low and we are looking to over establish locum posts in medicine, ITU and Anaesthetics.

Datix ID Number: 739 Health & Care Standard: 2.4 Infection Prevention & Control & Decontamination	HBR Ref Number: 4 Target Date: 31st March 2021
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Christine Williams, Interim Director of Nursing and Patient Experience **Assuring Committee:** Quality and Safety Committee
Risk: Failure to achieve **infection control** targets set by Welsh Government, increase risk to patients and increased costs associated with length of stays.	**Date last reviewed:** November 2020

Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 =12		**Rationale for current score:** Currently under targeted intervention for rates of infection, achievement of targets are variable with monthly fluctuations.
Level of Control = 40%		**Rationale for target score:**
Date added to the HB risk register January 2016		Once the infection control team is fully recruited to, ICNet is functioning to its full capability the infection control team will be able to support the clinical areas more and drive service improvements. In addition, a negative pressure isolation facility is being built into the new emergency department at Morriston hospital providing another facility to appropriately manage patients at the front door. Review and implementation of a robust clean of patient rooms following an infection will reduce the risk of cross infection.

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

- Regular monitoring on infection rates
- Policies, procedures and guidelines in place
- Regular reporting through internal processes
- ICNet information management system for infections is in place
- Infection control team support the clinical teams for issues relating to infection control
- A permanent infection control doctor has been recruited
- Recruitment is ongoing. Decontamination lead & assistant director of nursing in infection control appointed.
- Bug stop quality improvement programme
- Incident reporting

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Ongoing infection control team involvement in site level estates projects to ensure appropriate isolation facilities are factored in from the outset	Senior Infection Control Matron	30th November 2020

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

- Ongoing monitoring of infection control rates and feedback provided to delivery units

Gaps in assurance
(What additional assurances should we seek?)
ICNet provides information linked with PAS relating to patients who have been inpatients since the connection was made therefore additional manual records are

• Infection Control Committee monitors infection rates and identifies key actions to drive improvement • Sub groups to the infection control committee such as the decontamination group provide the assurances and operationally drive key areas of work. • Clear assurance framework in place at Corporate level with Health Board Infection Prevention & Control Committee, Health Board C. difficile Infection Improvement Group; Corporate Infection Prevention & Control Nursing Team; Water Safety Group; and Directly Managed Unit Infection Prevention & Control Groups. • Incident reporting • Root Cause Analysis to ensure monitoring and lessons continued to be learned from HCAI.	maintained by the infection control team creating additional work and some duplication.
Current Risk Rating **5 x 4 = 20**	**Additional Comments** Significant progress to date however trajectory not met overall. Work underway on recruitment to IPC, a work plan to improve practice and improved information available for reporting, oversite and also investigation. 13/06/19 Continue to make progress against annual IMTP profiles, however, incidence within the Health Board remains above that for the NHS in Wales. Recruitment to Matron IPC post on 03/06/19. Work in progress to improve incident reporting in relation to infections and pilot to commence on post infection review process. Appropriate environmental decontamination resource to be identified and staff trained in its appropriate use. Compliance with IPC standard precautions and ANTT training and competence needs to be improved. A review of cleaning of shared equipment such as beds, commodes is required to reduce risks of transmission. Increase in cleaning hours across the Units is required to meet national minimum standards. Dedicated protected decant facilities are required for each Unit to ensure appropriate cleaning. Sufficient isolation rooms required to manage patient's appropriately. Estate needs to be updated and maintained to reduce risks. IPCC resources required to support community and primary care. Increase numbers of Piis on the last two months. HB over trajectory on a number of the TI Tier 1 targets. Increased level of risk due to insufficient domestic hours at Singleton hospital and significant vacancies at Morrison, lack of decant facilities, over occupancy in bays. Approved for increase in establishment at IBG in October 2019. 4 new posts approved. Now within VCP Process plus 1 existing band 6 vacancy. All 5 posts to be advertised in January 2020. Although there has been some improvement against TI Tier 1 targets, it is challenging to sustain. PII currently at Morriston Hospital. Reduction initiatives are compromised by over-crowding of wards as a result of increased activity, over-

	occupancy, staff vacancies, and where activity levels are such that it is not possible to decant bays to effectively clean patient areas where there have been infections. From an All Wales perspective, not yet achieving NHS Wales Infection Reduction Expectations. 26.05.20 - Incidence of C. difficile infection has been increasing over the last 7 months from an average of 11 cases per month to an average of 13 cases per month. The Welsh Government target is <8 cases per month. There has been an improvement in E. coli and Klebsiella bacteraemia cases, but these are still above the Welsh Government targets. 09.07.20 - incidence of C. difficile has increase further to an average of 16 cases per month in the first quarter (this is double the Welsh Government monthly expectation). The incidence of Staph. aureus bacteraemia also is higher than Welsh Government expectations, however, there continues to be reductions in E. coli and Klebsiella bacteraemia cases. Public Health Wales will make C. difficle genomic results available to the Health Board (current anticipated date Sept. 2020). This may facilitate a better understanding of the epidemiology of this infection within the Health Board. 18.08.20 - recruitment now complete. All staff now in post and on induction. 3.11.20 - In the Written Statement: Escalation and Intervention Arrangements on 7th October 2020, Minister for Health & Social Services, Vaughan Gething, announced that there has been a clearer approach to performance and an improvement in some of the measures under consideration, including infections. As a consequence of improved performance in a number of the TI areas, SBUHB has been de-escalated to 'enhanced monitoring'. It is challenging to attain improvements in reduction of targeted infections. However, there has been year-on-year improvement in the following key infections: Staph. aureus, E. coli, Klebsiella, and Pseudomonas aeruginosa bacteraemia cases. Of concern, there has been an approximate 75% year-on-year increase in C. difficle cases. COVID has led to increased compliance with training for PPE. Increased ICN presence clinically supporting DUs with the increase in resource and a full 7 day ICN service.

Datix ID Number: 841 Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety	HBR Ref Number: 13 Target Date: 31st March 2021
Objective: Best Value Outcomes	**Director Lead:** Chris White, 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:** November 2020

Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 =12 Target: 4 x 3 = 12		**Rationale for current score:** HSE issued ten improvement notices. Lack of accommodation to meet statutory/health and safety requirements could have an adverse impact citizens, staff, financial and operational performance.
Level of Control = 90%		**Rationale for target score:**
Date added to the HB risk register April 2012		Risk assessments of premises.

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

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

Mitigating actions (What more should we do?)

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

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

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

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

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

Current Risk Rating **4 x 3 = 12**	**Additional Comments** Planned interviews to take on board a SCP 1ST / 2ND Week of November 20. 3 months to undertake verification of our design by the SCP then submit to the WG for approval and funding

Datix ID Number: 737 Health & Care Standard: Staying Healthy 1.1 Health Promotion	HBR Ref Number: 15 Target Date: 31st March 2021
Objective: Partnerships for Improving Health and Wellbeing	**Director Lead:** Keith Reid, Director of Public Health **Assuring Committee:** Quality and Safety Committee
Risk: If we fail to achieve **population health improvement targets** leading to an increase in preventable disease amongst the population resulting in increased morbidity impacting on operational and financial pressures.	**Date last reviewed:** November 2020

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 26.01.16

Rationale for current score:
If we fail to prevent a serious outbreak by effectively achieving herd immunity in the population through immunisation and vaccination programmes, or to effectively manage an outbreak by disrupting the spread, this will result in serious harm to individual, maybe death, and pressure on health services, disruption to flow, business continuity and reputational damage to the health board and public health team.

Rationale for target score:

Manage preventable disease.

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

- Public Health Strategy and work plan
- Internal Audit Management Plan
- Strategic Immunisation Group
- MMR Task & Finish group
- Childhood Imms Group;
- Primary Care Influenza Group
- Support from PHW Health Protection

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Deliver immunisation awareness training for pre-school settings to promote key vaccination messages	Consultant Public Health Medicine	30th November 2020
Contribute to the implementation of recommendations made in the "MMR Immunisation: process mapping of the child's journey" report.	Consultant Public Health Medicine	30th November 2020
Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins	Consultant Public Health Medicine	30th November 2020

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

- School imms target is over 70%, we are the 2nd highest in Wales. All other childhood imms targets below trajectory.

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

Current Risk Rating
5 x 3 = 15

Additional Comments
Scrutiny by internal audit, raise awareness, encourage uptake, target population. Co-production work with the public.

Datix ID Number: 840 Health & Care Standard: 5.1 Timely Care	HBR Ref Number: 16 Target Date: 31st March 2021
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee
Risk: Access and Planned Care. If we fail to achieve compliance **with waiting times** there is a risk that patients may come to harm. Further, the health board will face financial risk with Welsh Government if the agreed target is not met.	**Date last reviewed:** November 2020

Risk Rating
(consequence x likelihood):
Initial: 4 x 4 = 16
Current: 5 x 5 = 25
Target: 4 x 2 = 8

Rationale for current score:
The cancellation of all non-urgent activity 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 volumes. The significant reduction in theatre activity is obviously increasing the number of patients now breaching 36 and 52 week thresholds.

Level of Control
= 90%

Rationale for target score:

Date added to the HB risk register
January 2013

There is scope to reduce the likelihood score to reduce the Risk to an acceptable level

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

- Post Covid 19 - there is no requirement to meet RTT target in 2020/21 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.
- A risk assessment based system for outpatient is awaited.
- Monthly planned care supported delivery board in place, chaired by CEO. Monthly performance reviews track progress against delivery. Flexible resource identified to manage in-year waiting times risks. Weekly executive support meetings in place in high risk areas. Outsourcing of capacity is being considered for some specialist services.
- Weekly calls with Units to support delivery and monitor performance.
- Monthly performance and finance meetings between executive team and service directors.
- Modest investment package agreed to support additional activity to increase capacity.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Develop sustainability plans for specialties through the emerging Clinical Services Plan	Head of IMPT Development	31.12.2020
Patient Prioritisation and Management	Associate Dir Performance	31.12.2020
Development of a whole system model for NPTH as a centre for Orthopaedic and Spinal services, to include the scoping of ambulant trauma options and capital requirements	Service Directors	31.12.2020
Scope and undertake an option appraisal process for a PACU model at Singleton and NPTH to support enhanced care complexity	Service Directors	31.12.2020

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?)

Current Risk Rating
5 x 5 = 25

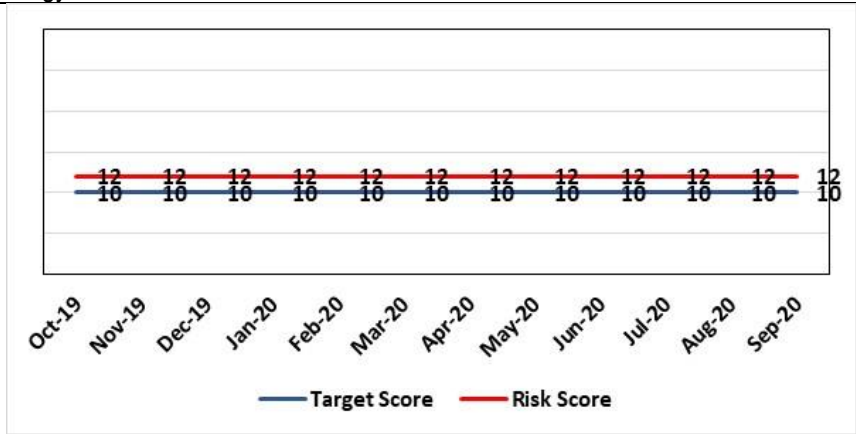
Additional Comments
The cancellation of all non-urgent activity due to COVID-19 has increased the backlog of planned care cases across the organisation. Whilst mitigating measures such as virtual clinics have been put in place new referrals are still being accepted which is adding to the outpatient volumes. The significant reduction in theatre activity is obviously increasing the number of patients now breaching 36 and 52 week thresholds.

Datix ID Number: 1035 Health & Care Standard: Effective Care 3.1 Clinically Effective Care	HBR Ref Number: 27 Target Date: 31st March 2021
Objective: Digitally enabled care	**Director Lead:** Chris White, Chief Operating Officer **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:** November 2020

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- There has been an increase in the number of devices in circulation by 3000 (39%) over the last 4 years (2015-2018) without an increase in IT support capacity. HB are currently only able to replace devices that are over 7 years old. Call volumes and wait times have increased over the last 4 years. Key IT maintenance work is not being completed in a timely fashion. Investment required in Informatics to deliver the Digital strategy is greater than the funding currently available. Informatics budget is estimated to be 0.73% of the HB budget - well below the recommended 4%. Resources available to provide digital services could be reduced because of the boundary change.

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
- Capital priority group for the HB considers digital risks for replacement technology which is fed into the annual discretionary capital plan
- IBG process allows for investment requests in projects to be submitted to the HB for

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Ensure informatics prioritisation process is embedded into the ways of working so that resource implications of digital solutions are transparent and agreed at outset of projects.	Assistant Informatics Business Manager	31st March 2021

consideration and provides scrutiny to ensure Digital resources required are considered for all projects • Informatics prioritisation process has been introduced to ensure requests for digital solutions are considered in terms of alignment to the strategy objective, technical solutions and financial implications • HB has invested £900k recurrently in the project staffing resources to facilitate the delivery of the Informatics Strategic Outline Plan • Working closely with WG to identify funding streams to support investment in digital including the approval of the Informatics Strategic Outline Plan	Ensure business cases requiring digital services include appropriate implementation and support costs.	Assistant Informatics Business Manager	31st March 2021
	Work with finance and the Health Board leadership team to identify additional revenue streams	Assistant Informatics Business Manager	31st March 2021
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 for new developments • IBG and CPG processes are in place and ensuring highest technology replacement risks are being addressed • There are 22 active projects in place and being delivered • Digital enablement is a cornerstone of the organization strategy. Two of the strategies, 8 areas, of focus are digital enablement. • WG have announced (Oct 19) £50m investment into Digital Transformation in 19/20. The HB are awaiting final confirmation of its allocation which is indicated to be £1,390k capital and £1,060k revenue. Whilst this is under what was requested it will be utilised against priority requirements for the HB.	**Gaps in assurance** **(What additional assurances should we seek?)** Lack of certainty over future funding streams makes planning and implementation difficult/less effective Revenue model for support unclear given the financial pressures of the organisation.		
Current Risk Rating **4 x 3 = 12**	**Additional Comments** This is further impacted by the boundary change which could have significant impact on resources and capability to deliver digital services going forward. Internal processes have been established to ensure that all informatics costs are included in Business cases developed by Informatics. Representation from Informatics at IBG and the Scrutiny Panel. Strategic Outline Plan based on the three year IMTP will be presented to the Health Board on the 30th January 2020. Three year plan to be developed in line with the Health boards IMTP Planning process The Strategic Outline Plan will be based on the Three Year Plan which will be developed in line with the Health Boards IMTP Planning process. The updated Strategy digital overview, priorities and maturity assessment was presented to January 2020 Health Board. –The Action has therefore been closed off 31/1/2020 within Datix and progress reported through to Audit Committee.		

Datix ID Number: 1043 Health & Care Standard: Effective Care 3.1 Clinically Effective Care	HBR Ref Number: 36 Target Date: 31st March 2021
Objective: Digitally enabled care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Audit Committee
Risk: Paper Record Storage: Lack of a single electronic record means there is greater reliance on the provision of the paper record. If we fail to provide adequate storage facilities for paper records then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if there is poor records management in some wards.	**Date last reviewed:** November 2020

Risk Rating (consequence x likelihood):
Initial: 4 x 5 = 20
Current: 4 x 3= 12
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
L - we know this happens from incidents raised

Rationale for target 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
L – RFID and digitalisation of the health record will reduce the constraints of the current filing methodology and reduce the volume of paper being added to the record. Further digitalisation of the paper record will reduce the reliance of clinicians on the paper record.

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

- Outpatient continuation Sheet has been rolled out and will form part of the plan to move Outpatients to paper light.
- MTED has been rolled out across Morriston and commenced in NPT
- Nursing Documentation (WNCR) piloted successfully in NPT
- Temporary retention and destruction plans are in place.
- Alternative storage arrangements are being identified and utilised where appropriate.
- Ward protocols and audits have been rolled out across sites.
- RFID project now approved. Implementation process has started and will change the way records are filed and release storage capacity.
- Roll out plan for WCP is in place and being enacted as outlined in the SOP
- All records must be documented and risk assessed in the Information Asset Register (IAR)
- Develop a case for improved storage solution both for paper and digitally.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Continue with the roll out of WCP	Interim Chief Information Officer	24th March 2021
Continue with roll out of digitisation of health record with a focus on Outpatients and Nursing documentation	Interim Chief Information Officer	30th March 2021
Develop case for improved storage solution for acute paper record.	Head of Health Records & Clinical Coding	24th March 2021

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 of records

Gaps in assurance
(What additional assurances should we seek?)
Investment required supporting the delivery and operational costs of the Digital strategy.

• Health Records performance reports to be developed in line with RFID technology Attainment of the Tier 1 Health Board target for clinical coding completeness which relies on the timely availability and quality of the Paper record • Monitoring complaints and incident reporting Gaps in Assurance Investment required supporting the delivery and operational costs of the Digital Strategy. Reliance on NWIS for delivery of the solution for a fully electronic patient record. Impact of the infected Blood Enquiry on the health boards ability to destroy notes is increasing the pressure on storage capacity and negating some of the mitigating actions that are being put in place	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.
Current Risk Rating **4 x 3 = 12**	**Additional Comments** All records must be documented and risk assessed in the Information Asset Register (IAR). This will mean that the risk can be quantified and understood. **Action - All SDU and corporate leads** Health Records Department will work with HB colleagues to develop a case for improved storage solution both for paper and digitally. In regard to the plans for the HB wide storage work, given the delay with the implementation of RFID, the timescales have been moved back slightly. Timescales for this work is as followed (based on current allocation of resources / no additional support. A dedicated project resource would get this done quicker) Scoping and requirements gathering exercise by October 19 - Options developed – Q4 2019-20 - Business case - Q1 2020-21 - Implementation Q3/4 2020-21 Discussions are ongoing with Welsh Health Supplies and Welsh Government on the availability of All Wales Records solution, the outcome of this scoping work will inform the options of the Business Case. Electronic results availability completed by August 2019. Other electronic documents ongoing. Timescales for completion of the Health Board storage work have slipped due to the impact of COVID and are now as follows:- - Options developed — Q1 20/21 - Business case - Q2 20/21 - Implementation Q1 21/22

Datix ID Number: 1217 Health & Care Standard: Effective Care 3.1 Safer & Clinically Effective Care	HBR Ref Number: 37 Target Date: 31st March 2021
Objective: Best Value Outcomes from Quality Care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Audit Committee
Risk: Operational and strategic decisions are not data informed:- • Business intelligence and information already available is not utilized • 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:** November 2020

Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 4 = 16 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
Level of Control = 70%		**Rationale for target score:**
Date added to the HB risk register June 2016		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?)

- COVID19 Dashboards Developed and are being used to inform the decision making process at Gold
- Strategy developed but not presented to Board due to COVID19
- The Health Board has continued to invest in the provision of Dashboards and we have doubled our licensing stock for both QlikSense and QlikView Business Intelligence Platforms in 2018/19.
- 17 dashboards in place including Mortality, Clinical Variation and Primary & Community Care Delivery Unit Dashboard and Ward Dashboard
- Safety Huddle implemented in Morriston is improving data quality and improving operational working
- Business Intelligent Information Manager appointed, who will take the lead for creating a Business Intelligence Strategy and Implementation Plan
- Investment and revised ways of working introduced within the coding department have achieved coding targets and data quality
- Flexible operational management of Coding Teams on a daily basis to cope with demand. Training programme in place for new coders.
- Short term funding secured at year end to support mtg tier 1 targets, does not resolve ongoing issues
- Information Dept. working with service leads in Planning and Finance to develop meaningful indicators also utilising dashboards to present information in a user friendly way
- New technologies being reviewed for advanced analytics and integration into a new Health Board analytics platform.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Investment and implementation of system to record patient outcome measures	Assist Information Business Manager	24th September 2021
Produce Business Intelligence Strategy and get signed off by the Board	Assist Information Business Manager	23rd October 2020
Produce BI strategy implementation plan outlining investment requirements in capacity and capability	Assist Information Business Manager	22nd January 2021

• Ensuring that the Health Board has representation on national groups such as the newly formed Advanced Analytics Group (AAG), all Wales Business Intelligence and Data Warehousing Group and Welsh Modelling Collaborative.			
Assurances (How do we know if the things we are doing are having an impact?) More evidence based and proactive decisions being made. Dashboard technology; assist in developing indicators / triangulating information to identify issues	**Gaps in assurance (What additional assurances should we seek?)** Culture of the organisation needs to change to focus on information and Business intelligence for operational rather than reporting purposes. Capability of operational staff to utilise the tools and capacity to act on the intelligence provided.		
Current Risk Rating **4 x 4 = 16**	**Additional Comments** PROMS currently being collected in Lung Cancer (Morriston) August 2019, Cataracts August 2019, Hip & Knee (Morriston) November 2018, and Breast Cancer June 2019 using PKB. Also Heart failure, April 2019, in one Community Clinic. COVID19 Dashboards Developed and are being used to inform the decision making process at Gold 13.08.20 – Please note amended timescales against the actions.		

Datix ID Number: 1297 Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety	HBR Ref Number: 39 Target Date: 31st March 2021
Objective: Demonstrating Value and Sustainability Risk in Brief: If the Health Board fails to have an approvable IMTP for 2018/19 then we will lose public confidence and breach legislation.	**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee**: Performance and Finance Committee / Strategy, Planning and Commissioning Group Health Board
Risk: Operational and strategic decisions are not data informed:- Health Board does not have an IMTP signed off by WG, primarily due to the inability to align performance and financial plans. WG also advised that the Health Board needed to have a clear strategic direction by developing an Organisational Strategy and refreshing our Clinical Services Plan. In September 2016, the Health Board was escalated to 'targeted intervention' and having an approved IMTP is a key factor in improving our WG monitoring status.	**Date last reviewed:** November 2020

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

Level of Control
= 70%

Date added to the HB risk register
July 2017

Rationale for current score:
Our Organisational Strategy was approved by the Board in November 2018
This Annual Plan includes a balanced financial plan.
We have agreed with Welsh Government that we will continue our detailed planning and submit an approvable IMTP when ready.
We have continued the work from January onwards on our detailed plans to submit an approvable IMTP when ready.
Quarterly and half year plans submitted for 2020/21.
WG expectations for 21/22 to be confirmed in November, but likely to be an annual plan for all organisations for 21/22 to be submitted March 21

Rationale for target score:
If the IMTP is approved it is likely our targeted intervention status will be improved when next reviewed and the risk can be closed.

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

- Organisational Strategy approved by the Board in November 2018
- Clinical Services Plan approved by the Board in January 2019
- Annual Plan submitted to Board and approved in January for submission to Welsh Government, accepted as a draft
- Good feedback received on the document.
- Due to the complexities of the Bridgend transfer, the CEOs of CTM and SB UHBs have formally asked WG for support to resolve the issues and formal arbitration process was initiated by WG.
- The results of the arbitration is now received as is the outcome of the Due Diligence Review.
- The Transformation Programme to deliver the Organisational Strategy and CSP including programme approach was established in April 2019
- Continuous planning through our CSP Programme and IMTP process will work up detailed plans to develop an integrated three year plan in line with the national timescales.
- The new Operating Model and Delivery Support Team will contribute to delivery of the financial plan.
- An Annual Plan in a three-year context was submitted to Board and approved in March 2020 for

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Development of Annual Plan within 3 year context to be considered By board in Jan 21	Director of Strategy, Director of Finance & Director OF Workforce & OD.	31st January 2021
Final plan to be submitted to Board for approval for submission to WG.	Director of Strategy	31st March 2021

submission to Welsh Government, accepted as a record of progress • Good feedback received on the document. • National IMTP Processes suspended in March due to the Covid-19 outbreak – and remain suspended • Quarterly Operational Plans developed and submitted in line with national guidance • Welsh Government written statement published on the 7 October 2020 advising that SBUHB been de-escalated from targeted intervention status to 'enhanced monitoring' status.			
Additional Comments IMTP Executive Steering Group in place for development of the integrated medium term plan. Integrated Planning Group in place to co-ordinate Transformation and planning activities and approaches • Performance and Finance Plans are be assured by the P&F Committee before presentation to Board •Through monthly IMTP briefings, TI meetings and bi-annual JET meeting with WG – planning approach and emerging plans discussed and WG fully supportive of the direction of travel.	**Gaps in assurance (What additional assurances should we seek?)** EIA in development for PFC assurance QIAs in development for joint PFC/Q&S assurance		
Current Risk Rating **4 x 5 = 20**	**Additional Comments** Need to note that P&F only looks at finance and performance, not the whole IMTP approval – that sits with Board. The W&OD Committee eg reviews the workforce plan. The HB submitted an Annual Plan to WG in March 2020 as a record of progress with our planning as the WG IMTP processes have been suspended due to the Covid-19 outbreak.		

Datix ID Number: 1567 Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety	HBR Ref Number: 41 Target Date: 31st December 2020
Objective: Best Value Outcomes	**Director Lead:** Christine Williams, Interim Director of Nursing and Patient Experience **Assuring Committee:** Health and Safety Committee
Risk: Fire Regulation Compliance – one improvement notice received relating to MH&LD Unit. Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations.	**Date last reviewed:** November 2020

Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 4 x 3 = 12 Target: 3 x 3 = 9		**Rationale for current score:** Improvement notice in relation to MH&LD Unit. Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations. General compliance with fire regulations and WHTM/WHBN requirements
Level of Control = 50%		**Rationale for target score:**
Date added to the HB risk register 31/05/2018		Target Score should be lower

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
• Fire risk assessments. • Evacuation plans (vertical and horizontal). • Fire safety training. • Professional advice sought on compliance of panels. • East flank panels removed • Business case being developed for south panel removal and updating .	**Action**	**Lead**	**Deadline**
	Change in fire evacuation plans and alarm and detection cause and effect	Head of Health & Safety	30th November 2020
	Finalise Business Case for permanent remediation of the external wall cladding to comply with HTM 05-02 and Building Control Regulations Approved Document B	Assistant Director of Strategy & Workforce	30th November 2020
	Replacing the existing cladding and insulation with alternative specifications and inserting 30 minute fire cavity barriers where appropriate	Assistant Director of Strategy & Workforce	31st March 2023

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
• Monitoring through the H&S committee to receive assurance and or identify gaps for key compliance and adherence to applicable legislation. • NWSSP internal audits • Site visits/tours to identify compliance and gaps in compliances. • Completion of FRA's within targeted schedule	Unclear if additional resources will be available
Current Risk Rating **4 x 3 = 12**	**Additional Comments** Professional assessment of panel compliance being taken forward with NWSSP-SES, building

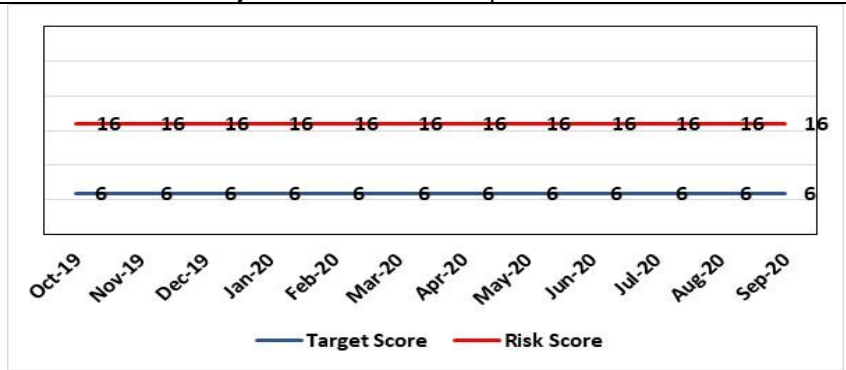
	control and WG colleagues. W/c 26/8/19 Cladding being removed from East and West end of main block. Escape route on west end redirected with approval of Fire and Rescue Service. Removal of flank cladding completed at end of 2019. Business case being developed for removal of cladding on south side of building. Review of numbers of fire wardens completed by Unit and new wardens being trained. Rationale for current score: Improvement notice in relation to MH&LD Unit. Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations. General compliance with fire regulations and WHTM/WHBN requirements Also: Phase 2 cladding replacement works scheduled to commence October 2020. Scheduled meeting with MWWFRS in August 2020 to cover cladding and general fire precautions for SBUHB sites. Priority completion of fire risk assessments for sleeping risk. Review of health and safety team resources being undertaken, with a target date of November 2020 to present to H&S committee. Provisional review undertaken, business case in draft format, costs being verified with finance on the draft options. Business case to be submitted to Execs in Q4. Fire resources are included in the overall H&S review.

Datix ID Number: 1514 Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety	HBR Ref Number: 43 Target Date: 31st March 2021
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Christine Williams, Interim Director of Nursing & Patient Experience **Assuring Committee:** Quality and Safety Committee
Risk: If the Health Board is unable to complete timely completion of DoLS Authorisation then the Health Board will be in breach of legislation and claims may be received in this respect.	**Date last reviewed:** November 2020

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 current score:
Although processes have been planned or implemented, the impact is yet to be measured over a longer term, and the challenges of managing a large backlog of breaches.

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?)

- Supervisory body signatories ~~increased from 3 to 7~~ in place
- BIA rota now implemented but limited uptake due to inability to release staff
- 2 x substantive BIA posts and additional admin post ~~advertised~~ in place
- DoLS database updated and DoLS dashboard devised to enable more accurate monitoring and reporting
- ~~Process in place within P&C Unit for management of authorisations and identifications of breaches in timescales. The Corporate Safeguarding Team is monitoring this.~~
- ~~31.07.19 2 WTE BIA's and a Band 4 Administrator have been appointed since April 2019. These individuals are managed by the Interim Head of Long Term Care, primary & Community Service Delivery Unit~~
- Regular reporting to Mental Health and Legislative Committee (MHLC)(Nov 20)
- QIA completed for re-introduction of DoLS BIAs attending Ward as part of Reset and Recovery Sept 2020
- QIA reviewed and service stood down in light of increased COVID incidence Oct 2020
- Managing and supporting all referrals remotely

Mitigating actions (What more should we do?)

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

• New legislation changes expected in 21/22 which will require a different service model, business case to meet existing and future requirements will be progressed March 21.			
Assurances **(How do we know if the things we are doing are having an impact?)** • Regular scrutiny at Safeguarding Committee and by DoLS Internal Audit; monitoring via DoLS Dashboard which is due to be rolled out imminently and will provide real-time accurate data. • Update report to MHLC regarding quarter 1 and 2 activity 2020, impact of COVID and focus on urgent cases via virtual process and plan to progress business case by year end.	**Gaps in assurance** **(What additional assurances should we seek?)**		
Current Risk Rating **4 x 4 = 16**	**Additional Comments** All actions attributable to safeguarding completed and Internal Audit aware.		

Datix ID Number: 1563 Health & Care Standard: Safe Care 5.1 Access	HBR Ref Number: 48 Target Date: 31st March 2021
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee:** Performance and Finance Committee, Health Board
Risk: Failure to sustain Child and Adolescent Mental Health Services	**Date last reviewed:** November 2020

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

Level of Control = 50%

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

Rationale for current score:
The specialist CAMHS Network is delivered by Cwm Taf University Health Board on behalf of ABMU.

Rationale for target score: New service model and improved performance

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Additional investment expected - from Welsh Government is supporting the delivery of Waiting List Initiative clinics to support the position.	CAMHS network	31st March 2021
The Network is seeking to recruit agency staff to fill existing and upcoming vacancies to ensure that core capacity is maximised.	CAMHS network	31st March 2021

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

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

Current Risk Rating
4 x 4 = 16

Additional Comments
The service is now in the 2nd cycle of CAPA with new job plans agreed from January, with updated demand & capacity mapping. WLI Clinics initiated at POW Hospital, Bridgend which enabled the 80% target to be achieved by end of end March. This was also achieved for NPT area. However Swansea had a significant backlog, which is starting to be addressed with waiting list initiatives from March 2018.
Primary & specialist CAMHS services are delivered by Cwm Taf University Health Board on behalf of ABMU (although this will only be for Swansea & NPT from 1/4/19).

	Cwm Taf achieved the non-urgent 28 day target for specialist CAMHS by the end of March 2019. Their ability to sustain this performance is dependent on consistency and availability of staff which due to the small numbers in the various CAMHS teams can affect achievement of waiting times significantly. Target achieved in March 2019, then missed for a number of months, but achieved from September 2019. However performance is still inconsistent, and will remain so until the existing 3 teams have been integrated into one service across West Glamorgan. New service model being implemented from June 2020 which will stabilise service. A new pathway for CAMHS patients is currently being developed which provides advice on the appropriate actions for dealing with these children and young people and will reduce the need to hold them in the Emergency Department at Morriston.

Datix ID Number: 922 Health & Care Standard: Effective Care 3.1 Clinically Effective Care	HBR Ref Number: 49 Target Date: 31st July 2021
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Richard Evans, Medical Director **Assuring Committee:** Quality and Safety Committee
Risk: Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI)	**Date last reviewed:** November 2020

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

Level of Control = 50%

Date added to the HB risk register July 2016

Rationale for current score:

- External review undertaken by Royal College of Physicians which will likely indicate that patients have come to serious harm as a result of excessive waits.
- Remains significant reputational risk to the Health Board

Rationale for target score:
External review by the Royal College of Physicians will provide a view on improvement required immediately and for sustainability.

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

- TAVI Recovery Plan implemented and backlog has been cleared..
- Plan is supported with Executive oversight at fortnightly TAVI OG meeting.
- TAVI has been prioritised in next year's WHSSC ICP for 2020/21. The UHB has commissioned the Royal College of Physicians to undertake a review of the service. Final report awaited, but anticipated that this will indicate that patients have come to serious harm

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Commission external review of the service by the Royal College of Physicians (Awaiting report)	Directorate Manager	30th November 2020

Assurances
(How do we know if the things we are doing are having an impact?)
Reduction in waiting times for TAVI.
Appointment to key posts (medical & nursing).

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

Current Risk Rating
4 x 4 = 16

Additional Comments
Business case for WHSSC funding has been agreed. There is considerable reputational risk to the organisation on the outcome of the Royal College of Physicians review.
Medical director in receipt of RCP report which will be shared widely in due course.
Extensive validation of pathway start dates for cardiothoracic and TAVI patients from external health boards has taken place (in line with recommendations from DU report).
Patients are now reported with true reflection of actual wait which has resulted in a reported position of 5 patients waiting >36 weeks. All patients will have TCI date before end of December 2019.
As part of external review, we have employed the 2nd TAVI nurse. The service remains challenging due to unscheduled care pressures particularly around cardiac short stay and also DDW has in recent weeks been closed to Norovirus. We are as a service soon to hit a 100 patient procedures as per contract base with WHSSC which leaves us with any new

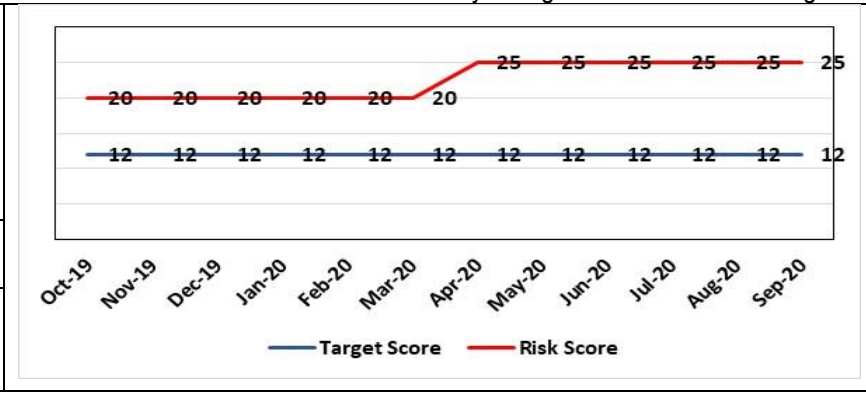
	patient who presents in Feb/March with a plan to undertake their procedures from a financial perspective. Update from Service Group Manager/Snr Matron 30/6/20 - Service is currently commissioned to undertake 100 procedures per annum ie, one list a week. Demands on service mean that currently two lists per week as being undertaken through an amended weekly timetable for team. Service has been asked by RE, Medical Director, that they support 3 lists per week. Senior Matron, advises currently enough nursing budget on DDW to run two TAVI lists per week, however at present it is difficult to meet the nursing demands for the service due to COVID pandemic (clean and dirty pathway for patients). Pathways for TAVI are now correct having been reviewed in depth over the last one year. Service Group Manager, advises a new business case needs to be considered through weekly Gold Command meetings chaired by Medical Director Risk at the moment can be reduced to 16. Cardiac Regional Service are trying to provide elective planned service and emergency service across a wider clinical area. JT meeting with Matron (LM), Anwen, Gwen 7/7/20 to agree what nursing is required (1:3 PACU type acuity - can cause some pressures on green / red pathways). Update from Senior Matron - It has been agreed that the staffing ration for patients will be 1:3 – current staffing on DDW allows for 2 lists per week to be provided. Any additional patients who are done or who are done on the red pathway will were possible be recovered in CCU. If bed not available there will be a risk assessment undertaken of the patients post procedure care needs, and the acuity of the other patients on the ward. Based on this an additional nurse may be required for the day and possibly the night shift. This is not funded and to note currently DDW can accommodate 2 lists per week but only one of these is funded.

Datix ID Number: 1761 Health & Care Standard: Timely Care 5.1 Access	HBR Ref Number: 50 Target Date: 31st March 2021
Objective: Best Value Outcomes from High Quality Care	**Director Lead**: Chris White, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee
Risk: Access to Cancer Services - Failure to sustain services as currently configured to meet cancer targets	**Date last reviewed:** November 2020

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:
Whilst every effort is being made to maintain cancer treatment, surgical cancer activity in particular is being impacted upon by both the reduction in elective theatre capacity and availability in critical care beds

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 unscheduled care (USC) Pathway.
- Initiatives to protect surgical capacity to support USC pathways have been put in place in RGH and PCH to protect core activity.
- Prioritised pathway in place to fast track USC patients.
- Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies.
- Overall Cancer target performance plateau at around 90% with ongoing monitoring of related actions in place at F,P&W Committee.
- Small numbers of patients breaching which is impacting on sustained delivery of the 31 and 62 day target.
- Rapid Diagnostic Clinic established at Neath Port Talbot Hospital. Discussions are ongoing with regard to patient flow and the boundary changes. Discussions are being held with the Executive team regarding the future direction and provision of the RDC service. Work is also ongoing to roll out the concept of the RDC across Wales.
- Delivery Units have Cancer Trackers to closely monitor and 'pull' patients through their pathways. Weekly cancer performance meetings are held at both Singleton and Morriston Delivery Units. Also a weekly HB Cross Unit Cancer performance meeting is held. This meeting is led by the Cancer Lead Manager/Cancer Information Team and the Units are challenged on delays and service issues.

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	30th November 2020
To explore the possibility of offering SBAR RT for high risk lung cancer patients in SWWCC	Service Manager Surgical Services	30th November 2020
Establishment of mobile unit to carry out PET/CT scans for Swansea and South West Wales patients.	Radiology Services Manager	30th November 2020
Introduce COVID testing for Oncology and Haematology patients and staff involved in service delivery in line with national guidelines.	Service Manager Surgical Services	30th November 2020

• The tumour sites of concern across the HB for breaches are now Breast, Gynaecological and Lower GI. Forecast performance remains a significant risk until sustainable solutions are identified for these tumour sites and new staff appointments to support tracking and pathways are fully embedded within services.	Continue to expand our Surgery capacity to allow our complex cancer surgeries to deal with any backlog of patients	Directorate General Manager	30th September 2020
Assurances **(How do we know if the things we are doing are having an impact?)** General improvement (sustained) trajectory. Need to continue improvement actions and close monitoring. Early diagnosis pathway launched and impact being closely monitored.	**Gaps in assurance** **(What additional assurances should we seek?)** Clear current funding gap.		
Current Risk Rating **5 x 5 = 25**	**Additional Comments** The need to deliver sustained performance. Whilst every effort is being made to maintain cancer treatment, surgical cancer activity in particular is being impacted upon by both the reduction in elective theatre capacity and availability in critical care beds due to the COVID-19 outbreak. Covid screening is in place for all patients starting their 1st cycle of SACT and for all Lung RT patients.		

Datix ID Number: 1759 Health & Care Standard: Staff & Resources 7.1 Workforce	HBR Ref Number: 51 Target Date: 31st March 2021
Objective: Excellent Staff	**Director Lead:** Christine Williams, Interim Director of Nursing **Assuring Committee:** Workforce and OD Committee
Risk: Non Compliance with Nurse Staffing Levels Act (2016) Graph being updated	**Date last reviewed:** November 2020

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

Level of Control
= 80%

Date added to the HB risk register
November 2018

Rationale for current score:

- Increased risk as a result of reduction in staff availability as a result of staff isolation/sickness - Covid-19. Frequently below minimum staffing number requirements.
- Increased risk due to opening of surge capacity

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:

Additional Controls re-instated in October 2020 include:

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

Additional Control's introduced in March include:

- Daily Silver Nurse staffing Cell meetings chaired by Executive Director of Nursing & Patient Experience to discuss hot spots and the staff available across the Health Board.
- Nurse Bank fully utilised and part of the nurse staffing meetings, Unit Nurse Directors can now sanction non contract agency without Executive approval to maintain a safe service.
- Corporate Nursing 7 day rota introduced.
- Database set up to record wards that have been repurposed as novel wards (COVID-19)
- Set up COVID-19 Corporate Training and Education Hub which outlines a clear plan for training and education
- 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.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Daily Staffing Tool has been agreed across the Delivery Groups to maintain a consistent approach.	Director of Nursing & Patient Experience	In place November 2020
The Ward Sister / Charge Nurse and Senior Nurse should continuously assess the situation and keep the designated person formally appraised.	Director of Nursing & Patient Experience	20th November 2020 Monthly ongoing
The Board should ensure a system is in place that allows the recording, review and reporting of every occasion when the number of nurses deployed varies from the planned roster. *(Progress being made, last paper went to Board in November 2019. Paper accepted by the Board)*	Director of Nursing & Patient Experience	5th October 2020
The responsibility for decisions relating to the maintenance of the nurse staffing level rests with the Health Board should be based on evidence provided by and the professional opinions of the Executive Directors with the portfolios of Nursing, Finance, Workforce, and Operations.	Director of Nursing & Patient Experience	5th October 2020
Risk register to be reviewed monthly to ensure compliance	Director of Nursing & Patient Experience	Monthly ongoing

Existing Controls • Confirmed the designated person • Represented the All-Wales Nurse Staffing Group and its sub groups • Contributed with the work undertaken at an all-Wales level on Acuity levels of care. • Undertaken a formal review across all acute Service Delivery Units for calculating and reporting nurse staffing requirements to ensure a Health Board wide consistent approach is adopted. • Presented a Health Board position status paper to both Board & Executive team outlining the preparedness for the Nurse Staffing Act (Wales). • Conducted a review of workforce planning procedures, for 2018 to 2021, which includes; Health Board recruitment events, retention, workforce planning & redesign, training and development. • Developed a monthly Health Board Multidisciplinary Nurse Staffing Act Task & Finish Group, chaired by the Interim Deputy Director of Nursing & Patient Experience, which reports to Nursing and Midwifery Board and Workforce & Organisational Development Committee. • Provided acuity feedback sessions to all Service Delivery Units included in the June audit. • Formally launched the Nurse Staffing (Wales) Act Guidance. • Raised the issue regarding Information Technology barriers around the capture of data required for the Act on an All-Wales and Health Board basis. • Circulated the Welsh Levels of Care and Operational Handbook to Service Delivery Unit Leads. • Confirmed the 32 acute medical & surgical clinical areas that fall within the Act. These areas have been agreed using the criteria set out in the Operational Handbook. • A Rigorous data approval process has been put in place to ensure accuracy of the 6 monthly acuity data prior to sign off. There has also been a number of workshops organised across the organisation to ensure a consistent approach to data collection and there is national work on solutions for electronic capture of acuity data. • The NSA Steering group continues to meet on a monthly basis. • Risks are presented at each meeting • Scrutiny panels are held for each SDU following the submission of acuity templates. • Impact assessment work is being undertaken to prepare for further roll out of the Act.	Health Board should agree the operating framework for these decisions to include actions to be taken, and by whom.	Director of Nursing & Patient Experience	5th October 2020
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. • Implement mobile devises to be used within adult acute medical and surgical wards included within the Act in readiness for the June Adult Acuity Audit. • Agreed establishments to funded. • Implementation of E-Rostering to enable accurate reporting of Compliance • Implement all Wales Templates, which are visible and signed within the agreed 32 ward areas, informing patients of planned roster. • At least Yearly Board reports outlining compliance and any key risks. August 2019 update In line with the Boundary changes there are now 29 reportable wards which excludes POW. E-rostering has been rolled out in Singleton and Morriston is in the process of being rolled out. Scrutiny panels are in place. Following the investment already provided to the funded establishments. The overall risks have reduced as outlined above. The quality and accuracy of the Acuity data has improved.	**Gaps in assurance** **(What additional assurances should we seek?)**		
Current Risk Rating **5x 5 = 25**	Non Compliance with Nurse Staffing Levels (Wales) Act (2016) The Nurse Staffing Levels (Wales) Act, which received Royal Assent on 21st March 2016, places an overarching duty on		

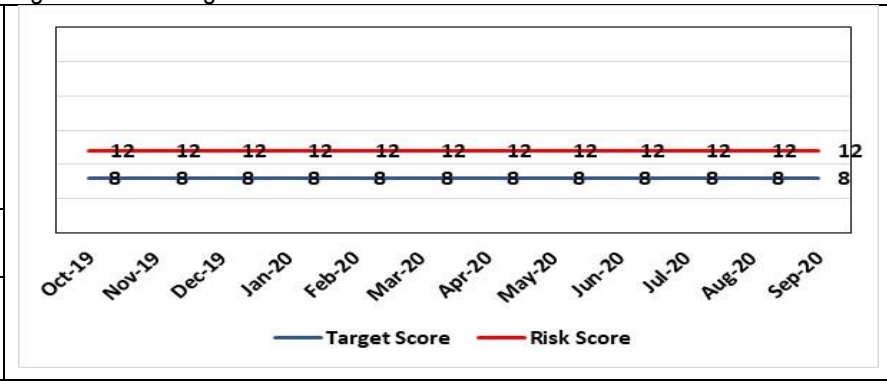
	Local Health Boards and NHS Trusts in Wales to ensure that nurses have time to care sensitively for their patients and codifies current best practice for determining nurse-staffing levels. It requires Local Health Boards and NHS Trusts in Wales to calculate and maintain staffing levels in specific clinical areas, which are Adult acute Medical & Surgical wards. In accordance with the Act, Health Boards/Trusts must submit annual reports to their board and three-yearly reports to Welsh Government in relation to their compliance with the staffing levels, the impact upon the quality of care where the nurse staffing level was not maintained and the actions required in response to this. The Act currently requires the reporting of adult acute medical and surgical inpatient wards, 32 wards in total across the Health Board. In preparation for the Act Service delivery Units have all produced detailed risk assessments in preparation for the Act: Morriston 20 Singleton 16 NPT 6 POW 16 Current Status Singleton 15 Morriston 15 NPT 6. Operating Framework in place. Progress is being made the last paper went to Board November 2019. The paper was accepted by the Board. Letters have been sent to Morriston & Singleton Delivery Unit confirming the outcome of Novembers Board and support for Funding. The templates are being signed. NPT Delivery Unit has already received a letter. 1st June due to COVID-19 a letter was received from the Chief Nursing Officer (Wales) outlining the impact of COVID-19 and actions to be considered. The Bi-Annual Nurse Staffing Act paper was postponed and a COVID-19 paper in relation to the disruption to the Nurse staffing levels Act was presented to May's Board in its place. The paper was based on an All Wales Template. Staffing has improved across the Health Board although the score remains the same in light of the uncertain time and a number of factors relating to the Covid-19 situation. Daily Silver Nurse staffing Cell meetings stood down on 30.7.20. The frequency and timings of these meetings will be reviewed at times of COVID Level 4 Super Surge level as per SOP “Nurse Resource during COVID -19”. Corporate Nursing 7 day rota stood down will be re-established when required. Reduction in vacancy factor Band 5 - 309 wte Band 2- 13 wte as at 9.7.2020. Student Streamlining - 151 due to commence September 2020. Plan to implement Safecare acuity based rostering tool in September 2020 QIA in progress. Jan 20 Acuity audit. The retrospective triangulation review has been undertaken in July 20. July 20 Acuity audit has been undertaken. The scrutiny panels set up in September 20. Risk Register has been reviewed and remains at 20 due to unpredictability at present with COVID-19 July Acuity Scrutiny panels have been re set for October 2020. Paediatrics Task & Finish Group has been formed in preparation for the extension of the Act. Current Risk remains at 20 due to the uncertainty surrounding COVID. October 2020 update NSA Board paper presented to Septembers Board. Scrutiny panels have taken place in October. Preparing Board paper for November BI-Annual review of staffing. Current Risk escalated to 25 due to the escalating concerns around COVID-19 and requirement around surge plans, including wards being re-purposed and opening and commissioning of new wards.

Datix ID Number: 1763 **Health & Care Standard: Staff & Resources 7.1 Workforce**	**HBR Ref Number: 52** **Target Date: 31st March 2021**
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:** November 2020

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?)

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Agreement of dedicated resource to support Engagement activity – through structure reviews	Director of Transformation	30th November 2020
Conclude work on Exec Equalities portfolios	Interim Assistant Director of Strategy	30th November 2020
Appoint to agreed Planning posts	Interim Assistant Director of Strategy	31st December 2020

Assurances (How do we know if the things we are doing are having an impact?)
Temporary additional resource in place for CSP (part of requirements). Now agreed by the Executive Team.
Equality Impact specialist advice and support to be considered as part of Exec portfolios for equality review.

Gaps in assurance
(What additional assurances should we seek?)
Permanent additional resources not yet available

Current Risk Rating
4 x 3 = 12

Additional Comments

Datix ID Number: 1762 Health & Care Standard: Staff & Resources 7.1 Workforce	HBR Ref Number: 53 Target Date: 31st March 2021
Objective: Partnerships for Care	**Director Lead**: Pam Wenger, Director of Corporate Governance **Assuring Committee:** Health Board (Welsh Language Group)
Risk: Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.	**Date last reviewed:** November 2020

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 now 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.
- A new Welsh Language Officer (WLO) has now been appointed, taking up her post in September 2020.
- Close constructive working relationships are in place with the Welsh Language Commissioner's Office
- Strong networks are in place amongst Welsh Language Officers 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.
- Working with NHS Wales Shared Services (NWSSP) to achieve compliance for workforce and recruitment standards.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Review and update the Welsh Language Standards Action Plan to reflect the findings of the independent baseline assessment	Director of Corporate Governance	31st January 2021
Following the appointment of the WLO, reinstate quarterly meetings of the Welsh Language Delivery Group.	Director of Corporate Governance	31st January 2021
Ensure the Board is fully sighted on the UHB's position through regular reporting to the Health Board. Update reports issued to the Executive Team and Board.	Director of Corporate Governance	31st January 2021

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.

Current Risk Rating	Additional Comments

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

Datix ID Number: 1724 Health & Care Standard: Safe Care 2.1 Managing Risk & Health & Safety	HBR Ref Number: 54 Target Date: 1st January 2021
Objective: Partnerships for Care	**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee:** Health Board (Emergency Preparedness Resilience and Response Group)
Risk: Failure to maintain services as a result of the potential no deal Brexit	**Date last reviewed:** November 2020

Risk Rating
(consequence x likelihood):
Initial: 4 x 5 = 20
Current: 5 x 3 = 15
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 services as business as usual

Rationale for target score:
By undertaking the actions highlighted it is anticipated that the arrangements put in place will ensure business as usual in light of a no deal Brexit.

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

- All services to identify high risks related to Brexit on risk register Engagement in health national groups
- Welsh Government is working with NWSSP procurement to commission a review of devices and consumables supply chain in Wales to complement the work already completed at UK level.
- Welsh Government has put in place national communication and co-ordination arrangements, including:
  - A Brexit Ministerial Stakeholder Advisory Forum made up of senior leaders from across the sector, and led by the Cabinet Secretary for Health and Social Services and the Minister for Children, Older People and Social Care;
  - An EU Transition Leadership Group, chaired by WG focusing on ensuring operational readiness arrangements for both health and social services in Wales (terms of reference attached);
  - Regular meetings of NHS emergency planners, chaired by Welsh Government, as part of established resilience arrangements;
  - A 4 Nations public health group addressing public health associated risks and health security concerns, and a joint Welsh Government – Public Health Wales working group considering specific Welsh issues;
  - Working in partnership with the Welsh NHS Confederation to ensure ongoing flexible and effective communication and engagement between us and other stakeholders in the health and care system; and Regular updates on Brexit to the monthly NHS Wales Executive Board meetings.
  - Assessing command and control requirements
  - Work programme monitored via EPRR Strategy Group
  - All services to complete business continuity plans
  - all services to identify high risks related to Brexit on risk register
  - Engagement in health national groups

Mitigating actions (What more should we do?)

Action	Lead	Deadline
To review and rehearse promptly the existing business continuity and resilience/contingency arrangements, and to do so working with your local and regional partners, including through your local resilience forums.	Head of Emergency Preparedness, Resilience & Response	(Monthly meetings to resume in September) 30th September 2020
Revision of business continuity plans to take account of Covid-19 impacts	Delivery Groups	November 2020

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

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

• All services to complete business continuity plans	To understand from the review what arrangements need to be in place to minimise the risks in relation to a potential no deal Brexit.
Current Risk Rating **3 x 5 = 15**	**Additional Comments** There is an obligation to maintain critical services and business as usual in an emergency and this includes Brexit and consequently there is the potential for disruption in commercial and public services and therefore supplies, services, transport, fuel, border issues, EU national issues, immigration, critical infrastructure, energy and command resilience etc. All EPRR and Brexit meetings were postponed temporarily due to the Covid-19 pandemic but are due to resume in September and updates will then be noted onto the risk.

Datix ID Number: 1799 **Health & Care Standard: Controlled Drug 2.6 Medicines Management**		**HBR Ref Number: 57** **Target Date: 31st December 2021**
Objective: Best Value Outcomes of High Quality Care		**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee**: Audit Committee
Risk: Non-compliance with Home Office Controlled Drug Licensing requirements		**Date last reviewed:** November 2020
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 2 = 8		**Rationale for current score:** The Health Board has limited assurance regarding whether or not it is compliant with Home Office Controlled Drug Licensing requirements at the present time, nor does it currently have processes in place to ensure any future service change complies. Risk: That the Health Board is operating in breach of the law by managing controlled drugs without an appropriate Home Office Controlled Drug License. Legal advice provided to the Health Board has indicated that failure to comply with the Home Office Controlled Drug licensing requirements could result in criminal and civil action, both against responsible individuals and the Health Board as a public body. Work has commenced to fully understand the licensing situation along with the drafting of a detailed policy that will ensure compliance going forward. Risk: That the Health Board is maintaining unnecessary Home Office Controlled Drug Licenses. Each Home Office Controlled Drug license costs around £3k plus additional administrative set-up and maintenance costs. Health Board wide scrutiny is required to ensure no unnecessary licenses are held (one such example has recently been discovered).
Level of Control = 40%		**Rationale for target score:**
Date added to the HB risk register January 2019		Once the new policy is complete and has been checked for legal compliance to the Home Office regulations there will be a training session held with all clinical areas supported at Executive level. The work currently underway includes checking areas of concern for compliance with the regulations.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
Legal advice received and principles upon which to decide whether a Home Office Controlled Drug	**Action**	**Lead**	**Deadline**

License would be required have been drafted. This forms the basis of a detailed policy that is currently in draft form. This will be sent for legal ratification to ensure compliance to the Home Office regulations. The Home Office have been advised work is currently being completed as a matter of urgency. Areas of specific concern regarding license compliance are being visited to enable an accurate assessment. Additionally, work is underway to develop a governance framework to ensure responsibility for management and use of controlled drugs is fully understood within the delivery units. The framework will enable both the Controlled Drug Accountable Officer and the Health Board Medical Director to discharge their individual accountabilities. The Executive Medical Director, the Executive Director of Nursing and the Chief Pharmacist/CDAO are fully involved and supportive of any potential changes for delivery units. .	Training session to be held for all clinical areas. All delivery units will be required to identify a responsible manager and ensure compliance with both the CD Licensing Policy and the new framework for management and use of controlled drugs.	Clinical Director of Medicines Management (Pending internal corporate governance review of controlled drugs governance in new organization)	30th November 2020 (Pending policy development and sign off in conjunction with Home Office)
Assurances **(How do we know if the things we are doing are having an impact?)** • To date the HB has received legal advice. Pending policy development, the principles contained within the legal advice are referred to when issues are raised in order to provide consistency in arrangements.	**Gaps in assurance** **(What additional assurances should we seek?)** The Health Board will develop a license compliance register, this is expected to be maintained by the Corporate Governance Team thus ensuring there is sufficient segregation of duty.		
Current Risk Rating **4 x 4 = 16**	**Additional Comments** The Home Office are aware that the Health Board have sought independent legal advice regarding the situations where a Home Office Controlled Drug license is required. Advice received to date from the Home Office regarding particular scenarios of Controlled Drug management by the Health Board has differed from the independent legal advice received. The Home Office are currently awaiting the Health Board policy on this matter so that they can review our position. Once completed the policy outlining the Health Board position on Controlled Drug licensing will be shared with both Welsh government and all other Health Boards in Wales as the Swansea Bay UHB position is likely to be used by the Home Office as a precedent. A baseline audit and assessment of current Controlled Drug management across the Health Board (including the degree of 'management and control' exercised) against the recently received legal advice. A baseline audit and review of any Home Office Controlled Drug licenses currently held by the Health Board. Ratification of a specific HB policy on need for HO licenses will go to HB Q&S at the end of August for sign off. After ratification the HB will start negotiations with the HO.		

Datix ID Number: 146 Health & Care Standard: Effective Care 3.1 Clinically Effective Care	CRR Ref Number: 58 Target Date: 31st March 2022
Objective: Excellent Patient Outcomes	**Director Lead**: Chris White. Chief Operating Officer **Assuring Committee**: Quality and Safety Committee
Risk: There is a failure to provide adequate clinic capacity to support follow-up patients within the **Ophthalmology** specialty. The consequence of this failure is a delay in patients with chronic eye conditions accessing ongoing secondary care monitoring of diagnosed conditions with the potential risk of permanently impairing eyesight.	**Date last reviewed:** November 2020

Risk Rating (consequence x likelihood):
Initial: 4 x 3 = 12
Current: 4 x 5 = 20
Target: 4 x 1 = 4

Level of Control = 40%

Date added to the HB risk register December 2014

Rationale for current score:
Sustainable plans underway - short term measures in process of being implemented. Serious incidents being reported to WG. Gold Command exec-led oversight established November 2018. Risk rating increased to 25 January 2019 as instructed by Gold Command. LJ advised change risk score to 16, 03/04/2019 as Probable x Major. Risk rating increased to 20 in July 2020 due to Covid-19 pandemic.

Rationale for target score:

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

- All patients are categorised by condition in order to quantify issue. Second glaucoma consultant appointed November 2018.
- Additional accommodation secured to increase capacity; implementation plan under development. Welsh government funding secured for 2019/20 to employ additional activity and deliver some services in a community setting. Virtual clinics established.
- Service Manager for Ophthalmology providing regular updates via Planned Care Programme.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
An overall Sustainability Plan to be delivered (Gold command process in place)	Service Group Manager Surgical Specialties	30th November 2020

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

- A Welsh Government pilot programme was implemented in June 2014. The purpose of the HES project is to use clinic capacity to assess, review and treat patients within clinical priority rather than prioritising new patients based on their waiting time. A Project Management Lead was in post to deliver on the HES objectives.

Gaps in assurance
(What additional assurances should we seek?)
Extended waiting times for patients requiring routine clinical intervention, but these are still listed as per RTT guidance.

Current Risk Rating 4 x 5 = 20	Additional Comments Additional Glaucoma practitioner (temporary for 12 months) commenced in post

	11/06/2018. 2nd Glaucoma Consultant started 05/11/2018. Advert for substantive consultant as part of regional development with Hywel Dda to be placed in November Accommodation in Corridor 3 reconfigured 08/02/2019. Further work needed on accommodation and additional rooms required. Ongoing discussions continue with Singleton Unit so that space can be created to house a co-located Ophthalmology Department Middle grade doctor to commence in post April 2019. Monthly tracker of glaucoma backlog patients indicates reduction of over 800 patients to end of January 2019. Diabetic Retinopathy Virtual Review clinics are to be increased via a WG funded successful bid. Reviewed by AD& PT Sustainable plans are under way and are on target against follow up trajectory backlog. 20/21 sustainable plans are currently being drafted. Risk score reviewed to maintain at 20. Although routine outpatient's appointment are not being undertaken due to COVID-19 those patients at high risk i.e. wet AMD are still being seen and receiving treatment and those patients in other high risk specialties such as glaucoma are being reviewed virtually and if deemed necessary attending for urgent appointments. Since the advent of the Covid-19 outbreak only the following essential Eye services have been maintained during Covid 19. • AMD treatments • Retina services • Rapid Access Eye clinic (RACE - Eye Casualty) As a consequence, the progress made through the previous eye care initiatives has been reversed. During the pandemic the following has been achieved: • Paediatric – 2 consultants have started with a post Covid timetable covering Hywel Dda sessions under SLA contract. • Diabetic Retina – Band 4 Coordinator appointed from interview 19th June 2020. • Glaucoma – Strawberry Place ODTC clinics to resume for 3 months from July 2020 while we look for alterative accommodation, which has now been secure in NPT Resource Centre. Some clinically urgent Cataract operations have been undertaken through May and June 2020

Datix ID Number: 2003 Health & Care Standard: Effective Care 3.1 Clinically Effective Care	HBR Ref Number: 60 Target Date: 31st March 2021
Objective: **Digitally Enabled Care**	**Director Lead:** Chris White, Chief Operating Officer **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 has increased digital services (users, devices and systems) and therefore the impact of a cyber-security attack is much higher than in previous years. The introduction of the Network and Information Systems Directive (NISD) in May 2018 means that large fines can be issued to organisations that are not compliant with the Directive. A report from the department of health following the Wannacry incident in May 2017 stated that attack cost the NHS (England) £92m as 19,000 appointments were cancelled and this was before the NISD came into effect. The largest risk to the organisation is on user awareness and unsupported software (old versions which are no longer patched for security vulnerabilities) and devices not managed by the ICT department e.g. medical devices.	**Date last reviewed:** November 2020

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 at an unprecedented level and health is a known target. The health board has increased digital services (users, devices and systems) and therefore the impact of a cybersecurity attack is much higher than in previous years.
Level of Control		**Rationale for target score:**
Date added to the HB risk register July 2019		C- Will remain the same or increase due to increased reliance in information L- The overall likelihood score would increase to (20) if the funding of the 8A and 2 x Band 6 are not recruited.

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
• Cyber Security Manager and supporting roles now in place. • The national security tools will highlight vulnerabilities and provide warnings when potential attacks are occurring. Swansea Bay will adopt these tools in financial year 2019/20. • The NHS in Wales is protected by a firewall by NHS Wales Informatics Service (NWIS). • Swansea Bay UHB has advanced firewall protection to protect the network from potential cyber-attacks.	**Action**	**Lead**	**Deadline**
	Implement National Cyber Security Tools	Cyber Security Manager	29th October 2020

• All emails coming into NHS Wales are scanned using the national email filter. Whilst malicious emails come into the health board on a daily basis, the number are vastly reduced using the email filter and NWIS issue warnings to users affected when the contents are discovered (same day). Users are warned to delete emails and if opened, contact ICT service desk for investigation. • A patching regime has been in place around 18 months which ensures desktops, laptops and servers are protected against any known security vulnerabilities. Anti-virus is in place to protect against known viruses with intelligent scanning on potential viruses not yet discovered. • Access to the internet is controlled through a smart filtering solution which restricts access to potentially vulnerable content. • Work is ongoing in order to replace out of date systems, this is a huge task given the number of clinical and administrative systems in place across the health board. The creation of the service management board will help in terms of getting stakeholder agreement and engagement. Capital funding has also been available to address this. • A Cyber Security training module has been developed and available in the Electronic Staff Record training to ensure staff are fully aware of the risk of cyber security and are vigilant in recognising malicious activity e.g. malicious email. This needs to be adopted as mandatory training.			
Assurances (How do we know if the things we are doing are having an impact?) This will be developed following the appointment of the Cyber Security Manager. In the meantime, the follow up Stratia report has confirmed a major improvement in terms of Microsoft Security patching and SBU are compliant with standards agreed. The Cyber Assurance Framework (compliance with NISD) has been submitted to the Operational Security Service Management Board and plan will be developed nationally to address areas of non-compliance.	**Gaps in assurance (What additional assurances should we seek?)**		
Current Risk Rating **5 x 4 = 20**	**Additional Comments** Band 8a Cyber Security Manager appointed October 2019. Microsoft patching is compliant. NISD CAF completed and submitted to OSSMB. 2 Band (6) Cyber Security staff have now been appointed and are due to commence shortly. (completed) National Security Tool - SIEM Systems integrated, currently working on the final interfaces. NESSUS still awaiting National timescales for NWIS for rollout. Meetings in progress to make Cyber Security Training mandatory across the Health Board. Papers on progress on Cyber Security have been sent to the Senior Leadership Team, Audit committee and Health Board meetings and were well received in each of those. The progress on the establishment of a dedicated Cyber Security team and adoption of local and national cyber tools to improve cyber defences and establish proactive monitoring was		

	noted. The risk score of 20 remains as the largest risk to Cyber Security are the staff that access computer systems such as inadvertently clicking on a malicious link in a Phishing email. The Senior Leadership Team agreed, in principle, for Cyber Security Training to be made mandatory. A further paper for approval, describing the implications for the workforce, will be submitted to a future SLT meeting. National Security Tool -SIEM Systems integrated currently working on final interfaces. NESSUS still awaiting national timescales from NWIS for rollout. Following from the previous update, Cyber Team now use the Security Information and Event Management system (SIEM) daily to provide a dashboard for security monitoring to ensure visibility of potential cyber threats. Training for Cyber staff on operational use of the SIEM is was due in March 2020, but was delayed as a result of COVID and is now scheduled for October.

Datix ID Number: 1587 Health & Care Standard: 3.1 Safe and Clinically Effective Care	HBR Ref Number: 61 Target Date: 31st March 2021
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:** Chris White, 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:** November 2020

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

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

- 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 2021

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.

Current Risk Rating 4 X 4 = 16	**Additional Comments** Task & Finish Group continue to progress transfer of service to Morriston. Action moved to May 2021 due to Covid pressures. However, PWC have now

	given the Health Board notice that they wish to terminate the contract at the end of January 2021. Transfer of this service to Morriston is not feasible by the end of January and given the limitations on staffing and theatre capacity is not achievable by May 2021 therefore T&F Group are looking at the other options available to deliver the service which, includes extending the contract with PWC through to March 2022 or transferring the service the NPTH. A paper setting the options will be presented the Senior Leadership on 18 November 2020

Datix ID Number: 2023 Health & Care Standard: Staff Resources 7.1 Workforce	HBR Ref Number: 62 Target Date: 31st March 2021
Objective: Excellent Staff **Risk:** Sustainable Corporate Services aligned to the Health Board's Annual Plan and organisational strategy, and with the skills, capability, behaviours and tools to successfully deliver in support of the whole organisation, and to do so in a way which respects and promotes the health and well-being of our staff and their work-life balance.	**Director Lead:** Tracy Myhill, CEO **Assuring Committee:** Workforce and OD Committee
Risk: Failure to deliver corporate services and organisational objectives due to insufficient staff.	**Date last reviewed:** November 2020

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

Level of Control
= 50%

Date added to the HB risk register
August 2019

Rationale for current score:
Constraints, stress and resourcing of corporate services post Bridgend Boundary Change and in light of the change agenda in the Health Board. Current resourcing levels have been benchmarked with other Health Boards, in some areas. The Finance department has been under considerable pressure due to the work required to support the Health Board's Targeted Intervention status and the Bridgend boundary change.

Rationale for target score: Sustainable services will always encounter turnover and need to develop skill set and capabilities.
Target score reflects requirement to resource to be able to meet the operational and Strategic priorities of the Health Board. Failure to do this will negatively impact of financial, service, performance and quality outcomes.
Failure to do this will negatively impact of financial, service, performance and quality outcomes.

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

- Designing and Developing new Operating model for the Health Board
- Designing and Developing HB HQ and Corporate structures
- Reviewing Directorate requirements
- Vacancy Panel to support prioritisation.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
To conclude the recruitment process for the critical corporate posts including the Workforce and OD function	Chief Executive	30th November 2020

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

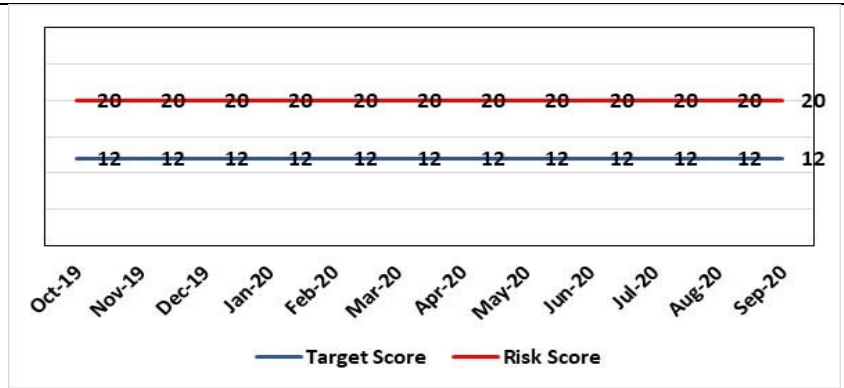
- Decisions late summer / early autumn on corporate services structures, operating model and resourcing.

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

Current Risk Rating
5 x 4 = 20

Additional Comments
Utilise temporary funded capacity to meet immediate areas of risk. Continue to raise resourcing issue at corporate level and through committee governance arrangements. Review of corporate 'critical' posts have been undertaken including resourcing required for investment in the Workforce and OD Function. These posts will be recruited to on a phased basis.
As a result of the COVID-19 all recruitment has been put on hold and resources diverted. Business as usual is on hold.

Datix ID Number: 1605 Health & Care Standard: 3.1 Safe and Clinically Effective Care	HBR Ref Number: 63 Target Date: 31st December 2020
Objective: Screening for Fetal Growth Assessment in line with Gap-Grow (G&G)	**Director Lead**: Christine Williams, Interim Director of Nursing and Patient Experience **Assuring Committee:** Quality and Safety Committee
Risk: There is evidence a growth restricted/small for gestational age fetus (SGA), has an increased risk of intra-uterine death before or during the intrapartum period. Identification and appropriate management for SGA in pregnancy should lead to improved outcomes. GAP & Grow standards were implemented to contribute to the reduction of stillbirth rates in wales. Obstetric USS scan appointments are at capacity leading to delays in obtaining required appointments. In addition, the guidance from Gap & Grow is for women requiring serial scanning with a risk factor for a growth restricted baby must have 3 weekly scans from 28 to 40 week gestation. Due to the scanning capacity there are significant challenges in achieving this standard.	**Date last reviewed:** November 2020
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?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
All staff have received training on Gap & Grow and detection of small for gestational babies. Obstetric scanning capacity across the HB is being reviewed and compliance with criteria for scanning is being monitored. Ultrasound are assisting with finding capacity wherever possible in order to meet standards for screening and complying with Gap & grow recommendations.	Adherence to Gap/Grow Standards	Deputy Head of Midwifery	31st December 2020
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?)**		
Current Risk Rating **4 X 5 = 20**	**Additional Comments** Meeting took place with Deputy Head of Therapies for the HB. Arrangement to meet in January 2020 to review radiology capacity and plan future service needs. This will form part of the antenatal clinic review. Audit of missed cases themes and trends to be presented to the MDT in February 2020. Approval from health board to progress training and recruitment of midwife sonographers. Working group in place chaired by exec lead for therapies.		

Datix ID Number: 2159 Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety	HBR Ref Number: 64 Target Date: 31st March 2021
Objective: Best Value Outcomes	**Director Lead:** Christine Williams, Interim Director of Nursing and Patient Experience **Assuring Committee:** Health and Safety Committee
Risk: Insufficient resource and capacity of the Health, safety and fire function within SBUHB to maintain legislative and regulatory compliance for the workforce and for the sites across SBUHB. .	**Date last reviewed:** November 2020

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

Rationale for current score:
The Health Board are in receipt of 10 Health & Safety Executive (HSE) improvement notices concerning health and safety management, violence and aggression and manual handling, limited assurance internal audit reports for water safety management and COSHH, and a fire enforcement notice for one of our sites. Fire risk assessment frequencies are not being kept up to date. Statutory/mandatory training provision and recording will not be sustainable. Unable to support units sufficiently for H&S, case management (V&A), fire and training or to conduct audits/inspections. Potential for litigation, with implications of financial and reputational consequences for not meeting legislative requirements.

Level of Control
= 70%

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

Date added to the HB risk register
September 2019

Additional resources and updated/refreshed/new systems will enable the Health Board to demonstrate that suitable resources are in place to undertake the roles and responsibilities of the department, and to undertake suitable and sufficient training, provide corporate overview/audit to ensure practices are being employed in the workplace. Risk assessments are being undertaken within required frequencies and periodic audits are taking place to support the various units and departments.

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

- HSE Improvement working group set up to address the HSE recommendations and meets fortnightly to monitor the improvement action plan.
- Interim posts of Assistant Director of Health and Safety and Interim Head of Compliance employed on secondment to support strengthening and developing the H&S function
- Health and Safety Operational Group meets quarterly and reports to the Health and Safety Committee
- Water safety management action plan in place
- COSHH procedure reviewed and updated
- Fire risk assessments are being undertaken at priority sites (patient areas) to address recommendations of the MAWWFRS

Mitigating actions (What more should we do?)

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

• Fire training in place and fire wardens in place			
Assurances **(How do we know if the things we are doing are having an impact?)** • Monitoring through the H&S committee to receive assurance and or identify gaps for key compliance and adherence to applicable legislation. • HSE focus group monitor compliance against the 10 improvement notices and report to the H&S operational group and H&S committee. • Site visits/tours to identify compliance and gaps in compliances.	**Gaps in assurance** **(What additional assurances should we seek?)**		
Current Risk Rating **5 X 4 = 20**	**Additional Comments** The re-inspections took place w/c 16 September 2019, visiting NPTH on 16th, Singleton & Morriston Hospital on 17th, Tonna Hospital and NPTH on 18th and NPTH on 20th. All visits went well overall with a number seven of the ten notices closed and three extended to 6th December 2019. A further visit was arranged for 5th December (Theatres at Singleton) where it was confirmed that two more notices were complied with and the other one extended to 31 January 2020. Confirmation via email was received on 7th February that all improvement notices have been complied with. Business case to be written by 31st October 2020. Re-structure review to be presented to H&S committee during 3rd quarter 2020/21. Long term plans to be developed to understand the Health and Safety resource requirements for the Health Board. The restructure is to be reviewed and business case written by 31st October 2020. Due to the pandemic (COVID-19) progress has been minimal and will review when operationally possible, this could be delayed until October/November 2020. Initial review undertaken and an early draft is currently having costs drawn up for the draft options to be submitted to Execs. COVID-19 has had an impact of the progression of this and will be presented on Q4.		

Datix ID Number: 329 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**	**HBR Ref Number: 65** **Target Date: 31st January 2021**
Objective: Digitally enabled Care	**Director Lead**: Christine Williams, Interim Director of Nursing and Patient Experience **Assuring Committee:** Quality & Safety Committee
Risk: Risk associated with misinterpreting abnormal cardiotocography readings in the delivery room. A central monitoring station would enable multi-disciplinary viewing and discussion of the readings to take place, and reduce the risk of a concerning CTG trace going unidentified. Provisionally scored C4 (irrecoverable injury) x L3= 12. The central monitoring system has a facility to archive the CTG recordings: currently these tracings are only available as a paper copy, which can be lost from the maternity records. There is also a concern that the paper tracings fade over time which makes defending claims very difficult.	**Date last reviewed:** November 2020 **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:**

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
Current controls include all staff undertaking RCOG CTG training and competency assessment. Protocol in place for an hourly "fresh eyes" on 'intrapartum CTG's' and jump call procedures. CTG prompting stickers have been implemented to correctly categorise CTG recordings. Central monitoring is also expected to strengthen the HB's position in defending claims. K2 fetal monitoring system has been identified as the best option for a central monitoring system.	Business case prepared for Central monitoring system to store CTG recordings of fetal heart rate in electronic format.	Deputy Head of Midwifery	31 December 2020

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?)**
Current Risk Rating **4 X 5 = 20**	**Additional Comments** Submission to IGB in January 2019. CTG envelopes placed in every set of records for safe storage of CTG. Business case completed by maternity service and multi-professional team. Remaining issue outstanding is the financial detail from IT. To ensure submission of case in January 2020

Datix ID Number: 1834 Health & Care Standard: 5.1 Timely Care	HBR Ref Number: 66 Target Date: 31st March 2022
Objective: Best values outcomes from high quality care	**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee:** Quality and Safety Committee
Risk: Unacceptable delays in access to SACT treatment in Chemotherapy Day Unit	**Date last reviewed:** November 2020

Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 5 = 25 Target: 2 x 2 = 4		**Rationale for current score:** Increased risk to 25 as waiting times starting to re-increase for Long chair regimes, discussed at oncology business meeting.
Level of Control =		
Date added to the HB risk register 30/11/2019		**Rationale for target score:**

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
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. Options appraisal to be completed for SSDU senior management team by service group	**Action**	**Lead**	**Deadline**
	Options appraisal paper to be produced for SSDU senior team by service group	Service Manager Surgical Services	30th November 2020

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

Current Risk Rating **5 X 5 = 25**	**Additional Comments**
	Additional staffing in place from Dec 19 to allow full use of chairs but capacity gap remains. Looking at options around use of additional SACT capacity via Tenovus. Also working with MSD/GE around potential partnership agreement to look at C&D mapping and best practice elsewhere with visit to Leeds being arranged by MSD colleagues. Covid has impact on demand WT continue to improve average wait for Chair time at present is 11days - decrease from 21days. Some of this links to Covid changes, as part of recovery plan need to understand better the future need. Currently lost 3chairs due to Covid-19 and waiting times at 15days at end of June 2020. Meeting with GE/MSD - taking place waiting on partnership agreement paperwork to take through legal team to ensure robust will then start with project plan that we are drafting while paperwork is being finalised between HB and MSD/GE

Datix ID Number: 89 Health & Care Standard: 5.1 Timely Care	HBR Ref Number: 67 Target Date: 31st March 2022
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 breeches in the provision of radical radiotherapy treatment to patients.	**Date last reviewed:** November 2020

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

Rationale for target score:

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
Requests for treatment and treatment dates monitored by senior management team.	**Action**	**Lead**	**Deadline**
	Additional risk capacity	Service Manager Surgical Services	31.12.2020
	Review of patient pathway	Assistant General Manager – Cancer Services	31.12.2020

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?)

Current Risk Rating
5 X 5 = 25

Additional Comments
Radiotherapy waiting times continue to cause concerns, new COSC guidelines launched this year mean we now reporting Rx waiting times to WG. Sept Performance has been added to this risk. Options to increase our capacity and include in PBC for SWWCC which is being developed and internal efficiency work with QI colleagues is also being reviewed. Rx Performance is discussed in Radiotherapy management meeting and papers are chased in Cancer Board.
Agreement has been reached around outsourcing 12 prostate radiotherapy cases per month for 6 months to Rutherford. Commencing in January 2020. While case for extended day is further reviewed.
Contract signed off by Executive Team Jan 2020. Patients are being approached to attend Rutherford Cancer Centre and patient details being sent to Rutherford Cancer Centre.

	Seen improvement in some WT performance in RT due to cases being referred to Rutherford and due to changes in practice due to Covid-19. Due to machine breakdowns and covid capacity has been effected to deliver RT. however outsourcing has mitigated some of this but not all. New action agreed 07/07/20- RT Covid Recovery plan is being developed that will include options around, further outsourcing, bringing back SBAR work from VCC, changes to fractions on BREAST and PROSTATE and how we could use this freed up machine capacity differently. This plan is to go to Reset and Recovery meeting as part of Essential Services Covid Recovery plans for Cancer.

Datix ID Number: 2299 Health & Care Standard: 2.4 Infection Prevention and Control (IPC) and Decontamination	HBR Ref Number: 68 Target Date: 31st March 2021
Objective: Best Value Outcomes from High Quality Care **Risk:** Risk of declared pandemic due to Coronavirus Infectious Disease outbreak 2020 leading to disruption to Health Board activities.	**Director Lead**: Keith Reid, Executive Medical Director **Assuring Committee:** Quality and Safety Committee **Date last reviewed:** November 2020

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

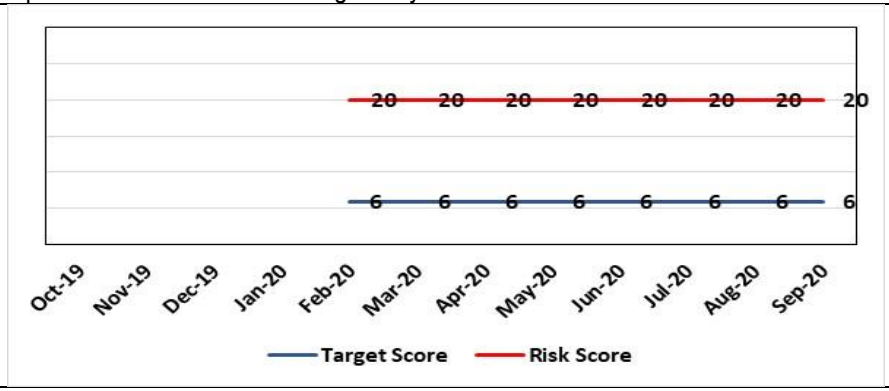
Gaps in assurance
(What additional assurances should we seek?)

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

Additional Comments

Current Risk Rating **5 X 5 = 25**	Mitigation as follows to identify and reduce risks of spread of infection: Pandemic plans invoked Command, Control and Coordination arrangements in place with Strategic, Tactical and bronze Groups in place to ensure Health Board wide engagement and instigate required planning including: o Patient flow pathway scenarios for unwell patients and well patients that may self-present in both acute and Primary and Community Care o Appropriate PPE kit and training o Appropriate support service pathways for cleaning, decontamination, waste and linen management o Multi-agency engagement o Community Testing arrangements o Workforce review • Identified isolation facilities. Pandemic was declared. Health Board stood up 3CF structures and response on 31 January 2020. System wide response in place. Lockdown established 23rd March. Current levels of demand are containable within existing capacity. Expectations that initial peak of infections has been managed within capacity.

Datix ID Number: 1418 Health & Care Standard: 5.1 Timely Access	HBR Ref Number: 69 Target Date: 31st March 2021
Objective: Best values outcomes from high quality care	**Director Lead**: Chris White, Chief Operating Officer/Christine Williams, Interim Director of Nursing and Patient Experience **Assuring Committee:** Performance and Finance Committee
Risk: Risk issues Related to **adolescent patients being admitted to Adult MH inpatient wards**- Inappropriate settings resulting in 'Safeguarding Issues' The WG has requested that HBs identify Secondary Care in -patient facilities for the care of adolescents- in Swansea Bay University Health Board Ward F NPT hospital is the dedicated receiving facility with one bed identified.	**Date last reviewed:** November 2020
Risk Rating (consequence x likelihood): Initial: 2 x 3 = 6 Current: 4 x 5 = 20 Target: 2 x 3 = 4 **Level of Control** = **Date added to the HB risk register** 27/02/2020	**Rationale for current score:** Risk score heightened after a DU wide RR meeting to review scores. **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.	**Action**	**Lead**	**Deadline**
	Review of Service by Swansea Bay Youth	Assistant Head of Operations MH	31.12.2020
	Learning event to be held facilitated by the Serious Incident Team to review a number of recommendations e.g. location of the crisis assessment.	Deputy Director of Nursing	31.1.2.2020
	Revised pathway and guidance for the management of CYP with emotional well-being issues presenting in the ED in Morriston has been developed in conjunction with CAMH service. A paper is being presented to Safeguarding Committee.	Deputy COO	31.12.202

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
Individual Rooms with ensuite facilities, joint working with CAMHS, monitoring of staff training, monitoring of admissions by the MH & LD DU Legislative Committee of the HB.	
Current Risk Rating **4 X 5 = 20**	**Additional Comments**

Datix ID Number: 2245 Health & Care Standard: 3.1 Clinically Effective Care	HBR Ref Number: 70 Target Date: 31st March 2021
Objective: Digitally enabled care	**Director Lead**: Chris White, Chief Operating Officer **Assuring Committee:** Audit Committee
Risk: There is a risk of **national data centre outages** which disrupt health board services. The failure of national systems causes severe disruption across NHS Wales, affecting Primary and secondary care services. The delivery of national services including the management of systems, infrastructure and hosting services are the responsibility of NHS Wales Informatics Service (NWIS).	**Date last reviewed:** November 2020

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

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, 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 center outages will never be fully eliminated. The current score of 5 is based on the fact there have been WLIMS outages over recent years.

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Representation at SMB, IMB and NSMB	Head of ICT Operations	29th January 2021
Representation on EPRR	Informatics Business Manager	29th January 2021
Representation at NWIS Directors Meetings	Associate Director of Digital Services	29th January 2021

Assurances

Gaps in assurance

(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 the NDC and BDC. The final report on the BDC outage has been received and recommendations put in place to increase maintenance levels and monitoring. NWIS have produced an action plan which is agreed in the IMB and progress monitored. Any deviation from the action plan will be escalated to the SMB and if appropriate to the NHS Wales Informatics Management Board which is chaired by the Chief Executive Officer of NHS Wales and has Executive level board members. In addition, it is recommended that serious consideration should be given to identifying and funding an alternative Tier 3+ facility (in line with the NDC) to host these critical systems. WLIMS 2016 upgrade is required to address some of the technical issues experienced on the existing version. This is planned for September 2020. A re- procurement of a new Pathology Laboratory Information Management system is in progress with timescales An architecture review is underway to assess current services and make recommendations on future services (including hosting services).	**(What additional assurances should we seek?)**
Current Risk Rating **4 X 5 = 20**	**Additional Comments**

Datix ID Number: 2448 Health & Care Standard: 2.1.1 Managing Financial Risk	HBR Ref Number: 71 Target Date: 31st December 2020
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Darren Griffiths. Director of Finance (interim) **Assuring Committee:** Performance and Finance Committee
Risk: The total quantum for funding for addressing COVID-19 across Wales remains fluid and uncertain. There is a risk that the organisation's operational cost of addressing the pandemic cannot be contained within available funding resulting in a potential breach of the planned outturn for 2020/21. In addition, the Health Board's ability to meet its planned savings programme is impacted by the service response to COVID-19, which will potentially also impact on the Health Board's underlying financial position.	**Date last reviewed:** November 2020

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

Graph being updated

Rationale for current score:

- Whist the Health Board submitted a financial deficit plan for 2020/21 of £24.4m this has never been formally agreed.
- Welsh Government articulated a clear message to NHS Wales that organisations needed to plan to meet the demands of COVID-19 based on clear planning assumptions. This involved the commitment of expenditure above funded levels
- The National funding response for COVID-19 costs is challenged in terms of levels of forecast spend driving uncertainty into the overall financial plan for NHS Wales; the Health Board is part of this
- Whilst some funding has been allocated to Health Board to support field hospital set up costs and staff cost in quarter 1, there is a lack of clarity of the source of future funds and the methodology for the allocation of funds to Health Board.

Level of Control
= 25%

Date added to the HB risk register
July 2020

Rationale for target score:
By working transparently with Welsh Government additional funds will be allocated to the Health Board to over the commitments made and support the underlying impact on the cost base of the Health Board.

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

The Health Board is doing the following: -

- Reporting system developed to accurately capture and describe impact of the response on the healthcare system in finance terms
- Active participation in weekly Director of Finance calls to shape All Wales response
- Routine reporting to Welsh Government of the position
- Finance Review Meetings with Units to explore opportunities to maintain cost control, savings delivery and a proportionate COVID-19 response
- Transparent exchange of position with Finance Delivery Unit

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Maintain real time monitoring of disease impact and flex services to maximize value for money	**Director of Finance**	**Monthly**
Financial reporting to Welsh Government on local costs incurred as a result of Covid-19 to inform central and local scrutiny, feedback and decision-making	**Director of Finance**	**Monthly**

• Review all of KPMG pipeline savings opportunities to test whether these can be accelerated in the light of COVID-19 impact.	Oversight arrangements in place at Board level and through the command structure.	**Director of Finance**	**Monthly**
Assurances **(How do we know if the things we are doing are having an impact?)** The Health Board financial performance is reviewed and monitored through: • Monthly financial recovery meetings • Performance and Finance Committee • Routine reporting to Board of most recent monthly position and impact on year end forecast of changes in response to the disease and national funding streams	**Gaps in assurance** **(What additional assurances should we seek?)** Budget delegation letters to be issued once budget setting round complete. This will include the management of COVID costs.		
Current Risk Rating **5 x 3 = 15**	**Additional Comments**		

Datix ID Number: 2449 Health & Care Standard: 2.1.1 Managing Financial Risk	HBR Ref Number: 72 Target Date: 31st December 2020
Objective: Best Value Outcomes from High Quality Care Impact of COVID-19 pandemic on the Health Board Capital Resource Limit and Capital Plan for 2020-21	**Director Lead:** Darren Griffiths. Director of Finance (interim) **Assuring Committee:** Performance and Finance Committee
Risk: Impact of COVID-19 pandemic on the Health Board Capital Resource Limit and Capital Plan for 2020-21	**Date last reviewed:** November 2020

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

Rationale for current score:

- As a result of the COVID-19 pandemic, the level of capital resource available to Welsh Government to support Health Boards is restricted. This means that Health Boards have been advised that their current agreed Capital Resource Limit will not be increased.
- The current Health Board capital plan included commitments for which further Welsh Government capital resource was anticipated, which results in a potential over-commitment of the capital plan of around £7.5m.
- It is likely that due to slippage on capital schemes, this over-commitment will reduce.
- There is a potential for further capital requirements arising from service model changes which will need to be managed.

Some schemes may have to be slipped in terms of timeframe to ensure the integrity of the CRL in 2020/21.

Level of Control
= 25%

Rationale for target score:
The continued prioritization of the capital plan and close management of slippage.

Date added to the risk register
July 2020

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	30th September 2020
Appraise Welsh Government of content of revised plan to consider possibilities of support for key areas.	Head of Capital Finance	30th September 2020
Routine assessment of local demands for discretionary capital spend through internal capital prioritization group	Head of Capital Finance	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.

Current Risk Rating
4 x 5 = 20

Additional Comments

Datix ID Number: 2450 Health & Care Standard: 2.1.1 Managing Financial Risk	HBR Ref Number: 73 Target Date: 31st March 2021
Objective: Best Value Outcomes from High Quality Care The Health Board underlying financial position may be detrimentally impacted by the COVID-19 pandemic. The COVID-19 pandemic has impacted on the Health Board ability to plan and execute the required level of recurrent savings delivery. There is a potential for a residual cost base increase post COVID-19 as a result of changes to service delivery models and ways of working.	**Director Lead:** Darren Griffiths. Director of Finance (interim) **Assuring Committee:** Performance and Finance Committee
Risk:	**Date last reviewed:** November 2020

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 financial plan included a required £23m savings delivery. The savings were developed supported by KPMG review. The plans were not fully developed and further work was required during March and April to produce clear plans and milestones.
- The COVID-19 pandemic has required a significant management response and therefore the development of these plans have been delayed.
- Where clear plans had been developed, in the majority of cases the implementation of the plan has been delayed and may no longer be able to be taken forward due to changes in service delivery models.
- Many of the service delivery models across the Health Board have had to change as a result of COVID-19 pandemic. Some of the changes to service delivery and ways of working will remain in place post pandemic which may recurrently increase the cost base of the Health Board.

Level of Control
= 25%

Date added to the HB risk register
July 2020

Rationale for target score:
By ensuring that opportunities are taken to drive forward efficiency opportunities and service changes to support improved service and financial sustainability.

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

The Health Board is doing the following: -

- Active participation in weekly Director of Finance calls to shape All Wales response
- Finance Review Meetings with Units to explore opportunities to maintain cost control, savings delivery and a proportionate COVID-19 response
- Transparent exchange of position with Finance Delivery Unit
- Review of opportunities through Reset and Recovery to ensure efficiencies are developed and maximised.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Monthly financial review and assessment of savings to be included in financial reporting	Director of Finance	Monthly
Savings opportunities and pipeline to be reviewed and options for development of plans taken forward through SLT	Director of Finance	Monthly

• Clear understanding of underlying impact of changes to service models and costs of new service models. • Review all of KPMG pipeline savings opportunities to test whether these can be accelerated in the light of COVID-19 impact.	Impact of reset and recovery to be assessed through QIA process to ensure clear understanding of impact on underlying cost base.	Director of Finance	Monthly
Assurances **(How do we know if the things we are doing are having an impact?)** The Health Board financial performance is reviewed and monitored through: • Monthly financial recovery meetings • Performance and Finance Committee • Routine reporting to Board of most recent monthly position and impact on year end forecast of changes in response to the disease and national funding streams	**Gaps in assurance** **(What additional assurances should we seek?)** Reporting on savings opportunities and service change impacts to be developed.		
Current Risk Rating **4 x 5 = 20**	**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

Appendix 2

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

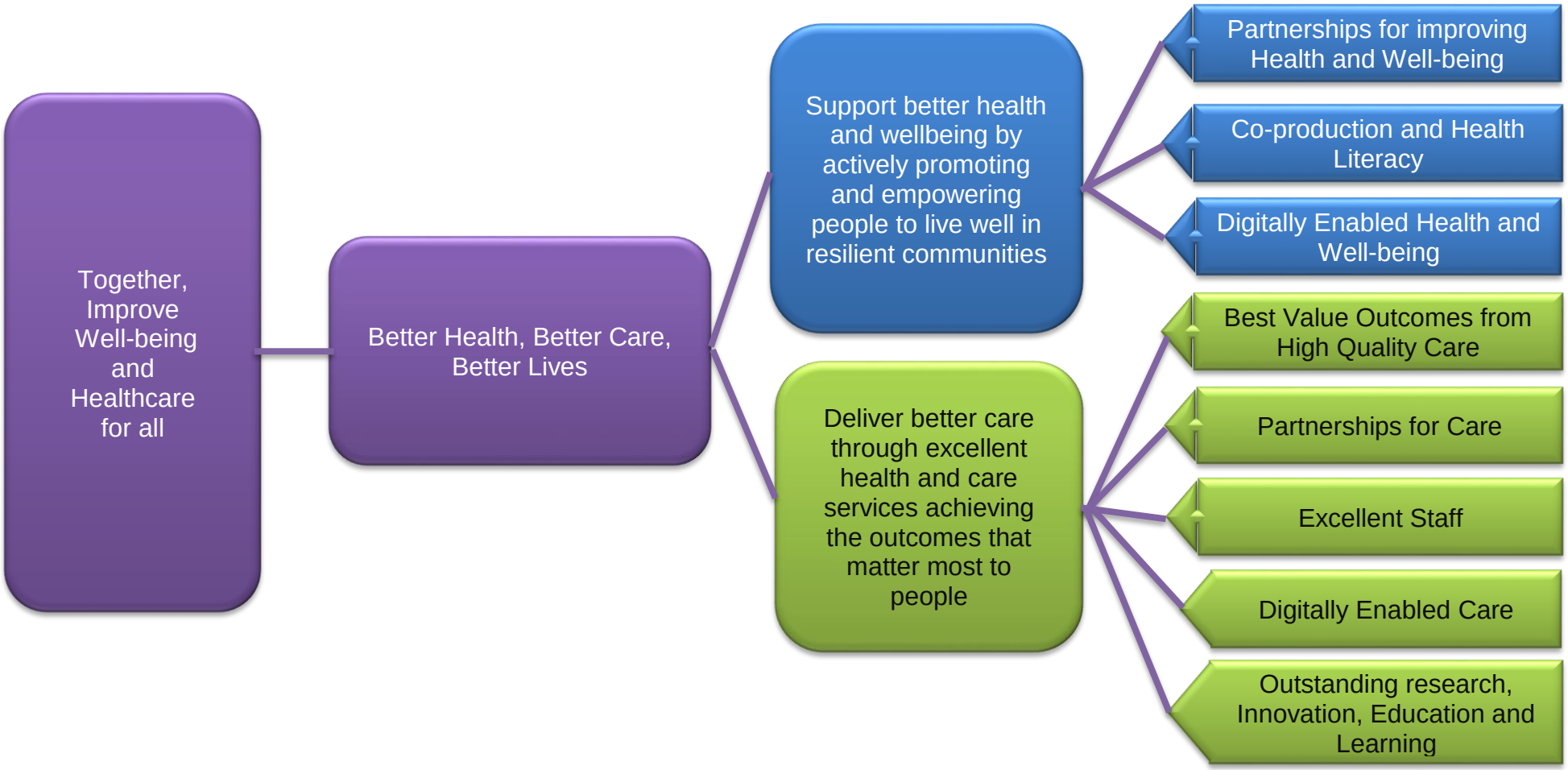
COVID-19 RISK REGISTER
GOLD COMMAND
OCTOBER 2020

caring for each other working together always improving

caring for each other working together always improving

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.



COVID-19 RISK REGISTER
DASHBOARD OF ASSESSED RISKS – GOLD COMMAND

Impact/Consequences						
5					**R_COV_17:** Nosocomial Transmission **R_COV_18:** Sustainable Services
4				**R_COV_008:** Capacity **R_COV_012:** Partnership Working	**R_COV_005:** Care Homes **R_COV_010:** Delivery of Essential Care **R_COV_015:** Mass Vaccination
3				**R_COV_016:** Bed Spacing	**R_COV_001:** Shortage of Critical Care drugs **R_COV_002:** Shortage of Palliative Care drugs **R_COV_003:** Inadequate supply of PPE **R_COV_009:** Workforce – Field Hospitals **R_COV_013:** Test, Trace and Protect **R_COV_014:** Keyworker Support from Schools - CLOSED
2					**R_COV_004:** Workforce Shortages – Self Isolation **R_COV_006:** Equipment Shortages - CLOSED **R_COV_007:** Oxygen Provision - CLOSED **R_COV_011:** BAME Workforce Risks
1					
C X L	**1**	**2**	**3**	**4**	**5**
	Likelihood				

COVID 19 Risk Register Dashboard

Risk Reference	Datix ID	Description of risk identified	Initial Score	Current Score	Trend	Controls	Last Reviewed	Scrutiny Committee
R_COV_001	2367	**Shortage of critical care drugs** Global shortages which is affecting the UK of a number of drugs/ fluids to manage patients cared for in critical care areas could restrict number of people able to be supported in critical care unit and restrict capacity to enact full COVID critical care response plan	25	15	↓	↑	30.10.2020	Gold Command COVID-19
R_COV_002	2368	**Shortage of Palliative Care Drugs** National shortage of palliative care drugs and access to syringe drivers which could impact on ability to provide timely care for patients at home or in hospital; causing pain for patients and distress for patients and their families. Inability to access drugs for patients at home could impact on hospital sector if these patients subsequently require hospital admission. Distress for patients in families in not being able to die in their place of choice.	25	15	↓	↑	30.10.2020	Gold Command COVID-19
R_COV_003	2378	**Inadequate Supply of PPE** Inadequate supply of PPE could place staff at risk of harm and an increase in the number of staff infected will increase absence rates, resulting in difficulties in staffing core capacity.	25	15	↓	↑	30.10.2020	Gold Command COVID-19
R_COV_004	2369	**Workforce Shortages** Number of staff who are absent from work through self-isolation or family illness will impact on ability to deliver safe care for patients; and will impact on ability to keep capacity open and to staff surge and super surge capacity	25	10	↓	↑	30.10.2020	Gold Command COVID-19
R_COV_005	2370	**Care Homes** Potential failure in local care home sector to manage staff absences could result in emergency closure of care home which will place undue pressure and therefore on community health and social services to support and/or lead to an increase in patient admission to hospital. Risk of patient harm if care homes are not adequately covered.	25	20	↓	↑	30.10.2020	Gold Command COVID-19
R_COV_006	2371	**Equipment Shortages** (Currently closed) Inability to secure adequate supply of equipment to support phases of capacity plan which may restrict ability of Board to respond to peaks in pandemic if not mitigated. This includes availability of ventilators, CPAP, suppliers, syringe drivers	25	10	↓	↑	30.10.2020	Gold Command COVID-19
R_COV_007	2372	**Oxygen Provision** (Currently closed) Capacity constraints on oxygen provision at Morriston will limit number of ventilator, CPAP and high flow oxygen beds. Lack of ability to secure direct suppliers via BOC will hamper plans for oxygen provision within field hospital	25	10	↓	↑	30.10.2020	Gold Command COVID-19

R_COV_008	2373	**Capacity** Capacity requirements against national modelling mean that the HB capacity may be either insufficient to cope with demand, resulting in an inability to care for patients as well as an increased risk of excess death. Alternatively, if demand is lower than predicted by the modelling we could develop capacity where it not needed resulting in avoidable expenditure.	25	16	↓	↑	30.10.2020	Gold Command COVID-19
R_COV_009	2374	**Workforce** Inability to recruit sufficient workforce to fulfil requirements for super surge capacity in field hospitals leading which leads to impact on ability to provide additional capacity and therefore impact on delivery of patient care.	25	15	↓	↑	30.10.2020	Gold Command COVID-19
R_COV_010	2375	**Delivery of Essential Care** Following the guidance to step down routine activity issued by Welsh Government and the pandemic Health and Social Care Response Plan. There is a risk that the HB's normal business will not be given sufficient focus and that this could lead to a negative impact on patient outcomes and experience , and cause delays to patient treatment resulting in harm	20	20	→	→	30.10.2020	Gold Command COVID-19
R_COV_011	2376	**BAME Workforce Risks (Closed 22.10.20)** There is growing evidence that COVID-19 is having a disproportionate impact on individuals from BAME backgrounds. The evidence continues to evolve but the UK Intensive Care National Audit and Research Centre findings on critical care published on 24th April 2020 and the data on BAME deaths published in the Health Service Journal on 22nd April provided sufficient evidence to indicate that individuals from BAME backgrounds may be at disproportionate risk from poorer outcomes from COVID-19.	25	10	↓	↑	30.10.2020	Gold Command COVID-19
R_COV_012	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.	20	15	↓	↑	30.10.2020	Gold Command COVID-19
R_COV_013	2388	**Test, Trace and Protect** Clarity over testing cell responsibility from a HB point of view and how this fits with the multi-agency TTP plan. Need to establish clear position on retesting. Staffing for expansion of Testing & establishment of Trace & Protect being identified from LAs and HB. Identifying sufficient trained / experienced staff for "clinical roles" in local and regional teams is being sourced from shielded staff. As core services are reintroduced there will be the need to recruit additional staff, which may be external and so incur costs. To date no funding from WG has been confirmed for this. Lack of availability of a digital platform from go live date for TTP of 1st June will limit capacity for Trace & Protect activities.	20	15	↓	↑	30.10.2020	Gold Command COVID-19

R_COV_014	2456	**Key worker support from schools** (Currently closed) Both Swansea and NT Local Authorities have indicated they do not have plans to provide key worker support over the 6 week summer break. As some staff may not be able to access the support they would have normally have relied upon during this period due to Covid restriction, these staff may have no options but to remain at home to care for their children. Existing policy during the pandemic was that we did support staff in these circumstances by providing basic pay only.	15	15	→	→	30.10.2020	Gold Command COVID-19
R_COV_015	2457	**Mass Vaccination** The Health Board will need to plan a mass vaccination programme for COVID-19 vaccine alongside management of the annual influenza programme. This will present a number of challenges, including workforce availability, logistics and supply, parallel delivery with the influenza programme and the constraints around co-administration, as well as administrative and information management considerations. Further detail is expected from WG shortly.	20	20	→	→	30.10.2020	Gold Command COVID-19
R_COV_016	2491	**Bed Spacing** Guidance was issued by WG in July setting out minimum requirements in respect of bed spacing between hospital beds. As a result of a detailed risk assessment carried out at Board level, the Board will not be able to fully comply with this guidance in respect of a minimum 3.6m mid to mid bed, and 3.7m between from bed head to middle of space across to opposite bed.	16	12	→	↑	30.10.2020	Gold Command COVID-19
R_COV_017	tbc	**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.	25	25	→	↑	30.10.2020	Gold Command COVID-19
R_COV_018	tbc	**Sustainable Services** 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	25	25	→	↑	30.10.2020	Gold Command COVID-19

- **Please note that some risks are deemed closed but may re-open if 2nd or 3rd wave occurs.**

Datix ID Number: 2367	R_COV_Strategic_001
Risk: <u>Shortage of critical care drugs</u> Global shortages which is affecting the UK of a number of drugs/ fluids to manage patients cared for in critical care areas could restrict number of people able to be supported in critical care unit and restrict capacity to enact full COVID critical care response plan. Drugs used to manage the critical care of these patients are required in much higher doses than standard care.	**Director Lead:** Richard Evans, Medical Director **Assuring Committee:** Gold Command COVID-19 **Date last reviewed:** 30 October 2020

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• Monitoring mechanism in place for critical care drugs. • Lack of hemofiltration fluids across the UK escalated to ECCW on 18/04/20. • Assessment of further local contingency plan to be undertaken week beg 20th April 20	*Escalate to WG via critical care network to seek mutual aid in event of drug shortages; ongoing liaison with WG and suppliers.*	*Clinical Director Pharmacy*	*Weekly ongoing*

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

Current Risk Rating
5 x 3 = 15

Initial Risk	25
Current	15
Target	10

Additional Comments

Monitoring mechanism in place for critical care drugs. Access to priority medicines dashboard with a formalised mutual aid agreements between HBs supported by Health Courier Wales. Situation improving due to UK government working to create new supply routes alongside ongoing work to reduce waste, increase production of ready to administer medicines and the availability of unlicensed medicines. Anxiety remains about the potential of further peaks alongside the recommencing of routine care. National guidance on the essential role of medicines in recommencing routine care is expected and will reiterate the importance of organisations ensuring that any procedure which requires an anaesthetic, sedative, analgesic or neuromuscular blocker has assessed that the Medicines are available and can be replenished, if not that there are readily available substitutes and that stocks are sufficient to manage any emergency requirement for these drugs such as in the case of Covid 19. SBU pharmacy team have a four day buffer stock which will be kept to manage any emergency situation.
There are ongoing discussions between DOH and pharmaceutical manufacturers to develop a 6 week buffer stock for the UK in anticipation of no deal Brexit, thus risk remains Amber currently.
Discussion at Gold 28.08.20: No alteration to post-MA risk score required currently. National procurement exercise ongoing to stockpile supplies. Deadline for completion was 10.08.20. Consider revision of score once assessment is available to consider.
Discussion at Gold 18.09.20: No alteration to post-MA risk score required currently.
16.10.20 - Remdesivir availability: manufacturer have signed a joint procurement agreement with EU to ensure improved availability for at least the next six months. The

	manufacturer has indicated that they expect to be in a position to meet global demand by the end of Oct 2020. The position of UK and the JPA with EU will also be monitored in the event that there is an impact resulting from Brexit arrangements in 2021. There are ongoing discussions between DOH and pharmaceutical manufacturers to develop a 6 week buffer stock for the UK in anticipation of no deal Brexit, thus risk remains Amber currently.

Datix ID Number: 2368	R_COV_Strategic_002
Risk: Shortage of Palliative Care Drugs National shortage of palliative care drugs and access to syringe drivers which could impact on ability to provide timely care for patients at home or in hospital; causing pain for patients and distress for patients and their families. Inability to access drugs for patients at home could impact on hospital sector if these patients subsequently require hospital admission. Distress for patients in families in not being able to die in their place of choice. The standard process of the just in case needs to be managed via a just in time approach.	**Director Lead:** Richard Evans, Medical Director **Assuring Committee:** Gold Command COVID-19 **Date last reviewed:** 30 October 2020

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• Local distribution plan now refined to be able to supply drugs at home quickly as required whilst preserving central stock. • The Health Board has adopted Welsh Government guidance on the potential for re-using critical supplies in nursing homes and will follow the all Wales Standard Operating Procedure in adopting this flexibility and will put in place a review and audit mechanism	Ongoing liaison with suppliers and WG to identify further supplies.	Clinical Director Pharmacy	Weekly ongoing

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

Current Risk Rating
5 x 3 = 15

Initial Risk	25
Current	15
Target	10

Additional Comments

Increased agility to supply limited stocks through the following access routes1st line - Community Pharmacies (including those holding additional palliative medicines stocks)
• 2nd line – The Palliative Hub at Morriston Hospital Pharmacy Department
• 3rd line – The national COVID-19 end of life medicine service (available 24/7)
• 4th Line – repurposing of medication at the care home in accordance with the attached SOP
Potential no deal Brexit – DOH discussion with suppliers for 6 week buffer. Brexit risk being discussed in EPRR group.
Discussion at Gold 28.08.20: No alteration to post-MA risk score required currently. National procurement exercise ongoing to stockpile supplies. Deadline for completion was 10.08.20. Consider revision of score once assessment is available to consider.
Discussion at Gold 18.09.20: No alteration to post-MA risk score required currently.

Datix ID Number: 2378	R_COV_Strategic_003		
Risk: <u>Inadequate Supply of PPE</u> Inadequate supply of PPE could place staff at risk of harm and an increase in the number of staff infected will increase absence rates, resulting in difficulties in staffing core capacity.	**Director Lead:** Christine Williams, Interim Director of Nursing **Assuring Committee:** Gold Command COVID-19 **Date last reviewed:** 30 October 2020		
Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Alternative decontamination options being worked through for some items to enable re-use. Military assistance in place in Morriston from 20/04/20 to support improvement in logistics operation	**Action**	**Lead**	**Deadline**
	Strengthened central distribution of PPE in place with electronic feed of supply requirements from individual units. Stock levels monitoring via dashboard. Pursue of local supply options underway for PPE with large supply anticipated in 01/05/20 and further quantities on order.	Director of Nursing	Weekly ongoing
Assurances **(How do we know if the things we are doing are having an impact?)** • Executive monitoring/support to achieve improvement plans on a weekly basis.	**Gaps in assurance** **(What additional assurances should we seek?)** The need to deliver sustained service.		
Current Risk Rating **5 x 3 = 15** **Initial Risk** 25 **Current** 15 **Target** 10	**Additional Comments** Alternative decontamination options being worked through for some items to enable re-use. Military assistance in place in Morriston from 20/04/20 to support improvement in logistics operation. 12.05.20 - Supplies have increased with regular reporting from units of a minimum of 24hrs in unit stores, most PPE items 48hrs plus, with a further 48hrs held in HQ central store. Confirmation of current and new suppliers providing steady supply of PPE to the Health Board. Discussion at Gold 28.08.20: No alteration to post-MA risk score required currently. Issues ongoing re 9332+ and 8833 masks given that the flight containing supplies didn't arrive on 09.08.20, as expected. All-Wales PPE Executive meeting to be held next week. Hoods and alternative masks on order. Reconsideration of score to occur next week. Discussion at Gold 18.09.20: No alteration to post-MA risk score required currently.		

Datix ID Number: 2369	R_COV_Strategic_004
Risk: Workforce Shortages Number of staff who are absent from work through self-isolation or family illness will impact on ability to deliver safe care for patients; and will impact on ability to keep capacity open and to staff surge and super surge capacity	**Director Lead:** Kathryn Jones, Interim Director of Workforce **Assuring Committee:** Gold Command COVID-19 **Date last reviewed:** 30 October 2020

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• Operational deployment group now operational to balance staff workforce across current capacity. • Field hospital staffing model identified; and will be triggered on basis of move to super surge with deployment in line with agreed minimum staffing requirements	Workforce silver is leading a recruitment drive to secure additional workforce; robust occupational health service in place to identify and test staff quickly and get them back to work;	Director of Workforce	Weekly ongoing

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

Current Risk Rating
5 x 2 = 10

Initial Risk	25
Current	10
Target	8

Additional Comments

Staff absent for covid reasons self-isolation/shielding or symptomatic continues to reduce to less than a third of the peak levels. Workforce continue to review shielding staff with a view to possible use in priority work that can be undertaken at home. Announcement on paused shielding and changes wb 16th August likely to see some shielding staff able to return in some capacity.
Discussion at Gold 11.09.20: No alteration to post-MA risk score required currently. Watching brief in place due to issues beginning to surface.
Discussion at Gold 18.09.20: No alteration to post-MA risk score required currently. Watching brief in place due to increase in numbers over last 10 days. 40 asymptomatic and 47 symptomatic staff, included. Units seeing rise in staff self-isolating with children who are sent home from school ill. This is not currently causing operational issues.
22.10.20 - Symptomatic absence has increased to levels last seen in June 2020. Asymptomatic absence is fluctuating as there has been significant success in reviewing shielding staff and bringing them back into some role. This is balanced by an increase in asymptomatic absence due to self isolation.

Datix ID Number: 2370	R_COV_Strategic_005
Risk: Care Homes Potential failure in local care home sector to manage staff absences could result in emergency closure of care home which will place undue pressure and therefore on community health and social services to support and/or lead to an increase in patient admission to hospital. Risk of patient harm if care homes are not adequately covered.	**Director Lead:** Hilary Dover, Director of Primary and Community Services **Assuring Committee:** Gold Command COVID-19 **Date last reviewed:** 30 October 2020

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

- HB has provided temporary support to one care home and working closely with social services. Emergency care home procedure in place enacted via CSSIW.
- Escalated to WG on 16/04/20 with strong view from WG that HB should not step in unless in extremis.
- Patients in vulnerable care homes being assessed and actions put in place on individual clinical basis to admit if required.

Since April 2020 the Unit has:

- Increased our monitoring of care homes;
- Established weekly reporting of care homes;
- Manage our hotspots with our partners;
- Testing of residents and staff has been completed and pathways to testing remain in place.
- When needed we have stepped in and physically supported the homes.
- The risk is being mitigated and has reduced from 25 to 20.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Further plan required from Community Silver on alternative models - eg step up care. Update required on 23/04/20	Director of Primary and Community Services	Weekly ongoing

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

- Executive monitoring/support to achieve improvement plans on a weekly basis.

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

Current Risk Rating
5 x 4 = 20

Initial Risk	25
Current	20
Target	15

Additional Comments

The risk is being mitigated by close monitoring of care home capacity and issues reviewed at the Externally Commissioned Care Group which reports weekly to Community Silver. Also, enhanced multi agency support has been put in to most vulnerable homes to provide short term support which has enabled the risk score to be reduced from 25 to 20.
Discussion at Gold 04.09.20: No alteration to post-MA risk score required currently. General risk in sector re capacity.
Discussion at Gold 11.09.20: No alteration to post-MA risk score required currently. Increasing concern re cases in sector, however, which are to be monitored closely.
Discussion at Gold 18.09.20: No alteration to post-MA risk score required currently.

Datix ID Number: 2371	R_COV_Strategic_006
Risk: <u>Equipment Shortages</u> Inability to secure adequate supply of equipment to support phases of capacity plan which may restrict ability of Board to respond to peaks in pandemic if not mitigated. This includes availability of ventilators, CPAP, suppliers, syringe drivers	**Director Lead:** Darren Griffiths, Interim Director of Finance **Assuring Committee:** Gold Command COVID-19 **Date last reviewed:** 30 October 2020

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
• Detailed equipment schedule prepared. CLOSED	**Action**	**Lead**	**Deadline**
	Infrastructure Silver reviewing equipment provision to ensure that all requests are being pursued via national and local supply chains. For update on 23/04/20	Head of Capital Finance	Weekly ongoing

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

Current Risk Rating
5 x 2 = 10

Initial Risk	25
Current	10
Target	5

Additional Comments

Ventilators to come through critical care network - all other items either ordered or in place.
Llandarcy and Bay (phases 1, 2 and 3A equipped) - hold on equipping final phase to assess demand,
Risk likelihood reduced to reflect progress made.
Update 27.07.20 - based on revised modelling figures from WG (24.06.20) the equipping group has now covered all capacity requirements. This risk to be closed and re-opened if modelling requirements change adversely from current plans.

Datix ID Number: 2372	R_COV_Strategic_007
Risk: <u>Oxygen Provision</u> Capacity constraints on oxygen provision at Morriston will limit number of ventilator, CPAP and high flow oxygen beds. Lack of ability to secure direct suppliers via BOC will hamper plans for oxygen provision within field hospital	**Director Lead:** Darren Griffiths, Director of Finance **Assuring Committee:** Gold Command COVID-19 **Date last reviewed:** 30 October 2020

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• Detailed risk assessment completed and mitigating actions in place to balance the oxygen usage across Morriston across the 2 VIE systems. • Alternative source of supply being sourced to provide oxygen at field hospital. CLOSED	Further request submitted to WG to support prioritisation of Morriston for upgrade in flow rates at one VIE at Morriston to boost oxygen flow rate.	Head of Capital Finance	Weekly ongoing

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

Current Risk Rating 5 x 2 = 10	Additional Comments
Initial Risk 25 **Current** 10 **Target** 3	BOC solution agreed for Llandarcy - risk reduced to reflect this. Risk will reduce further when in situ. 19.06.20: Concrete base complete for Oxygen facility at Llandarcy, building under construction. BOC due to attend site end of week commencing 22nd June and MES piping to complete installation week commencing 29th June. Recently closed but being monitored in relation to provision at Bay Hospital.

Datix ID Number: 2373	R_COV_Strategic_008
Risk: Capacity Capacity requirements against national modelling mean that the HB capacity may be either insufficient to cope with demand of 2nd surge, resulting in an inability to care for patients as well as an increased risk of excess death.	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Gold Command COVID-19 **Date last reviewed:** 30 October 2020

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
•	**Action**	**Lead**	**Deadline**
	Create flexible capacity plans that can be stepped up or down depending on demand and in line with other factors such as workforce, or medicines constraints	Chief Operating Officer	Weekly ongoing

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

Current Risk Rating
4 x 4 = 16

Initial Risk	25
Current	16
Target	8

Additional Comments

Reduce to 16 due to localised planning and modelling.
31.07.20: Localised planning and modelling in place allowing sufficient mitigation for the reduction of the risk score.
Discussion at Gold 21.08.20: No alteration to post-MA risk score required currently. Ongoing updates to modelling work provide reassurance.
Discussion at Gold 04.09.20: No alteration to post-MA risk score required currently. Requires ability to step up/down in line with competing demands.
Discussion at Gold 11.09.20: No alteration to post-MA risk score required currently. Scope to review post-completion of capacity and Q3&4 planning.
Discussion at Gold 18.09.20: No alteration to post-MA risk score required currently.

Datix ID Number: 2374	R_COV_Strategic_009
Risk: Workforce Inability to recruit sufficient workforce to fulfil requirements across all functions including TTP, testing, vaccination surge and super surge capacity including field hospitals leading which leads to impact on ability to provide additional capacity and therefore impact on delivery of patient care. Risk incorporates staffing requirements for TTP.	**Director Lead:** Kathryn Jones, Interim Director of Workforce **Assuring Committee:** Gold Command COVID-19 **Date last reviewed:** 30 October 2020

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
•	**Action**	**Lead**	**Deadline**
	Additional workforce are being recruited through national and local campaigns including the return of retired NHS professionals	Clinical Director Pharmacy	Weekly ongoing

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

Current Risk Rating
5 x 3 = 15

Initial Risk	25
Current	15
Target	10

Additional Comments

Both Medical and Nursing student now deployed within the HB. Plans for recruitment and deployment under regular review to meet service planning as it evolves. Additional recruitment to be undertaken as required.
Issues remain with drop-out rates and staff returning to pre Covid roles affected TTP deployment. Due to low activity the TTP workforce requirements on an all Wales basis the requirements have been reduced by 50% for the time being easing the concerns over recruitment in the short term whilst the substantive recruitment continues.
Discussion at Gold 21.08.20: No alteration to post-MA risk score required currently. Future consideration required for possible revision upwards.
Discussion at Gold 04.09.20: No alteration to post-MA risk score required currently.
Discussion at Gold 11.09.20: No alteration to post-MA risk score required currently. Monitoring pressures on TTP and testing workforce. Possible need for review next week.
Discussion at Gold 18.09.20: No alteration to post-MA risk score required currently. Concerns ongoing; resolution dependent on success of ongoing recruitment.

Datix ID Number: 2375	R_COV_Strategic_010
Risk: Delivery of Essential Care Following the guidance to step down routine activity issued by Welsh Government and the pandemic Health and Social Care Response Plan. There is a risk that the delivery of essential and routine services will be disrupted through a 2nd peak in COVID admissions.	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Gold Command COVID-19 **Date last reviewed:** 30 October 2020

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

- Urgent OP work will continue utilising digital solutions wherever possible.
- Agreed list of exceptions in place; urgent cancer work is being preserved as far as practicable given other constraints.
- Use of Sancta to provide some urgent cancer treatment.
- Discussions on regional footprint to identify potential solutions for urgent work where appropriate.
- Morriston remains open to the Burns network.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Development of recovery framework to support return to delivery of core services	Chief Operating Officer	Weekly ongoing

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

- Executive monitoring/support to achieve improvement plans on a weekly basis.

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

Current Risk Rating
5 x 4 = 20

Initial Risk	20
Current	20
Target	8

Additional Comments

Update as at 21.08.20: No alteration to post-MA risk score required currently, however, effects of numerous guidelines published to be monitored, as well as the effect of some staff being able returning to work.
Discussion at Gold 11.09.20: No alteration to post-MA risk score required currently.
Discussion at Gold 18.09.20: No alteration to post-MA risk score required currently. Increase in number of service being brought online. Ensuring capacity to meet demand is challenging.
An essential services assurance tool has been developed by Welsh Government, and through the Reset and Recovery group, the delivery of essential care is regularly monitored. An escalation framework has been developed and will be tested to ensure that the HB makes decisions taking into account the potential direct and indirect harm from COVID. (To be updated after prioritisation discussion on 28/09/20)

Datix ID Number: 2376	R_COV_Strategic_011
Risk: <u>Workforce Risk Assessment Tool</u> There is growing evidence that COVID-19 is having a disproportionate impact on individuals from BAME backgrounds. A national risk assessment tool has been developed to support the Board in managing risks including for staff who have been in a shielded category. There is also a further risk that if shielding is reintroduced in Wales that this will exacerbate staffing difficulties in critical services There is a risk that staff members will not feel comfortable or safe in returning to the workplace which will have a negative impact on staffing levels.	**Director Lead:** Kathryn Jones, Interim Director of Workforce **Assuring Committee:** Gold Command COVID-19 **Date last reviewed:** 30 October 2020

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• A risk assessment tool has been made available by Welsh Government to support the identification of health care workers who are at risk and to support the a risk assessment is to identify those individuals who may fit into this additional vulnerable group in order to prevent insofar as is possible, a worsening of the existing racial disparities in our communities. This tool was adapted and utilised for staff who have returned from shielding. • BAME individuals will need to have a discussion with their line managers and a risk assessment undertaken on an individual basis giving due recognition to their profession or role in the organisation and their likely risk of current exposure to COVID-19. • It is recognised that it is not possible to assess for all possible risk factors in this current environment. • Factors such as genetics, socioeconomic factors, geographical and above all cultural factors will have an effect on risk – however they cannot be assessed here in this context and will need to form part of the risk assessment tool. • Currently no reported service impact from the use of the tool. CLOSED	The impact on services will be reassessed after the initial risk assessment process has concluded.	Director of Workforce	Weekly ongoing

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

Current Risk Rating
5 x 2 = 10

Initial Risk	25
Current	10
Target	8

Additional Comments

Discussion at Gold 28.08.20: No alteration to post-MA risk score required currently, however, watching brief in place in light of changes to method of implementation of shielding risk assessment.
Discussion at Gold 04.09.20: No alteration to post-MA risk score required currently. Potential to review and reduce following discussion at next week's LNC.

	Discussion at Gold 11.09.20: No alteration to post-MA risk score required currently. Discussion at Gold 18.09.20: Dealt with issues arising with LNC. No significant reduction in shielding noted, possibly due to those affected being patient-facing. KR wondered whether the title of the risk ought to be changed as it now has a more general application. Potential for all-Wales reinstating of shielding in light of increase in cases seen. KR pointed out that the shielding cohort could include different people who have developed eligibility going forward. This could affect mission-critical individuals with the biggest impact likely to be seen in areas which have already successfully returned shielders. JRQ to review score and title. To date, a number of staff have successfully returned to the workplace. There is no current plan to return to a national shielding programme. 22.10.20 - No issues reported with the use of the risk tool for some time now - risk can be closed.

Datix ID Number: 2377	R_COV_Strategic_012
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.	**Director Lead:** Kathryn Jones, Interim Director of Workforce **Assuring Committee:** Gold Command COVID-19 **Date last reviewed:** 30 October 2020

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

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

Current Risk Rating 4 x 4 = 16		Additional Comments
Initial Risk	20	Partnership principles and ways of working will be emphasised as the most effective approach to secure progress. Discussion at Gold 21.08.20: Effects of recent activity to be monitored and score revised if subsequent change noted. Discussion at Gold 18.09.20: No alteration to post-MA risk score required currently.
Current	16	
Target	8	

Datix ID Number: 2388	R_COV_Strategic_013
Risk: Test, Trace and Protect The TTP programme is operational and staff have been recruited to both regional and local teams. There is a risk that there will be insufficient capacity locally to contend with significant or prolonger outbreaks and the sustainability of the service is a concern given the temporary nature of deploying people from core roles. There is also a risk that testing capacity may not be sufficient to deal with sudden upsurges in demand.	**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee:** Gold Command COVID-19 **Date last reviewed:** 30 October 2020

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• Public Health Protection and Response Plan in place and submitted to WG. TTP teams are operational and decisions made to recruit staff into roles on a longer term basis to provide continuity. Additional support requested in light of upsurge of cases in September and recruitment/deployment plans being reassessed. Discussion around release of additional clinical leads from Health Board. • Review of testing capacity has taken place and additional slots created at both CTU's. Mobile Testing Units operational from 28th September. Additional walk in site scoped and will be operational during October. Additional Laboratory capacity has been confirmed through national TTP programme.	Need to establish clear position on retesting.	Director of Strategy	Weekly ongoing

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
• Executive monitoring/support to achieve improvement plans on a weekly basis.	.

Current Risk Rating
5 x 3 = 15

Risk	20
Current	15
Target	8

Additional Comments

Discussion with WG planned over funding w/c 25.06.20 with potential for follow up letter - TBA at Chairs/Leaders/CEOs Call on 02.07.20.
Amber 15 - appropriate at the moment. Still significant uncertainty.
Discussion at Gold 28.08.20: No alteration to post-MA risk score required currently, however, increasing concern re ability to scale-up TPP operations in light of increased cases seen in Cardiff.
Discussion at Gold 04.09.20: No alteration to post-MA risk score required currently. Remains under review; situation currently stable.
Discussion at Gold 11.09.20: No alteration to post-MA risk score required currently.
Discussion at Gold 18.09.20: For review in light of national concerns. Locally, the system is strained but continues to operate.
22.10.20 - Confirmed release of clinical leads within Health Board to support TTP. Capacity of TTP to deliver as required escalated nationally due to shortage of specialist health protection staff on a national level

Datix ID Number: 2456	R_COV_Strategic_014
Risk: <u>Key worker support from schools</u> Both Swansea and NT Local Authorities have indicated they do not have plans to provide key worker support over the 6 week summer break. As some staff may not be able to access the support they would have normally have relied upon during this period due to Covid restriction, these staff may have no options but to remain at home to care for their children. Existing policy during the pandemic was that we did support staff in these circumstances by providing basic pay only.	**Director Lead:** Kathryn Jones, Interim Director of Workforce **Assuring Committee:** Gold Command COVID-19 **Date last reviewed:** 30 October 2020

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• Workforce considering how to assess the numbers of staff this may affect. Issue raised on all-Wales basis. LA offering to provide details of available child care and financial support available but it is yet unclear the scale of options available. The net effect would be an increase to the numbers of staff off work but asymptomatic. CLOSED	TBC	Interim Director of Workforce	Weekly ongoing

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?) .
Current Risk Rating **5 x 3 = 15** **Initial Risk** 15 **Current** 15 **Target** 8	**Additional Comments** Discussion with WG planned over funding w/c 25.06.20 with potential for follow up letter - TBA at Chairs/Leaders/CEOs Call on 02.07.20. HB policy issued 13th July 2020 providing local guidance on managing for those staff who cannot find suitable child care options for the summer break. Initial estimates were numbers of staff affected were low. WG have confirmed that Schools will open fully in Sept so we are assuming this issue will cease from that date although we will keep the situation under review to address any issues with pre-school childcare. Very low levels of reported issues - guidance and flexibility seems to have been used sensibly by staff and managers.

Datix ID Number: 2457	R_COV_Strategic_015
Risk: <u>Mass Vaccination</u> The Health Board will need to plan a mass vaccination programme for COVID-19 vaccine alongside management of the annual influenza programme. This will present a number of challenges, including workforce availability, logistics and supply, parallel delivery with the influenza programme and the constraints around co-administration, as well as administrative and information management considerations. Planning parameters have been released by Welsh Government. The most significant risk in the delivery of the programme is in securing sufficient workforce.	**Director Lead:** Keith Reid, Director of Public Health **Assuring Committee:** Gold Command COVID-19 **Date last reviewed:** 30 October 2020

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• A Silver immunisation cell has been mobilised and work cells identified to establish detailed plans within known parameters. Influenza planning is proceeding at pace and this will be prioritised for early delivery in Sept/Oct ahead of COVID-19 vaccine. Exercise to test mass vaccination planning set up for 20th August and further risks will be quantified at this point. Initial plan presented to WG and feedback received. Presentation to National COVID Vaccination Board scheduled for 29th September. Critical path under development.	TBC	Director of Public Health	Weekly ongoing

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?) .
Current Risk Rating **4 x 5 = 20** **Initial Risk** 20 **Current** 20 **Target** 10	**Additional Comments** Discussion at Gold 28.08.20: Post-MA risk score is accurate for the moment. Considerable uncertainty re supply of vaccine, sequencing of delivery and rate of availability. Discussion at Gold 04.09.20: Post-MA risk score is accurate for the moment. Health Board Vaccination Plan submitted to WG on 03.09.20. New planning parameters received. Discussion at Gold 11.09.20: Post-MA risk score is accurate for the moment. Discussion at Gold 18.09.20: No alteration to post-MA risk score required currently. Silver Immunisation Group met yesterday and made progress, however, there are a number of critical dependencies for which clarity is awaited.

Datix ID Number: 2491	R_COV_Strategic_016
Risk: Bed Spacing Guidance was issued by WG in July setting out minimum requirements in respect of bed spacing between hospital beds. As a result of a detailed risk assessment carried out at Board level, the Board will not be able to fully comply with this guidance in respect of a minimum 3.6m mid to mid bed, and 3.7m between from bed head to middle of space across to opposite bed. This increases the potential risk of nosocomial transmission. If beds are withdrawn from use due to non-compliance with the minimum standards, then this introduces risk around the loss of capacity and potential for patient harm to be caused across the system due to flow issues.	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Gold Command COVID-19 **Date last reviewed:** 30 October 2020

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• A detailed risk assessment has taken place and all inpatient areas have been reviewed for compliance with the guidance. A Red /Amber/Green rating has been deployed which means that Green = fully compliant; Amber - between 2m and 3.6m; Red = below 2metres. All Red bed areas have been removed. Mitigating action is being deployed and will be in place by end October. This includes the erection of Perspex curtains or screens between.	TBC	Chief Operating Officer	Weekly ongoing

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?) .
Current Risk Rating **4 x 3 = 12** **Initial Risk** 20 **Current** 12 **Target** 10	**Additional Comments** Discussion at Gold 22.10.20 - We have received a delivery of curtains which will be installed in the first week of November 2020.

Datix ID Number: tbc	R_COV_Strategic_017
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.	**Director Lead:** Richard Evans, Executive Medical Director **Assuring Committee:** Gold Command COVID-19 **Date last reviewed:** 30 October 2020

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

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?) .
Current Risk Rating **5 x 5 = 25**	**Additional Comments** Discussion at Gold 22.10.20 – risk added to register

Initial Risk	25
Current	25
Target	12

Datix ID Number: tbc	R_COV_Strategic_018		
Risk: Sustainable Services 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	**Director Lead:** Chris White, Chief Operating Officer (COO) **Assuring Committee:** Gold Command COVID-19 **Date last reviewed:** 30 October 2020		
Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
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	**Action**	**Lead**	**Deadline**
	Business Continuity plans in place to be reviewed by operational silver command.	Jan Worthing/Deb Lewis	Weekly ongoing
Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)** .		
Current Risk Rating **5 x 5 = 25**	**Additional Comments** Discussion at Gold 22.10.20 – risk added to register		

Initial Risk	25
Current	25
Target	15

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