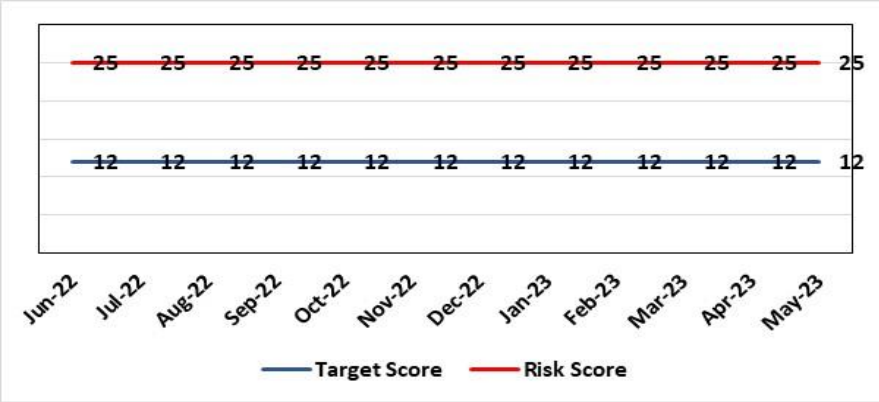
HEALTH BOARD RISK REGISTER
May 2023
RISKS ASSIGNED TO THE QUALITY & SAFETY COMMITTEE

Risk Schedules

Datix ID Number: 738 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 1** **Risk Target Date: 31/03/2023**	**Current Risk Rating** **5 x 5 = 25**
Objective: Networked Hospitals – A Systems Approach – Urgent & Emergency Care	**BAF Ref: 3.3**	**Director Lead:** Deb Lewis, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee **For information:** Quality & Safety Committee	
Risk: Access to Unscheduled Care If we fail to provide timely access to Unscheduled Care then this will have an impact on quality & safety of patient care as well as patient and family experience and achievement of targets. There are challenges with capacity/staffing across the Health and Social care sectors.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 5 x 5 = 25 Target: 3 x 4 =12		**Rationale for current score:** Post wave 2 of COVID 19 Morriston and Singleton have experienced a steady increase in emergency demand to pre-covid levels. Capacity is limited due to covid response and therefore remains a high risk. Current score raised due to increasing pressures. Recent implementation of All Wales Immediate Release Protocol puts additional pressure on already overcrowded ED dept.	
Level of Control = 50%		**Rationale for target score:** Our annual plan is to implement models of care that reflect best practice. This will improve patient flow, length of stay and reduce emergency demand.	
Date added to the HB risk register 26.01.16			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Programme management office in place to improve Unscheduled Care. • Daily Health Board wide conference calls/ escalation process in place. • Regular reporting to Executive and Health Board/Quality and Safety Committee. • Increased reporting as a result of escalation to targeted intervention status. • Targeted unscheduled care investment of £8.5m in the annual plan, including a new Acute Medical Model focused on increasing ambulatory care. • Development of a Phone First for ED model in conjunction with 111 to reduce demand. • 24/7 ambulance triage nurse in place • Joint WAST Stack review by GP and APP (Advanced Paramedic Practitioner) • OPAS (Older People's Assessment Service) have undertaken training with nursing homes (on management of patient falls) & set up direct contact details with nursing homes	Increase of hours in SDEC planned.	SGD (Morriston)	31/03/2023
	OPAS – exploring internal & external funding options	SDEC Clinical Lead	31/03/2023
	Work ongoing in ED/SDEC to pilot additional initiatives	Chief Operating Officer / Deputy Medical Director	31/03/2023

• Frailty short-stay unit re-established Additionally, actions to improve the discharge of clinically optimised patients (risk HBR80) expected to assist with patient flow, are anticipated to free capacity to assist to address this risk HBR1 also.			
Assurances (How do we know if the things we are doing are having an impact?) • New Urgent & Emergency Care Board is meeting monthly.	**Gaps in assurance (What additional assurances should we seek?)** The need to deliver sustained service.		
Additional Comments / Progress Notes 06/01/2023: Review of roles & service models in order to increase SDEC working hours and throughput of patients sustainably is complete – expect increase to come into effect after end of January, following movement of staff resource from Singleton. Morriston have set up a workstream to review SAFER discharge - SAFER rollout has commenced starting with AMU at Morriston. It was reviewed by national team and commended as good practice. Ten-week rollout plan in place. AMU opened on 5th December. Weekend take in Singleton is transferring from 6th January. Full implementation planed from 23rd January. Primary care group are reviewing FNOF pathway and the use of virtual wards to reduce length of stay has started on limited basis. Breaking the Cycle week planned for w/c 7th November 2022 was completed. 07/02/2023: Whilst AMSR has been implemented further work is ongoing on increasing out of hospital capacity. Bed decommissioning group has been set up chaired by the CEO. First meeting took place on 23/01/2023 and the paper is expected at Management Board in March. 02/03/2023: Action Completed: Looking to extend to non-surgical fractures – options to resource have been quantified and approved by CEO.			

Datix ID Number: 739 **Health & Care Standard: 2.4 Infection Prevention & Control & Decontamination**		**HBR Ref Number: 4** **Risk Target Date: 31st March 2024**	**Current Risk Rating** **4 x 5 = 20**
Objective: Demonstrably Improved Quality, Safety & Reduced Harm	**BAF Ref: 1**	**Director Lead:** Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality and Safety Committee	
Risk: Risk of patients acquiring infection as a result of contact with the health care system, resulting in avoidable harm, impact on service capacity, and failure to achieve Tier 1 national infection reduction goals.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 =12		**Rationale for current score:** Health Board incidence of key Tier 1 infections per 100,000 population above All Wales rates, indicating Health Board's population at greater risk of infection. High occupancy rates & frequent ward moves associated with increased risk of infection transmission. Lack of decant facilities compromises environment deep cleaning & decontamination, and planned preventative maintenance programmes.	
Level of Control = 40%			
Date added to the HB risk register January 2016		**Rationale for target score:** Improved governance structures for IPC and antimicrobial stewardship will drive improved local ownership and embed responsibility for these priorities for all levels of staff. Adequately maintained & clean environments facilitate good IPC & minimise infection risks. Reduced occupancy & frequency of patient moves mitigate against infection transmission. Compliant ventilation systems and water safety minimise infection risks. Access to timely data on infections, training, antimicrobial stewardship, cleaning at ward/unit/practice level enables Service Groups to identify areas for focused QI programmes, drive improvement, & effectively measure outcomes.	

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Drive improvements in prudent antimicrobial prescribing	Cons. Antimicrobial Pharmacist	31/03/24
Reduce Key Tier 1 Infections to no more than WG maximum quarterly profile	Head of Infection Control	31/03/24
Achieve 85% compliance with IPC mandatory training	Service Group Directors	31/03/24
Maintain National Standards of Cleanliness compliance >95%	Support Services	31/03/24
Develop a proactive schedule of IPC-	Head of Infection Control	31/03/24

	related audit for Service Groups wards & services, and for IPC team.	Service Group Directors	
Assurances (How do we know if the things we are doing are having an impact?) • Clear Corporate and Service Group IPC Assurance Framework in place. • Infection Prevention Improvement Plans for HB and Service Groups with progress reported at SG Infection Control Committees, HB Infection Control Committee and at Management Board. These include trajectories to meet national targets and report performance against them. This is also reported to Quality & Safety Committee. • Ongoing monitoring of infection control rates. • IPC, antimicrobial, decontamination and cleaning audit programmes. • Compliance and validation systems for water safety, ventilation systems and decontamination.	**Gaps in assurance (What additional assurances should we seek?)** • High occupancy rates & frequent ward moves associated with increased risk of infection transmission. • Lack of decant facilities compromises environment deep cleaning & decontamination, and planned preventative maintenance programmes. • Lack of robust system for Board oversight regarding IPC and ANTT training compliance due to ESR limitations.		
Additional Comments / Progress Notes 10.05.2023 – action complete - Develop ward to board Dashboard on key Tier 1 infections. Progress update re Tier 1 infection reduction goals - cumulative infection cases 01 April – 30 April 2023: • C. difficile - 18 (cumulative profile - 10 maximum) • Staph. aureus bacteraemia - 16 (cumulative profile - 8 maximum) • E. coli bacteraemia - 26 (cumulative profile - 22 maximum) • Klebsiella spp. bacteraemia - 8 (cumulative profile - 9 maximum) • Pseudomonas aeruginosa bacteraemia - 2 (cumulative profile - 2 maximum).			

Datix ID Number: 841 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**		**HBR Ref Number: 13** **Risk Target Date: 30th June 2023**	**Current Risk Rating** **4 x 4 = 16**
Objective: Delivering Care in Safe, Modern Environments	**BAF Ref: 7**	**Director Lead:** Darren Griffiths, Director of Finance **Assuring Committee**: Quality & 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:** May 2023	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 =16 Target: 4 x 3 = 12		**Rationale for current score:** The accommodation is varied in age, tired and in need of upgrading/refurbishment to enable improved condition and compliance to regulations and WHBN/WHTMs. Score has increased following the Health Board commissioning a 6 FACET survey, this has highlighted key areas around compliance that require addressing	
Level of Control = 90%		**Rationale for target score:** Risk assessments of premises.	
Date added to the HB risk register April 2012			

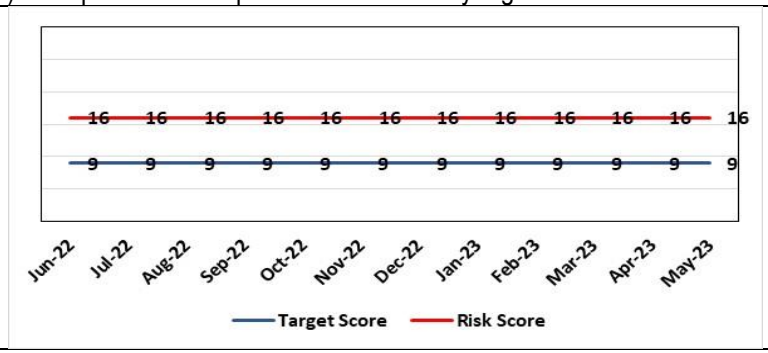
Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Key areas where performance linked to health & safety/fire issues. Health & Safety and Quality & Safety Committees and agreed actions to mitigate impacts. • Actions addressed through site meetings trade improvements on the 2 acute hospital sites. • Primary Care premises, audits commissioned and delayed due to Covid. • Development of estates strategy and DCPs • Capital programmes • Priority of discretionary capital funding • Development of appropriate capital business cases and present to Welsh Government	A review is currently taking place of current PCST structures and governance arrangements for estates and H&S to cover key compliances and escalation processes	Service Group Director (PCT) & Assistant Director of Health & Safety	30/06/2023
	A Task & Finish Group to be established to further develop with a target of submitting a final, scrutinised Estates Strategy to the Board in May 2023. The Health Board has DCP's in the strategy and will assist in the overall condition and compliance of the estate. However, this will be over the next 10 years at least.	Assistant Director of Estates Assistant Director of Capital	10th May 2023 ahead of Board meeting on 25th May 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?)**

Additional Comments / Progress Notes

17/02/2023: Estates strategy presented to Independent Members 09/01/23. First Task and Finish Group chaired by Health Board Vice Chair met on 22nd February 2023. On-going dialogue with PC&TSG on structures, with further reviews in Q4. Analysis of the 6 FACET survey has highlighted a number of areas that require significant investment, therefore the score has been increased based on likelihood raising to 4, so 4 x 4 = 16. Action complete - Estates strategy has been developed and a draft will be received at the estates utilisation group on 15/11/22. Estates strategy

presented to a Board Development session in January 2023. 19/04/23: A final session of the T&F group is scheduled 11 May 2023, with outcomes then being presented to management board end May 2023. PC&TSG have agreed to pilot recommended structures to support the estate at Cimla, this will commence May/June 2023.

Datix ID Number: 1567 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**		**HBR Ref Number: 41** **Risk Target Date: February 2024**	**Current Risk Rating** **4 x 4 = 16**
Objective: Delivering Care in Safe, Modern Environments	**BAF Ref: 7**	**Director Lead:** Darren Griffiths, Director of Finance & Performance **Assuring Committee:** Quality & Safety Committee	
Risk: Fire Regulation Compliance Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 4 x 4 = 16 Target: 3 x 3 = 9		**Rationale for current score:** Cladding applied to Singleton Hospital front flank is not compliant with fire regulations. General compliance with fire regulations and WHTM/WHBN requirements.	
Level of Control = 50%		**Rationale for target score:** Once sufficient resources and the cladding is replaced the risk score will reduce significantly. This will be reduced in stages as resources are implemented and cladding replaced.	
Date added to the HB risk register 31/05/2018			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Fire risk assessments. • Evacuation plans (vertical and horizontal). • Fire safety training. • Professional advice sought on compliance of panels. • East flank panels removed • Business case being developed for south panel removal and updating.	Change in fire evacuation plans and alarm and detection cause and effect	Head of Health & Safety	01/11/2023
	Replacing the existing cladding and insulation with alternative specifications and inserting 30 minute fire cavity barriers where appropriate	Service Improvement Manager	28/02/2024

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance** **(What additional assurances should we seek?)**
• Monitoring through the H&S committee to receive assurance and or identify gaps for key compliance and adherence to applicable legislation. • NWSSP internal audits • Site visits/tours to identify compliance and gaps in compliances. • Completion of FRA's within targeted schedule	Suitable resources to be in place, all fire risk assessments and actions from them completed. Fire safety audits carried out internally. Fire compartmentation surveyed to provide assurance of fire stopping. Fire schematics updated and fire evacuation drawings updated in in place.

Additional Comments / Progress Notes

13.12.22: Estates strategy/DCP developed with priorities identified and will be incorporated in future capital plans. No change in current risk score based on current available information.
16.01.23: Cladding programme continues, still scheduled for completion March 2024, with no change to risk score.
18/04/23: Cladding programme monitored through cladding project board and remains on target for completion March 2024, with no change in risk score.

Datix ID Number: 840 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 16** **Risk Target Date: 31/10/2023**	**Current Risk Rating** **5 x 4 = 20**
Objective: Networked Hospitals – A Systems Approach – Planned Care	**BAF Ref: 3.4**	**Director Lead:** Deb Lewis, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee **For information:** Quality & Safety Committee	
Risk: Access and Planned Care There is a risk of harm to patients if we fail to diagnose and treat them in a timely way.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 4 = 20 Target: 4 x 2 = 8		**Rationale for current score:** All non-urgent activity was cancelled due to response to the Covid-19 pandemic and has increased the backlog of planned care cases across the organisation. Whilst mitigating measures such as virtual clinics have been put in place new referrals are still being accepted which is adding to the outpatient backlog particularly in Ophthalmology and Orthopaedics. The significant reduction in theatre activity during the pandemic increased the number of patients now breaching 36 and 52 week thresholds.	
Level of Control = 90%		**Rationale for target score:** There is scope to reduce the likelihood score to reduce the overall risk to an acceptable level. The Risk target date indicates when we expect to see some reduction in waiting lists – albeit the overall risk level may remain as work continues.	
Date added to the HB risk register January 2013			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Post Covid 19 the focus is on minimising harm by ensuring that the patients with the high clinical priority are treatment first. The Health Board is following the Royal College of Surgeons guidance for all surgical procedures and patients on the waiting list have been categorised accordingly. • There is a bi-weekly recovery meeting for assurance on the recovery of our elective programme. • Specialty level capacity and demand models set out the baseline capacity and identify solutions to bridge the gap. Non-recurring pump – prime funding is available to support initial recovery measures. Fortnightly performance reviews track progress against delivery. • A focused intervention is in train to support to the 10 specialties with the longest waits. • Long waiting patients are being outsourced to the Independent Sector • Additional internal activity is being delivered on weekends (via insourcing) • Planned care trajectories developed and submitted to WG as part of IMTP. • Governance process put in place to monitor performance against trajectories internally, and with Welsh Government. • External & internal validation has commenced. • A 10 bedded orthopaedic ward was created at Morriston Hospital in December to address the longest waits in the specialty that can only be operated on at Morriston.	Work ongoing with Finance colleagues to establish the funding allocation for elective recovery for 2023/24.	Deputy COO	31/10/2023

Assurances (How do we know if the things we are doing are having an impact?) • Weekly meetings in place to ensure patients with greatest clinical need are treated first.	**Gaps in assurance (What additional assurances should we seek?)**		
Additional Comments / Progress Notes 15/12/22 The Health Board is on target to exceed the trajectories for both 52 week and 104 weeks agreed with Welsh Government. A review of the risk rating will be undertaken at the next Planned Care Recovery Board in January 2023. Two actions closed - Morriston Service Group is looking at a plan for dedicated elective orthopaedic bed capacity at Morriston site. Recovery trajectory has been reviewed and shows further improvement – awaiting final signoff. 07/02/2023; The trajectory submitted to WG has been exceeded to date and the expectation is that we will exceed the end of March projection. Ten ring-fenced orthopaedic ward beds at Morriston will deliver 500 procedures per year going forward. 20/04/2023 – The trajectory for the 104 week target at the end of March was exceeded with 6012 patients reported.			

Datix ID Number: 1043 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**		**HBR Ref Number: 36** **Risk Target Date: 31st March 2024**	**Current Risk Rating** **4 x 4 = 16**
Objective: Adopting and Developing Innovative Digital Solutions to Support Care Delivery	**BAF Ref: 5**	**Director Lead:** Matt John, Director of Digital **Assuring Committee:** Workforce & OD Committee **For information:** Quality & Safety Committee	
Risk: Paper Record Storage: Lack of a single electronic record means there is greater reliance on the provision of the paper record. If we fail to provide adequate storage facilities for paper records, then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if there is poor records management in some wards. There is an increased fire risk where medical records are stored outside of the medical record libraries.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 4 = 16 Target: 3 x 3 =9		**Rationale for current score:** C - Inability to find records for patients could delay care/increase length of stay over 15 days. Could also mean patients receive incorrect treatment. Increased risk of fire where records are stored outside of the medical record libraries. L - we know this happens from incidents raised	
Level of Control = 70%		**Rationale for target score:** C - The increased development and adoption of the digital record will reduce the need for the paper health record being available at the point of care. L - The increased development and adoption of the digital record, the introduction of RFID and the approach to management of the paper record identified in the Business case process should reduce the amount of paper required to be stored and managed.	
Date added to the HB risk register June 2016			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• There is a plan in place to increase the functionality of the electronic record to document patient care. The delivery of the plan is overseen by the Digital Leadership Group and progress provided to Management Board. (Supported by individual project boards as appropriate) • Records managed by the Medical Records libraries are RFID tagged and location tracked • Medical Record libraries are regularly risk assessed for fire by health and safety • Alternative offsite storage arrangements have been identified. • All records must be documented on the Information Asset Register (IAR).	Amended: Re-develop a joint outline Business Case for centralisation of the health records and the scanning model.	Head of Health Records & Clinical Coding	30/06/2023
	Assessment of the impact of the Records Management code of practice	Head of Health Records & Clinical Coding	01/06/2023
	Develop a revised destruction plan	Head of Health Records & Clinical Coding	30/06/2023

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
• RFID has been implemented for the acute record improving the management and storage of records • Health Records performance reports developed in line with RFID technology • Attainment of the Tier 1 Health Board target for clinical coding completeness which relies on the timely availability and quality of the Paper record and electronic sources • Monitoring complaints and incident reporting. • Electronic record is being implemented in accordance with the plan eg implementation of WNCR, ETR, HEPMA etc.	Investment required supporting the delivery and operational costs of the Digital strategy. Reliance on DHCW for delivery of the solution for a fully electronic patient record. Impact of the Infected Blood Enquiry on the Health Boards ability to destroy notes. Process for ensuring clinical adoption of electronic ways of working and cessation of adding information to the paper record that is already available electronically needs to be agreed and enforced by the Health Board. Impact of the infected Blood Inquiry on the health boards ability to destroy notes and the change in the records code of practice is being reviewed by the Director of Digital.

Additional Notes

15/12/2022 – This risk will remain on-going throughout the development process and timescales will continue to change until the implementation of scanning for the acute record, however 'paper-lite' ways of working continue.
11/01/2023 – A business case is being submitted to the Scrutiny panel by 13/01/2023 for BCAG at the end of the month. Date is 31/01/2023 for action update.
15/03/2023 – The intended location for the centralisation of Health Records is no longer available due to the vendor withdrawing from negotiations. This means the outline business for scanning can no longer be completed. A revised requirement for the accommodation of the centralisation of the health records and scanning provision is being drawn up and a revised business case will be developed once a suitable location has been identified. The current action to transfer records to previously identified location is closed and the action to produce the business case has been revised.
In March we have received notification that the blood enquiry embargo on the destruction of records has been lifted. However, due to a change in the 'Records Management Code of Practice for Health and Social Care 2022' around the increased retention of records for patients with long term illness, an assessment is required to determine the impact on the destruction and continued storage of records. This assessment needs to inform the requirements for a centralised unit and scanning model. Destruction of records outside of this change has begun following the lifting of the embargo.
10/05/2023 – Units are still being considered/viewed. None currently meeting the requirements.

Datix ID Number: 1514 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**		**HBR Ref Number: 43** **Risk Target Date: 15/05/2023**	**Current Risk Rating** **4 x 5 = 20**
Objective: Mental Health & Learning Disability Services	**BAF Ref: 3.2**	**Director Lead:** Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality and Safety Committee	
Risk: Deprivation of Liberty Safeguards Due to a lack of Best Interest Assessor resource, there is a risk of failure to complete and authorise the assessments associated with Deprivation of Liberty within the legally required timescales, exposing the health board to potential legal challenge and reputational damage.		**Date last reviewed:** May 2023 **Rationale for current score:** Although processes have been planned in order to reduce the breach position they have yet to be fully implemented. The impact is yet to be realised. Risk increased in Feb 2023 following discussion at Mental Health Legislative Committee.	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 5 = 20 Target: 3 x 2 = 6		**Rationale for target score:** Consequences of DoLS breaches for the Health Board will not change. With controls in place, over time likelihood should decrease.	
Level of Control = 40%			
Date added to the HB risk register July 2017			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Additional supervisory body signatories in place – this is being undertaken as overtime using additional WG funds. Additional funding received from WG to manage the backlog of DoLS assessments. DoLS assessments are being undertaken via a number of difference sources to address the backlog; • Liquid Personnel Agency – 250 assessments commissioned and contract has now ceased. • External BIA's payment to be increased from £120 to £250 (utilising substantive recurring funding) to encourage a large cohort of BIA's to undertake role. • 2 band 6 WTE BIA's have been appointed (using WG money). This will reduce the need for agency BIA's. • Overtime/additional hours agreed utilising WG money for health board BIA's to undertake DoLS assessments to reduce backlog and for sign off completion. • DoLS database updated and DoLS dashboard in place, monitoring applications and breaches via dedicated BIAs and Admin. • Delivery of DOLS Action plan reviewed monthly. • Regular reporting to Mental Health and Legislative Committee (MHLC). • Monthly reporting to Unit Nurse Director and Finance on DoLS breaches. • Health Board presence at National and regional meetings relating to DoLS / LPS. • Increased IMCA services to support increased BIA resource. • Current MCA practice reviewed to support MCA DoLS issues in practice.	Overtime/additional hours agreed to fund sign off from nurse assessor team to process the backlog assessments	GND Primary and Community	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?)
Regular scrutiny at Service Group and Safeguarding Committee and by DoLS Internal Audit; monitoring via DoLS Dashboard this will provide real-time accurate data. Update report to MHLC, impact of backlog of DoLS breaches and new LPS implementation. Monthly updates with Unit Nurse Director and Finance.	
Additional Comments / Progress Notes	
05.05.2023 - Risk level remains at 20. Current DoLS backlog to date is 65. Liquid Personnel (LP) have completed their 250 assessments and contract has now ceased. The breach time remains at approximately 6 weeks. 2 WTE band 6 BIA's have commenced and undertaken BIA training. Additional reoccurring funds are to be made available by WG to strengthen MCA & DoLS structure. Bids to be submitted by 9th May 2023. Task & Finish group to restart to clarify where MCA & DoLS will sit within the health board following LPS not being implemented. Action completed - Agency commissioned to support backlog of assessments. Action closed - Business case for revised service model (cannot be finalised prior to WG consultation).	

Datix ID Number: 1563 **Health & Care Standard: Safe Care 5.1 Access** To be refreshed		**HBR Ref Number: 48** **Risk Target Date: 31st March 2023**	**Current Risk Rating** **4 x 3 = 12**
Objective: Children, Young People & Maternity Services	**BAF Ref: 3.6**	**Director Lead:** Deb Lewis, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee, Health Board **For information:** Quality & Safety Committee	
Risk: Failure to sustain Child and Adolescent Mental Health Services		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 = 12 Target: 4 x 2 = 8		**Rationale for current score:** Difficulties with sustainable staffing affecting performance. Due to improvements being made within the service the current score is on track to be reduced next month.	
Level of Control = 50%		**Rationale for target score:** New service model and improved performance.	
Date added to HB the risk register 31/05/2018			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Performance Scrutiny - is undertaken at monthly commissioning meetings between Swansea Bay & Cwm Taf Morgannwg University Health Boards. Improved governance - ensures that issues and concerns are discussed by all interested parties including local authorities to support the network identify local solutions. • New Service Model was established by Summer 2019 which gave further stability to service. • Staffing of service is being strengthened & supplemented by agency staff • External support secured to determine future delivery arrangements and more immediate performance improvements. • Following a service review, and option appraisal, the Health Board approved the preferred option – to repatriate Swansea Bay CAMHS at its September Board meeting.	The ongoing utilisation of agency staff to fill vacancies has been agreed via the commissioning arrangements and the Service have had ongoing agency workers in the service since April. The Service will continue to look for opportunities for agency to support the service.	Assistant Director of Strategy	01/04/2023
	Repatriation of Service to SBUHB	Assistant Director of Strategy	01/04/2023
	CAMHS Implementation Plan to be progressed in line with the agreed timelines to manage demand & capacity and improve waiting times.	Assistant Director of Strategy	Ongoing (multiple milestones)

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
As a result of focussed work, the vacancy rate has improved considerably. Utilisation of agency will continue to improve the backlog, and support the trajectories received. ***% Patients waiting < 28 days*** The number of referrals reduced to 138 in August 2022, compared to 259 in May 2022 when referrals were at their highest this year. The proportion of referrals redirected/not accepted increased in August to 55% reflecting the average for 21/22. The number of patients on the waiting list at the end of August 2022 has decreased from 324 in May	

to 100. The current waiting time for assessment as at 23rd September 2022, is included within the table below:

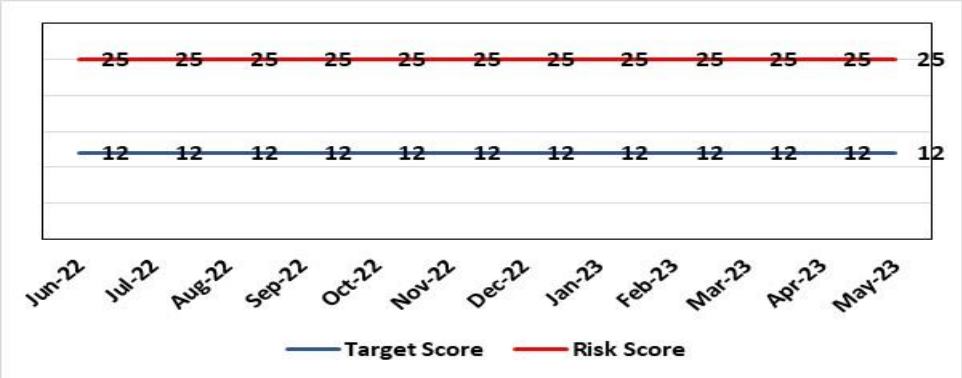
Team	Total waiting	Waiting >28 days	% compliance	Average wait (weeks)
CAMHS Swansea Bay	100	31	69%	2.7

Additional Comments / Progress Notes

Update: August 2022 – work has been progressed to develop options for the repatriation of CAMHS, and these are due to be reviewed by Management Board in August. A service specification has been drafted, and engagement is ongoing. Trajectories have now been received aligned to the schemes in the Improvement Plan – these will be monitored via the monthly commissioning arrangements.

Update: September 2022 – Service Specification complete and preferred option confirmed for future repatriation of service to Swansea Bay UHB. Recommended that risk is downgraded in October 2022. Two actions completed - Service Specification being developed. Engagement on Specification is now complete, document has been finalised and endorsed by CTM and SBUHB via the commissioning arrangements in place. Board to consider future delivery arrangements. Option appraisal complete – preferred option approved by Management Board and by Health Board members at the September meetings.

21.11.2022 – Action complete – The Network is seeking to recruit agency staff to fill existing and upcoming vacancies to ensure that core capacity is maximised.

Datix ID Number: 1761 **Health & Care Standard: Timely Care 5.1 Access**		**HBR Ref Number: 50** **Risk Target Date: 31/03/2023**	**Current Risk Rating** **5 x 5 = 25**
Objective: Networked Hospital – A Systems Approach – Cancer Care	**BAF Ref: 3.5**	**Director Lead**: Deb Lewis, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee **For information:** Quality & Safety Committee	
Risk: Access to Cancer Services A backlog of patients now presenting with suspected cancer has accumulated during the pandemic, creating an increase in referrals into the health board which is greater than the current capacity for prompt diagnosis and treatment. Because of this there is a risk of delay in diagnosing patients with cancer, and consequent delay in commencement of treatment, which could lead to poor patient outcomes and failure to achieve targets.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 5 x 5 = 25 Target: 4 x 3 = 12		**Rationale for current score:** Risk score updated based on being off trajectory for SCP and Backlog increasing.	
Level of Control = 70%		**Rationale for target score:** Target score reflects the challenge this area of work present the Board and where small numbers of patients impact on the potential to breach target.	
Date added to the HB risk register April 2014			

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Phased and sustainable solution for the required uplift in endoscopy capacity that will be key to supporting both the Urgent Suspected Cancer backlog and future cancer diagnostic demand on Endoscopy Services.	Service Group Manager	31/03/2023
Expand OMF & colorectal operating capacity.	Deputy COO	31/03/2023
Developing trajectory for 2023/24 for sign off in March 2023.	COO	31/03/2023

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

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

Additional Comments / Progress Notes
22/11/2022 Further enhanced SCP specific D&C plans will be produced in Qtr 4 to inform sustainable service delivery plans for 2023/24 06/01/2023: WG template received for enhanced monitoring & includes performance against cancer trajectories. 07/02/2023: A detailed recovery plan is due to go to the Board in March 2023. 02/03/2023: CEO has completed deep dives with each tumour site. Considerable changes to pathways and capacity agreed and revised trajectories are being set based on these improvements in April 2023.

Datix ID Number: 1799 **Health & Care Standard: Controlled Drug 2.6 Medicines Management**		**HBR Ref Number: 57** **Risk Target Date: 31st March 2023**	**Current Risk Rating** **4 x 3 = 12**
Objective: Demonstrably Improved Quality, Safety & Reduced Harm	**BAF Ref: 1**	**Director Lead**: Hazel Lloyd, Director of Corporate Governance **Assuring Committee**: Quality & Safety Committee	
Risk: Non-compliance with Home Office (HO) CD Licensing requirements. The Health Board (HB) currently has limited assurance regarding compliance with HO CD Licensing requirements, nor does it have processes in place in respect of future service change compliance.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 3 = 12 Target: 4 x 2 = 8		**Rationale for current score:** Legal advice has indicated that failure to comply with the HO CD licensing requirements could result in criminal and civil action, both against responsible individuals and the health board as a public body. The CDAO met with representatives from the Home Office Drugs & Firearms Licensing Unit on the 10th January 2023. At the conclusion of the meeting, the Home Office made clear to the Health Board that at that point in time we were non-compliant with our statutory obligations in this area. The Home Office gave the Health Board a deadline of the 27th January 2023 by which to make any required applications - failure to do would result in enforcement action by the Home Office. Several areas where licensing is required have been agreed and the corresponding applications to the Home Office have been made. The risk likelihood level has been reduced reflecting this action to comply. The CDAO, in conjunction with Director of Corporate Governance continue to explore potential additional licensing requirements around care provided by external providers on SBU Health Board sites and private healthcare provision.	
Level of Control = 80%			
Date added to the HB risk register January 2019		**Rationale for target score:** Upon completion of mitigating actions, there will be a training session held with all Service Groups supported at Executive level.	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
The CDAO has worked with the Medical Director and Director of Corporate Governance to ensure the Health Board identifies areas where a Home Office Controlled Drugs License is required. Service Group senior teams together with pharmacy colleagues have reviewed controlled drug activity, and in discussion with the CDAO have agreed several areas where licensing is required and have made the corresponding applications to the Home Office.	HB to develop and implement a control system to ensure compliance with HO license requirements.	CD Pharmacy	30/09/2023
	CDAO to work with the Medical Director and Director of Corporate Governance to complete review of Home Office Controlled Drug License requirements by the Health Board.	CD Pharmacy	30/06/2023

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Services have fed back to the CDAO that a number of Home Office Controlled Drug Licenses have been applied for.	The HB will develop a license compliance register, this is expected to be maintained by the Corporate Governance Team thus ensuring there is sufficient segregation of duty.

Additional Comments / Progress Notes

20/01/23 - The CDAO met with representatives from the Home Office Drugs & Firearms Licensing Unit on the 10th January 2023. The purpose of the meeting was to conclusively determine the requirement for Home Office Controlled Drug Licenses by the Health Board and resolve the conflict in advice between the Home Office and legal representatives of the Health Board.

During the meeting the Home Office advised on licensing requirements for a small number of paradigm examples of controlled drug management by the Health Board. At the conclusion of the meeting, the Home Office made clear to the Health Board that we are currently non-compliant with our statutory obligations in this area and have given a deadline of the 27th January 2023 by which to make any required applications. Failure to do so will result to enforcement action by the Home Office which includes the possibility of criminal sanction against individuals as well as the Health Board. The CDAO is currently working with the Medical Director and Director of Corporate Governance to ensure the Health Board meets the deadline given by the Home Office.
14/02/23 - Service Group senior teams together with pharmacy colleagues have reviewed controlled drug activity, and in discussion with the CDAO have agreed several areas where licensing is required and have made the corresponding applications to the Home Office. The CDAO, in conjunction with Director of Corporate Governance continue to explore potential additional licensing requirements around care provided by external providers on SBU Health Board sites and private healthcare provision.
Two actions closed: HB to discuss and agree a policy position on the requirements for HO CD Licenses with the HO (no longer applicable). Upon agreement of policy with the HO HB to undertake baseline assessment of current CD management (including any HO CD licenses currently held) in line with agreed policy on requirements for HO CD licenses (baseline assessment complete).
04/04/23 - Corporate Governance team exploring options that could provide a control system to ensure ongoing compliance with HO CD license requirements. CDAO continuing to work with the Director of Corporate Governance to complete review of Home Office Controlled Drug License requirements by the Health Board. Several notices of compliance visits received from the Home Office in response to recent CD license applications.
04/05/23 - No change since the update on 04/04/23.

Datix ID Number: 146 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**		**HBR Ref Number: 58** **Risk Target Date: 31/10/2023**	**Current Risk Rating** **4 x 4 = 16**
Objective: Networked Hospitals – A Systems Approach – Planned Care	**BAF Ref: 3.4**	**Director Lead**: Deb Lewis, Chief Operating Officer **Assuring Committee**: Quality and Safety Committee	
Risk: Failure to provide adequate clinic capacity for follow-up patients in **Ophthalmology** results in a delay in treatment and potential risk of sight loss.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 4 = 16 Target: 4 x 2 = 8		**Rationale for current score:** Risk rating increased to 20 in July 2020 due to Covid-19 pandemic but has now been decreased due to the progress made by the department to reduce the number of delayed followed appointments.	
Level of Control = 40%		**Rationale for target score:** Mitigation plan via outsourcing of work to optometrists where possible and re-introduction of pre-covid capacity levels.	
Date added to the HB risk register December 2014			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• All patients are categorised by condition in order to quantify issue. • Community optometry scheme successfully implemented to reduce number of diabetic retinopathy patients on follow up list. • Scheme developed for assessment of glaucoma patients by community optometrists for virtual review by consultant ophthalmologists to reduce follow up backlog. • Outsourcing of cataract activity to reduce overall service pressures.	**Action**	**Lead**	**Deadline**
	An overall Regional Sustainability Plan to be delivered	Service Group Manager Surgical Specialties	31/10/2023
Assurances (How do we know if the things we are doing are having an impact?) • Deputy COO holds Gold Command meetings on a monthly basis to monitor progress.	**Gaps in assurance (What additional assurances should we seek?)** Regular liaison with patients on extended waiting list/times and validation.		

Additional Comments / Progress Notes

15/12/2022 – There has been an increase in the number of follow up 7,411 at the end of November partially to the increase in new patients being seen. However, there is still a trajectory of improvement through to March 2023.
07/02/2023: Longer-term regional recovery options are being explored jointly with Hywel Dda but the opening of additional clinical capacity locally will be key – this is not resolved as yet but in progress.
20/4/2023 – There has been a 22% reduction in the number of follow up not booked since July 22 and the figure is 4984 at the end of March 2023.

Datix ID Number: 1587 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 61** **Risk Target Date: 31st May 2023**	**Current Risk Rating** **4 X 4 = 16**
Objective: Networked Hospitals – A Systems Approach – Planned Care	**BAF Ref: 3.4**	**Director Lead:** Deb Lewis, Chief Operating Officer **Assuring Committee:** Quality and Safety Committee	
Risk: Paediatric dental GA (General Anaesthetics)/Sedation services provided under contract from Parkway Clinic, Swansea. Medical Safety risk as GA are performed on children outside of an acute hospital setting. Repatriation of service to acute site delayed due to theatre capacity which means the health board continues to commission services for delivery outside of national guidance (WHC 2018-09). There is also an associated risk in that the diagnosing clinician does not deliver the care to the patient.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 4 x 4 = 16 Target: 4 x 2 = 8		**Rationale for current score:** There is no immediate access to crash team/ICU facilities in in Parkway Clinic – the client group are undergoing G/A/sedation. Paediatric GA/Sedation services provided under contract from Parkway Clinic, Swansea continue due to lack of capacity for these patients to be accommodated in Secondary Care.	
Level of Control = 60%		**Rationale for target score:** Relocation of the paediatric GA service [provided by Parkway Clinic] to a hospital site being treated as a priority.	
Date added to the HB risk register 4th July 2018			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
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	**Action**	**Lead**	**Deadline**
	Transfer of services from Parkway.	Interim Head of Primary Care	31/05/2023
Assurances (How do we know if the things we are doing are having an impact?) RMC collate referral and treatment outcome data for review by Paediatric Specialist Regular clinical meeting arranged with Parkway to discuss individual cases/concerns Regular clinical/ management meeting for CDS/primary care management team to discuss service pathway /concerns/issues arising Roll out of new pathway to encompass urgent referrals T&F Group established to lead transfer from community centre to MHSDU.	**Gaps in assurance (What additional assurances should we seek?)** ToR for the task and finish group should continue to include consideration of the pressures on the POW special care dental GA list and this service is considered alongside any plans for the Parkway contract.		

Additional Comments / Progress Notes

30.01.23 Risk description updated to reflect risk surrounding the diagnosing clinician does not provide the care to the patient. No change to score at present.
20/04/2023 The current contract arrangements with Parkway will be extended for a further 12 months from June 2023.

Datix ID Number: 1605 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 63** **Risk Target Date: 30th June 2023**	**Current Risk Rating** **4 X 5 = 20**
Objective: Children, Young People & Maternity Services	**BAF Ref: 3.6**	**Director Lead**: Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality and Safety Committee	
Risk: Screening for Fetal Growth Assessment in line with Gap-Grow (G&G). There is not enough Ultrasound capacity within Swansea Bay UHB to offer all women serial ultrasound scan screening in the third trimester in line with the UK perinatal Institute Growth Assessment Programme (GAP). Welsh Government mandate fetal growth screening in line with the GAP programme, which states serial ultrasound growth scans should be performed at three weekly intervals and serial scans for all women who smoke. There is significant evidence of the increased risk for stillbirth or neonatal mortality/morbidity (hypoxic ischaemic encephalopathy (HIE)), where a fetus is growth restricted (IUGR) and/or small for gestational age fetus (SGA). SBUHB are also not screening for PAPP-A in accordance with recommendations from the Perinatal Institute.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 5 = 20 Target: 3 x 4 = 12		**Rationale for current score:** Current score of 20 is 4 (consequence) x 5 (likelihood). Consequence score of 4 calculated due to the governance and assurance – non-compliance with national standards with significant risk if unresolved and likelihood of 5 as expected to happen daily/>50%. The service group have introduced the scanning of all women who book their pregnancy and declare they smoke from January 2023. The service group advise the risk continues on the risk register as the service is unable to provide third trimester scans at three weekly intervals in line with the Perinatal Institute recommendations. Although the frequency of stillbirth is low the health board are up to 10% above the national rate for stillbirth as published by MBRRACE. Although infrequent when IUGR/SGA baby is stillborn or diagnosed hypoxic ischaemic encephalopathy (HIE) which is deemed avoidable this impacts on: • the wellbeing of families • can lead to high value claims • loss of reputation and adverse publicity for the health board.	
Level of Control = 60%			
Date added to the HB risk register 1st August 2019		**Rationale for target score:** When the service is able to provide third trimester ultrasound scan in line with GAP recommendations we will be providing care in line with evidence based best national practice as mandated by Welsh Government.	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
All staff are required to complete the GAP e-learning on an annual basis. Compliance is monitored via the Training & Education forum. Staff compliance was reported as 56% by the Perinatal Institute for 2022. For CPD Midwives to identify staff not compliant and escalate to the Deputy Head of Midwifery. To aim for improved compliance by 31st March 2023. A local policy is in place to identify the priority risk factors for the offer of serial growth scans while there is not enough capacity Health board maternity ultrasound group convened to develop future services Training 4 midwives for an advanced practice role in ultrasound scanning to reduce capacity gap. Three midwives have qualified as midwifery sonographers. One midwife sonographer continues training due to long term sickness. Introduction of midwife third trimester scan service will increase USS capacity by a minimum 2,200 scans per annum (50 scans per week/44 weeks) commencing April 2022	Compliance for GAP and Grow for Midwives for 2022 was 56% reported by the Perinatal institute. Midwives provided until 31/01/2023 to complete training. CPD Midwives to escalate those non-compliant with training to Deputy Head of Midwifery	CPD Midwives & Deputy Head of Midwifery	31/05/2023
	Business case to be completed to include administrative support for midwife sonographer clinics to be secured to ensure streamlined service	Maternity service business manager	31/05/2023

Two additional ultrasound rooms are fully equipped toward increased scan capacity The midwifery sonographer service has commenced third trimester scanning for all women who are smokers from January 2023. Lead sonographers created a governance process for the review of scan images of babies born with a birth weight centile under 10th centile to identify themes and trends within the department and areas for quality improvement			
Assurances (How do we know if the things we are doing are having an impact?) The third trimester ultrasound capacity will increase by a minimum 2200 scans per annum in year one increasing to 4400 in year 2. The detection rate of IUGR/SGA will increase leading to improved antenatal management plans and intrapartum planning. We will report a reduced rate of stillbirth and/or neonatal mortality/morbidity with improved management of IUGR/SGA babies. The administration support for the service will be fully functional. Lead Sonographers for Singleton and Neath and Lead Midwife sonographer have developed a governance review group to meet monthly to review all ultrasound scan images where there was a baby born under the 10th centile to identify themes and learning for quality improvement. The Midwifery sonographer service have commenced third trimester ultrasound scans for all women who smoke in Swansea Bay UHB as recommended by the Perinatal Institute	**Gaps in assurance (What additional assurances should we seek?)** Assurance of maintaining a sustainable third trimester ultrasound service. The provision of serial ultrasound scans on a three weekly schedule in accordance with the recommendations from the Perinatal Institute. (Currently the provision of serial ultrasound scans is provided on a four weekly schedule.)		
Additional Comments / Progress Notes 16/12/2022 – One trainee sonographer who commenced training in January 2022 is on long term sick and an extension for completion of training has been granted. One permanent midwife sonographer also long term sick. 14/02/2023 – The midwife sonographer service has commenced scanning all women who smoke in the third trimester. There continues to be sickness within the team, with one student midwife sonographer on long term sick and one qualified sonographer on maternity leave. GAP Grow training compliance for 2022 was extended to 31st January 2023, The Perinatal Institute recorded 56% of staff are compliant with the GAP Grow training package, Action created for CPD to escalate to the Deputy Head of Midwifery staff who are not compliant with GAP Grow training package to be supported in completing training by April 2023. 2 Actions completed - Complete the governance framework for third trimester scanning to include CPD programme. Two midwives to complete UWE course December 2022. (One student midwife sonographer remains outstanding as on long term sick, To continue training when returns to work). 25/04/2023 - CPD Midwives reported GAP Grow compliance as 58%. Escalated to Deputy Head of Midwifery. For action plan. Absence continues with one qualified midwife sonographer on maternity leave and one student midwife sonographer on long term sick. Successful completion of training of student midwife sonographer who joins team as qualified sonographer – therefore increasing capacity of team to current three qualified midwife sonographers providing the service. Development of governance meeting between midwifery sonographer service and radiology service to ensure the review of ultrasound images where ultrasound scans were performed which did not identify fetal growth under the 10th centile for audit and improvement.			

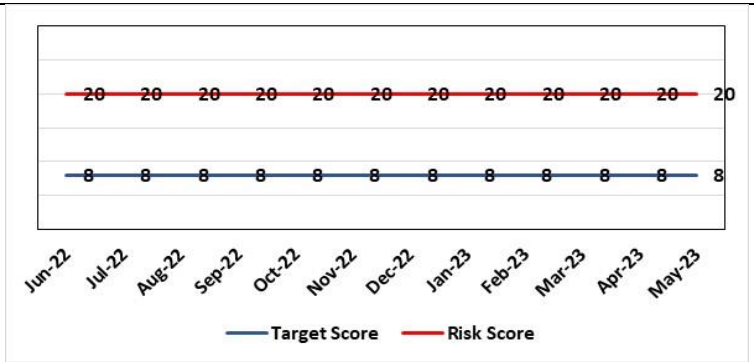
Datix ID Number: 2159 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**		**HBR Ref Number: 64** **Risk Target Date: 31st March 2024**	**Current Risk Rating** **4 X 4 = 16**
Objective: Delivering Care in Safe, Modern Environments	**BAF Ref: 7**	**Director Lead:** Darren Griffiths, Director of Finance & Performance **Assuring Committee:** Quality & 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:** May 2023	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 3 = 12		**Rationale for current score:** The Health Board received 12 Health & Safety Executive (HSE) improvement notices during 2019-20 covering various Health & Safety legislative breaches covering a range of areas. There is the potential for future multiple notices for not meeting legislative requirements. Score to be reduced to 16.	
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 and demonstrate that suitable resources are in place to undertake the roles and responsibilities of the department, and to undertake suitable and sufficient training, provide corporate overview/audit to ensure practices are being employed in the workplace.	
Date added to the HB risk register September 2019			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Assistant Director of Health and Safety in post to support strengthening and develop the H&S function to support the organisation. Business case submitted for additional resources. • Health and Safety Operational Group and the Health and Safety Committee monitor compliance. Refreshed the Fire Safety Group with additional controls in place. • Fire risk assessments are being prioritised with temporary additional resources put in place in March 2021 to reduce the number of FRA overdue. • Fire training in place and fire wardens in place • Fire risk assessment schedule in place for the next 12 months to maintain 100% compliance of completion and is regularly reviewed	It has been agreed to identify posts to progress recruitment on a phased approach over the next 12/24 months. This will be dependent upon availability of funding.	Assistant Director of H&S	31/03/2024

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
• Monitoring through the appropriate group/committees (H&S committee) to receive assurance and or identify gaps for key compliance and adherence to applicable legislation. • Site visits/tours to identify compliance and gaps in compliances.	Agreement of funding for resources identified in business case to implement structure in business case by Q2/3 2022/23 financial year.

Additional Comments / Progress Notes

13.12.22 – FSA post resignation reducing resources in fire, 1 MH and 1 H&S advisor to commence in Jan 23. Risk score to remain the same based on current information.
06.02.23 – H&S and MH posts commenced in January 2023 – one fire officer leaving end January 2023.
18.04.23 – Commenced recruitment process for Fire officer to be completed end June 2023. No change in current risk score.

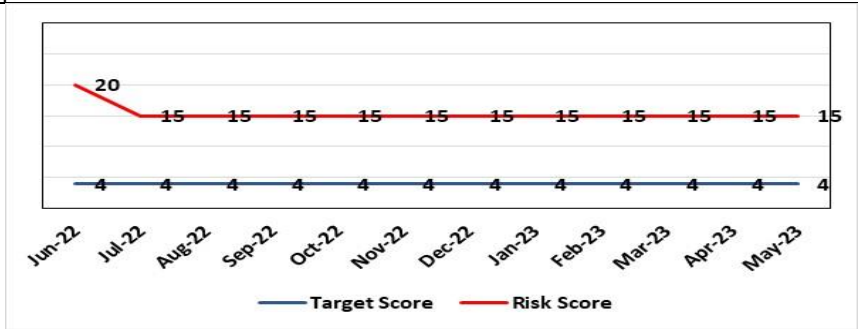
Datix ID Number: 329 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 65** **Risk Target Date: 30/04/2023**	**Current Risk Rating** **4 x 5 = 20**
Objective: Children, Young People & Maternity Services	**BAF Ref: 3.6**	**Director Lead**: Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality & Safety Committee	
Risk: Misinterpretation of cardiotocograph and failure to take appropriate action is a leading cause for poor outcomes in obstetric care leading to high value claims. The requirement to retain maternity records and CTG traces for 25 years leads to the fading/degradation of the paper trace and in some instances traces have been lost from records which makes defence of claims difficult.		**Date last reviewed:** May 2023 **Rationale for current score:** The K2 central monitoring system has been purchased by the health board however is not yet installed. A project team is being established to ensure oversight of installation and training. Full use of the system will be available from December 2022 when the risk will reduce as appropriate.	
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:** A central monitoring station will enable senior clinicians to support decision making across the service, and from home, leading to senior involvement in management decisions toward improved outcomes. All CTG traces will be stored electronically and therefore will not fade and cannot be lost.	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
All staff receive annual training in fetal surveillance as mandated by Welsh Government. SBU have appointed a midwife and obstetric lead for training and development of staff Compliance with training is reported annually in 2021/2022 the training year has been extended due to the service ability to release staff for training A "fresh eyes" protocol in place requiring intrapartum CTG classification hourly by two clinicians which is monitored via audit of records A "jump call" policy is available to request additional support where there is disagreement over CTG classification CTG prompt labels in use to support staff with CTG categorisation.	**Action**	**Lead**	**Deadline**
	Standing order of practices to be completed for implementation date of K2	Project Board	01/06/2023
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?)** Assurance all staff are able to transition to a new way of working		

Additional Comments / Progress Notes

19/12/2022 – Fetal surveillance midwife shortlisted, and interviews planned for 22/12/2022.
16/02/2023 – Fetal surveillance midwife secondment filled and in practice. Computerised CTG 'Super User' training undertaken 31st January and 1st February training key staff to become super users for implementation. End user training cannot be completed until the service receive alternative portals. At present the portals have been returned to Germany, awaiting update from manufacturer on date will be returned. At present, aiming for introduction of computerised CTG monitoring end of March 2023. Action complete - Arrange backfill for fetal surveillance midwife secondment to maintain training and reflections.

02/03/2023 - Meeting with K2 Board - Implementation date pushed back by K2 to end of March/beginning of April. Engineers attending Singleton site next week to update equipment - there have been delays in receiving packing to send equipment to K2 for work to be completed.
25/04/2023 - Further delays noted due to K2 and Digital Health Cymru Wales (DHCW). Due to National breech in WPAS with Patient details the DHCW are unable to prioritise Maternity's request for implementation of K2 therefore delayed implementation until start of July. Super user training was completed by staff in February 2023. In view of time elapsed between Super User training and predicted implementation date, training team created to provide in house training to staff. Screens were implemented in ward areas week commencing 24/04/2023. Aim for full implementation to K2 by July 2023. Two actions completed - For the project Board to complete a risk assessment to manage the changeover from paper based to electronic monitoring to ensure all risks are captured. Fetal Surveillance Midwife to complete clinical sign off of K2 system and changes.
12/05/2023 – Action complete - Fetal Surveillance Midwife to complete clinical sign off of K2 system and changes has been completed. Training team continues to provide training to all staff due to delay in time from Super User training sessions to implementation date. Implementation date delayed due to K2 unable to meet the deadline previous agreed.

Datix ID Number: 1834 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 66** **Risk Target Date: TBC**	**Current Risk Rating** **5 X 3 = 15**
Objective: Networked Hospital – A Systems Approach – Cancer Care	**BAF Ref: 3.5**	**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee:** Quality and Safety Committee	
Risk: The demand & complexity of planned treatment regime for cancer patients requiring chemotherapy currently exceed the available chair capacity, risking unacceptable delays in access to SACT treatment in Chemotherapy Day Unit with impact on targets and patient outcomes.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 3 = 15 Target: 2 x 2 = 4		**Rationale for current score:** Risk reduced to 15 (July) – last 3 months have now consistently delivered 100 additional patients per month via CDU.	
Level of Control =			
Date added to the HB risk register 30/11/2019		**Rationale for target score:** Reduced delays in treatment will reduce risk of harm.	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Review of CDU by improvement science practitioner was completed in 2020. Resulted in change to booking processes to streamline booking process and deferral. Review of scheduling by staff to ensure all chairs used appropriately. Business case endorsed by CEO for shift of capacity to home care to be considered by the Management Board A Daily scrutinizing process in progress to micro manage individual cases, deferrals etc	Relocation of SACT linked to AMSR programme and phase 2 of home care expansion case brought forward	Service Director Lead for Cancer	30th June 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?)**
Additional funding agreed to support increase in nurse establishment to appropriately staff the unit during its main opening hours. Additional scheduling staff also agreed. Pre-assessment process has been separated from start date in an attempt to fill deferral slots at short notice where possible. Improved communication between MDT to streamline booking and deferral process. Continue to monitor patient experience via friends and family in conjunction with the Welsh Cancer Patient Experience Survey results under our PTR procedures. Monitoring our waiting times against new SACT metrics, which is a measure based on treatment intent and is no longer reported as average waiting time so is more linked to expected outcomes etc. This performance metric is included in our Cancer Performance report we send to WG and Management Board and internally via governance arrangements with NPTSSG where Oncology services sit.	Capital & Revenue assumptions & resources for second business case for increasing chair capacity in 2022/23 to meet increased demand.

Additional Comments / Progress Notes

17.01.2023 - Weekly monitoring of the waiting times and breaches has been implemented.
December 2022 breaches have increased from 41 to 43 due to staffing deficits and Bank holidays; however, average waiting times continues to be 3 weeks
3 chairs have re-opened post-covid, increasing chair capacity further.
19.04.23 Relocation of CDU to main Singleton site in progress to provide 8 additional chairs. Working with pharmacy mitigating risks regarding their staffing constraints. Group pre-SACT assessments will commence May 2023 to further streamline SACT pathway. Breach data improved Jan-Feb 59% breached in Dec down to 29% in Feb.

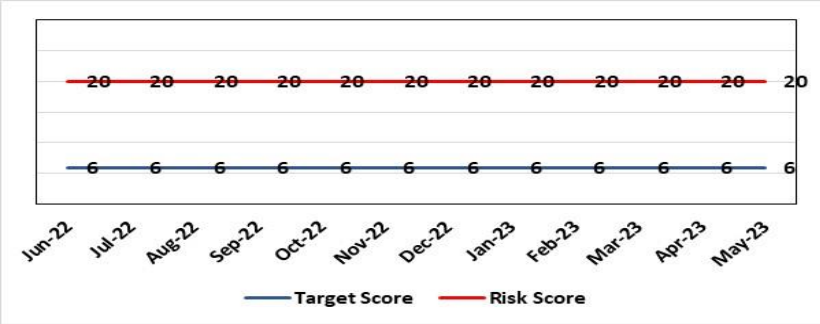
Datix ID Number: 89 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 67** **Risk Target Date: Subject to Review**	**Current Risk Rating** **5 X 3 = 15**
Objective: Networked Hospital – A Systems Approach – Cancer Care	**BAF Ref: 3.5**	**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee:** Quality and Safety Committee	
Risk: Clinical risk-target breaches in the provision of radical radiotherapy treatment. Due to capacity and demand issues the department is experiencing target breaches in the provision of radical radiotherapy treatment to patients.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 3 = 15 Target: 2 x 2 = 4		**Rationale for current score:** Waiting times deteriorating for elective delays patients, particularly prostates discussed in Oncology business meeting. Current Risk reduced to 15. At present 70 patients to be outsourced which increases capacity. New Linac building work underway, which will increase capacity in near future.	
Level of Control =			
Date added to the HB risk register 30/11/2019		**Rationale for target score:** Reduced delays in treatment will reduce risk of harm.	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
Capacity for treatment increased across the department with investment in Linac replacement programme. CT business case submitted for temporary weekend working to increase the capacity for CT scanning.	**Action**	**Lead**	**Deadline**
	New Linac required – Linac case agreed with WG	Service Manager Cancer Services	01/04/2023 (on track)
	Currently working on business case to increase CT and Pre Treat capacity by weekend working	Service Manager RT services	Qtr 2 23/24
	Business case for 2nd CT case (capital and revenue)	Service Manager RT services	End Qtr 3 23/24

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Performance and activity data is being monitored and monthly data shared with radiotherapy management meeting and cancer board. It is also now included in scorecard.	Performance and activity data monitored, but delays to treatment continue while sustainable solutions found. Performance for Scheduled and Urgent Symptom Control patients remains challenging with only 15% and 30% of patients now hitting the 21 day and 14 day targets

Additional Comments / Progress Notes

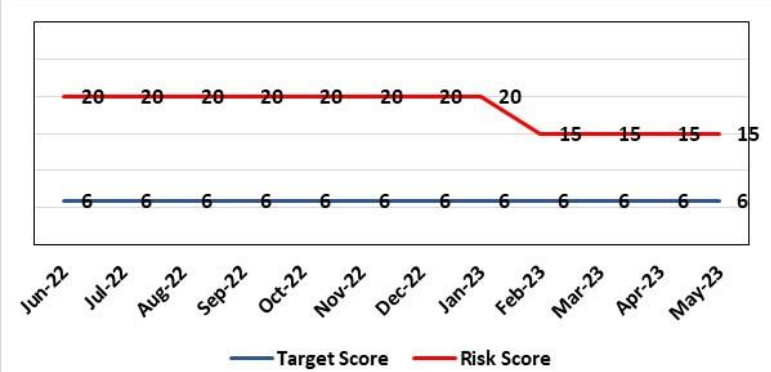
13/12/22 - Lin 5 work continues with no delays remain on track for increased capacity for start of Jan 23.
18/01/23 - Building work complete. Delivery of Linac 7.1.23. Commissioning has begun, clinical Summer 2023.
CT Capacity increases being explored through temporary weekend working/ new CT purchase.
15.03.23 – Looking at options around AI system to support planning pathway improvement.
19.04.23 – CT1 (old CT) not currently in use due to absence of maintenance contract.

Datix ID Number: 1418 **Health & Care Standard: 5.1 Timely Access**		**HBR Ref Number: 69** **Risk Target Date: 31/03/2023**	**Current Risk Rating** **5 X 4 = 20**
Objective: Children, Young People & Maternity Services	**BAF Ref: 3.6**	**Director Lead**: Deb Lewis, Chief Operating Officer / Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality & Safety Committee	
Risk: Risk issues related to **adolescent patients being admitted to Adult MH inpatient wards**- Inappropriate settings resulting in 'Safeguarding Issues' The WG has requested that HBs identify Secondary Care in -patient facilities for the care of adolescents- in Swansea Bay University Health Board Ward F NPT hospital is the dedicated receiving facility with one bed identified.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 2 x 3 = 6 Current:5 x 4 = 20 Target: 2 x 3 = 6		**Rationale for current score:** Every health board is required to have an admission facility for adolescent Mental Health patients. Whilst ward F has been identified as the single point of access in SBU and a dedicated bed is ring-fenced for adolescent admissions it is a mixed sex adult ward. Therefore the facilities are less than ideal for young patients in crisis.	
Level of Control =			
Date added to the HB risk register 27/02/2020		**Rationale for target score:** The longer term aim for the Health Board remains to create an admission facility for adolescent Mental Health patients.	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Safeguarding Training for Staff, Joint protocol with Cwm Taf LHB [CAMHS] currently subject to review, Local SBUHB policy on providing care to young people in this environment. This includes the requirement for all such patients on admission to be subject to Level 3 Safe and Supportive observations. Only Adolescents within 16-18 age range are admitted to the adult ward. The health board works with CAMHS to make sure that the length of stay is as short as possible.	Next service group review of effectiveness of current controls.	MH&LD Head of Operations & Clinical Directors	1st August 2023
Assurances (How do we know if the things we are doing are having an impact?) Individual Rooms with en Suite Facilities, Joint working with CAMHS, monitoring of staff training, Monitoring of admissions by the MH&LD SG legislative Committee of the Health Board. The ongoing issues with the risks presented by the use of this has recently been raised at an all Wales level with Welsh Government and a formal review is anticipated. The Service Group continues to flag the risk particularly in light of Ward F being identified as the SPOA for AMH in the Health Board which has resulted in an increase in acuity and a greater concentration of individuals who are experiencing the early crisis of admission - this has served to increase the already identified risks for young people in the environment.	**Gaps in assurance (What additional assurances should we seek?)**		

Additional Comments / Progress Notes

24/10/2022 – No change. Next review date assigned.

Datix ID Number: 2595 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 74** **Risk Target Date: Subject to Review**	**Current Risk Rating** **5 x 3 = 15**
Objective: Children, Young People & Maternity Services	**BAF Ref: 3.6**	**Director Lead**: Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality and Safety Committee	
Risk: Delay in Induction of Labour (IOL) or augmentation of Labour Delays in IOL can introduce avoidable risk and unnecessary intervention which can lead to poor clinical outcome for mother and/or baby. Delays in IOL lead to increased complaints and decreased patient satisfaction.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 3 = 15 Target: 2 x 3 = 6		**Rationale for current score:** Review of current score, reduced from 20 to 15. Rationale for change to score, the likelihood of the score has been assessed as 5 due to the likelihood of occurring daily/over 50% of the time. The consequence of the score is assessed as 3, moderate under governance and assurance, as treatment or service has significantly reduced effectiveness, risk of formal complaint and repeated failure to meet internal standards and 'red flags'. Delay in IOL is a frequent occurrence in maternity care. Delays can be for a number of reasons including high acuity, Maternity staffing levels and Neonatal staffing levels. All incidents for delays in IOL are linked to the risk register and reviewed for the level of harm the delay in IOL caused for the service user and unborn. While adverse outcomes as a result of delay in care are infrequent, there may be long term consequences for mother and/or baby leading to high value claims. The service group are completing work through Datix incident report to review the purpose of the delay (acuity, staffing, neonatal capacity) when reviewing incidents to have a better understanding of the factors which contribute impacting delays in IOL. The service group recommend this risk continues on the HBRR, as NICE guidance for IOL is changing with IOL being offered at an earlier gestation. This is likely to have an impact on the current score and risk for the service.	
Level of Control = 60%		**Rationale for target score:** IOL delays are minimal with increased patient flow, increased patient satisfaction and prevent avoidable poor outcomes	
Date added to the HB risk register 30th April 2021			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
IOL rate is static at around 30%. Maintain a maximum number of IOLs on a daily basis with emergency slot. Daily obstetric consultant ward round to review all women undergoing IOL. Ongoing/regular monitoring by cardiotocograph for fetal wellbeing during IOL on hold. Labour ward coordinator and labour ward obstetric lead ensure women on ward 19 for IOL are factored into daily planning of	Prepare midwifery workforce paper to present recommendation for future staffing levels in the obstetric unit to ensure adequate staffing each shift.	Deputy Head of Midwifery and Director of Nursing (Head of Midwifery to be	30/03/2023

workload on labour ward. Obstetric consultant review when IOL on hold for appropriate pan of care. The MDT (Obstetric, Neonatal and Midwifery) consider individual risk factors and Escalation Policy is implemented. Neighbouring maternity units are contacted to ask if they are able to support by accepting the transfer of women. Daily acuity is gathered and sent to the senior midwifery management team who can anticipate potential problems and support the clinical team. The matron of the unit is contacted in office hours and the senior midwife manager on call is contacted out of hours. If required midwifery staffing are redeployed including the specialist midwives and the community midwifery on call team.		appointed for interim)	
	Manage Critical midwifery Staffing (HBRR ref 81) to minimise disruption in IOL delay.	Deputy Head of Midwifery and Lead Midwife Governance	28/02/2023
	Review of the Maternity Escalation guideline to include escalation for Induction of Labour.	Lead Midwife Governance	30/03/2023
Assurances (How do we know if the things we are doing are having an impact?) There will be minimal delays in IOL. We will reduce the number of clinical incidents related to this risk. We will receive fewer complaints related to IOL as women's experience will be improved. We will not report avoidable harm related to IOL process.	**Gaps in assurance (What additional assurances should we seek?)** Workforce plan in preparation to include review of staffing on the Obstetric unit to reduce risk related to midwifery staffing and high acuity		

Additional Comments / Progress Notes

06/01/2023 - Head of Midwifery retired. Interim post released. Birthrate+ report received, to meet with team to finalise report as missing information regarding antenatal assessment unit admissions. Nursing Director supporting Senior team with future workforce plan.

16/02/2023 – Birthrate+ assessment completed. Senior Management team prioritising the midwifery workforce paper. Additional action for the review of the Maternity escalation guideline to include escalation for the delay of induction of labour. Maternity services have reviewed risk and reassessed as 15, however it is anticipated NICE guidance will recommend a change in the gestational age recommended for IOL. Therefore, the service group will need to review the risk following the published NICE guidance. Action completed - Complete Birthrate+ Cymru assessment for future workforce needs on the obstetric unit.

02/03/2023 - Escalation policy to include induction of labour - sent to Interim HOM for review. Antenatal ward manager appointed - advised the need to collate data regarding delayed IOL due to staffing or acuity. Senior team continue to work on workforce paper and BR+ - transformational midwife in post.

12/05/2023 - Incidents continue to be reported on a monthly basis. Escalation policy sent to senior management for review.

Datix ID Number: 2521 (& COV_Strategic_017) **Health & Care Standard:** 2.4 Infection Prevention and Control (IPC) and Decontamination		**HBR Ref Number: 78** **Risk Target Date: 31st March 2023**	**Current Risk Rating** **3 x 4 = 12**
Objective: Demonstrably Improved Quality, Safety & Reduced Harm	**BAF Ref: 1**	**Director Lead:** Richard Evans, Executive Medical Director **Assuring Committee:** Quality & Safety Committee	
Risk: Nosocomial transmission Nosocomial transmission of Covid-19 in hospitals could cause patient harm; increase staff absence and create wider system pressures (and potential for further harm) due to measures that will be required to control outbreaks.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 3 x 4 = 12 Target: 3 x 4 = 12		**Rationale for current score:** 11.08.2022 – Risk reduced to 12. Reasoning: (1) incidence reducing in the community (2) incidence reducing in hospital (3) current variants associated with low mortality in vaccinated population (4) communication to families to notify that cases which resulted in patients death (reported on the death certificate) are starting to be reviewed with a small number of cases reaching outcome stage, none so far resulting in legal / redress cases.(5) remains high priority work for all HBs and NHS Trusts.	
Level of Control = 40%		**Rationale for target score:** Measures in place will require regular review and scrutiny to ensure compliance. Levels of community incidence or transmission may change and the HB will need to respond. Vaccination programme on going but not complete.	
Date added to the HB risk register May 2021			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
A nosocomial framework has been developed to focus on: (a) prevention and (b) response. Preventative measures are in place including testing on admission, segregating positive, suspected and negative patients, reinforcing PPE requirements, and a focus on behaviours relating to physical distancing. As part of the response, measures have been enacted to oversee the management of outbreaks. Process established to review nosocomial deaths. Audit tools developed to support consistency checking in key areas re: PPE, physical distancing. Testing on admission dashboard in use. Further guidance on patient cohorting produced.	Following dissolution of Gold and Silver COVID command structures, the function of monitoring nosocomial spread and implementing preventative actions will be taken on by the IP&C committee.	Executive Medical Director & Deputy Director Transformation	Monthly ongoing
	Nosocomial Death Reviews using national toolkit. Need to ensure outcomes are reported to the HB Exec and Service Groups with lessons learnt	Executive Medical and Nursing Director	31/03/2024 Requires on going updates until conclusion of reviews
Assurances (How do we know if the things we are doing are having an impact?) Monitor Outbreaks throughout the HB / Review Nosocomial Deaths and lessons learnt	**Gaps in assurance (What additional assurances should we seek?)** Audit compliance of sustainable IPC practices and training compliance		

	Implement lessons learnt from outbreaks and death reviews.

Additional Comments / Progress Notes

The HB has started to contact families to notify them followed up by written information on the process.
Working with the DU to standardise processes within each HB.
Scrutiny Panels established and commenced in September to feedback lessons learnt to Service Groups and estimate level of harm.
Legal and Risk services have been involved in overseeing the process and are assured of the process.
Board updated on a regular basis with progress.
1.11.2022 – 667 cases under review so far with 15 reaching conclusion and moving to final letter / outcome with families.
Lessons learnt being shared throughout the HB. Scrutiny panels for complex cases and where harm is identified being established.
Process funded until March 2024, currently working on cases in wave one.
16.1.2023 - Pathway review completed with outcome letter to families agreed and responses now increasing with completion of wave 1 buy Wednesday, the number of investigations / responses need to double by April to match timelines to complete up to wave 4 cases.
Lessons learned through the review now has a clear feedback for relatives in the outcome letter, Q&S groups to feedback to service groups and exceptions via ICC up to Exex team.
Number of live cases in wave 5 are reaching their peak. ITU attendances remain low for COVID.
16/03/23 - Nosocomial COVID Mortality reviews continue, with weekly review of cases at MDT Scrutiny Panel.
Also reviewing cases from Waves 1-4 that are not deceased to review levels of harm.
Review progress reported monthly to NHS Wales Delivery Unit.
Contact with families of patients whose cases have been reviewed at Scrutiny Panel has commenced.

Datix ID Number: 1832 **Health & Care Standard: : 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 80** **Risk Target Date: 31/03/2024**	**Current Risk Rating** **4 x 5 = 20**
Objective: Networked Hospitals – A Systems Approach – Urgent & Emergency Care	**BAF Ref: 3.3**	**Director Lead:** Deb Lewis, Chief Operating Officer **Assuring Committee:** Quality & Safety Committee	
Risk: If the health board is unable to discharge clinically optimised patients there is a risk of harm to those patients as they will decompensate, and to those patients waiting for admission.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 2 = 8		**Rationale for current score:** • Sustained levels of clinically optimised patients (COPs) leading to overcrowding within ED, use of inappropriate or overuse of decant capacity in ED and delays in accessing medical bed capacity, clearly emerged as themes. • Constraints in relation to all patient flows out of Morriston to a more appropriate clinical setting, identified and included in an expanded risk. • Delay in discharge for clinically optimised patients can result in deterioration of their condition.	
Level of Control = 25%		**Rationale for target score:** Targeted reduction of Clinically Optimised patients remains a priority for the HB in order to minimise risk of avoidable harm to patients within the HB and in the wider community.	
Date added to the HB risk register May 2021			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Clinically optimised numbers are monitored and reviewed weekly by the MDU. Delays are reported and escalated to try to ensure timely progress along a patient's pathway. • Review on a patient by patient basis – with explicit action agreed in order to progress transfer to appropriate clinical setting. • Critical constricts in relation to access/time delays for social workers and assessment for package of care and social placement – lead times in excess of 5 weeks. • Patient COVID-19 status has added an additional level of complexity to decision making. • The health board has procured 63 additional care home beds to provide additional discharge capacity. • Clinically optimised patients have been cohorted into the available capacity at Singleton Hospital to ensure that their needs can be met more appropriately. This has reduced the number of COPs at Morriston Hospital. • Weekly escalation meetings are held with health and social service colleagues to ensure the requirements of the patients are reviewed and patients are pulled through the system where possible.	Proposal to go to Management Board in March 2023.	Senior Project Director	31/03/2023

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
• Patient level dashboard allows breakdown by delay type • Close management of utilization of additional care home beds	

Additional Comments / Progress Notes

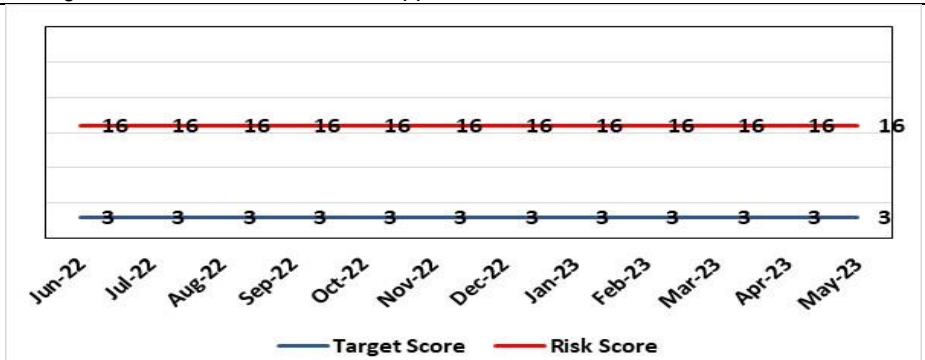
06/01/2023: Action complete: COO and Medical Director met with WAST MD to review current pathways into ED with aim to identify opportunities for admission avoidance. Health Board has received Welsh Government letter from Chief Medical Officer and Chief Nursing Officer with regarding to discharge arrangements and it has been circulated to all clinicians to aid decision-making. Action: Primary care group are looking at FNOF pathway and use of virtual wards to reduce length of stay – Started on a limited basis.
07/02/2023: Action completed: First meeting held of specific bed decommissioning programme to look at decommissioning of contingency beds at Singleton hospital.

Datix ID Number: 2788 **Health Care Standards: 7.1 Workforce**		**HBR Ref Number: 81** **Risk Target Date: 30th June 2023**	**Current Risk Rating** **5 x 5 = 25**
Objective: Children, Young People & Maternity Services	**BAF Ref: 3.6**	**Director Lead:** Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality & Safety Committee **For Information:** Workforce & OD Committee	
Risk: Critical staffing levels – Midwifery Vacancies and unplanned absences resulting from Covid-19 related sickness, alongside other long term absences including maternity leave, have resulted in critical staffing levels, which undermine the ability to maintain the full range of expected services safely, increasing the potential for harm, poor patient outcomes and/or choice of birthplace. Poor service quality or reduction in services could impact on organisational reputation.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 5 x 5 = 25 Target: 4 x 4 = 16		**Rationale for current score:** Pressure on staffing increased at the end of June 2022 as a result of increasing short term sickness, particularly COVID-19 related - 12.24wte midwives are absent due to COVID-19 which equates to 7.6% of the overall clinical midwifery workforce. Vacancies exist within the service however and two rounds of recruitment for Band 6 midwives have failed to fully appoint to the vacancies available. A third round of recruitment is progressing to interview stage. Some aspects of service provision have been suspended in order to ensure resource is best directed to support safe provision. Increased to 25.	
Level of Control = %		**Rationale for target score:** It is intended that through actions currently identified to address vacancies we can reinstate services fully and reduce the likelihood of the need to suspend elements further.	
Date added to the risk register 12/10/2021			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• All midwives are working at the hours they require up to full time. • Specialist midwives and management redeployed to support clinical care as required • Birth rate plus Intrapartum acuity tool completed 4 hourly to guide safe service provision and escalation; • Escalation meeting continues three times a week to review rotas and reallocate staff as required – this is Director led • Morning safety huddle for community midwifery teams • Additional shifts offered via Bank, additional hours and overtime • Utilisation of off-contract midwifery agency authorised by Executive Director of Nursing (from 24/06/2022) – prospective bookings in place to end of February 2023. • Six Graduate midwives employed October 2022 • Open advert for recruitment on TRAC • On-Call Manager Rota in place.	Review of the Maternity Escalation guideline to ensure robust processes in place if acuity is high or critical staffing. Guideline receiving comments following discussion in Maternity Quality and Safety.	Lead Midwife for Governance	01/06/2023

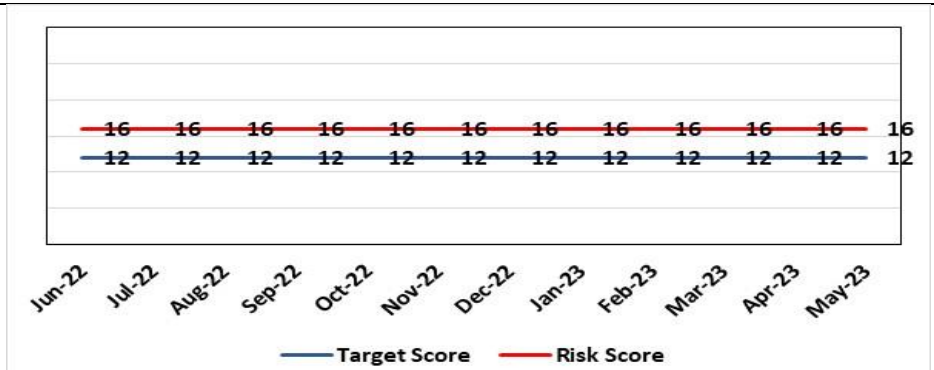
• Medical team support used when required. • Continue to suspend services in the FMU at NPT. • International recruitment campaign initiated with MEDACS. • Offer of additional support worker shifts particularly in the postnatal area for additional support for women • Maternity Care Assistance (MCA) role to increase support for Midwives in providing care in women and their families. • Appointment of a Transformational Midwife to support Senior Management team in workforce paper. • Appointment of a Band 5 service support manager to support ward managers with roster management. • Regular communication with stakeholders includes: Early warnings to Welsh Government; Verbal and formal communication with CHC; Internal communications on home births, RCM updates; weekly staff briefings and bulletins.			
Assurances (How do we know if the things we are doing are having an impact?) We will be able to maintain safe staffing rotas and women and families will receive safe and effective care wherever they chose to birth. We will report increased staff satisfaction. We will have a reduction in complaints to the service. we will have reduced sickness rates. We will be able to effectively support secondments for staff development without depleting the clinical service. Long term sickness and maternity leave will not impact on our ability to sustain staffing levels within the clinical areas. The following assurance mechanisms in place currently: Birth-rate Plus Intrapartum acuity tool completed 4 hourly Daily Director-led midwifery staff escalation meetings which considers sickness & other absences and daily review of safety and quality outcomes. The Group Head of Quality Safety & Risk is supporting daily oversight of Datix incidents (commenced July 2022). Red flag events are monitored and reported in accordance with NICE Guidance 2021: • Cancelled elective caesarean sections; • Missed or delayed care; • Delayed or cancelled induction of labour; • Delay of 2 hours or more between admission for induction of labour and beginning of process; • Delay of 30 minute or more between presentation and triage.	**Gaps in assurance (What additional assurances should we seek?)** Incorporate Birthrate+ Cymru required staffing levels when available. To restructure the management SIP for robust management and governance including succession planning for management roles in line with RCM recommendations Evidence has shown midwifery led intrapartum services have high value from reduced intervention rates and improved satisfaction/experience as well as financial benefits as births in midwifery led intrapartum care has lower financial cost to obstetric unit births. SBU are reporting an increase in the caesarean section rates year on year. The ability to recruit graduate midwives to the commissioned numbers.		
Additional Comments / Progress Notes 16/12/2022 – Recruitment to backfill secondments for Practice Development Midwife, Fetal Surveillance Midwife and for Interim Matron for community services undertaken in December 2022. The development of additional roles to assist with workforce including Band 5 Service support manager and Band 8a transformational workforce midwife fixed term for one year. Head of Midwifery retiring in January 2023. 16/02/2023 – Homebirth and FMU services remain suspended. Successful appointment of roles to assist with workforce, including Band 5 service support manager and Band 8a Transformational workforce midwife. Senior Management team to prioritise workforce paper. Vacancies for the role of Maternity Care Assistant have been advertised. Shortlisting currently ongoing prior to arranging interviews. Action complete - Review the role and capacity of the HCSW to maximise registered midwife capacity.			

19/04/2023 Transformation Board developed, weekly meetings commenced.
25/04/2023 - Maternity Care Assistants appointed and commence training May 2023. Transformational Midwives completed competency assessment in preparation for training.
April 2023- OCP being developed for proposed changes to community and obstetric models, following approval of workforce paper at management board. Two actions completed - Complete workforce paper with HR and finance to establish vacancy position and develop vacancy tracker going forward. Support for Cwm Taf secured to develop this. Presented at board on 3/05/23. Role of the Maternity Care Assistance developed and advertised. To shortlist applicants for interview.

Datix ID Number: 2554 **Health & Care Standard:** Standard 5.1 Timely Access		**HBR Ref Number: 82** **Risk Target Date: 1st December 2023**	**Current Risk Rating** **4 x 4 = 16**
Objective: Networked Hospitals – A Systems Approach – Urgent & Emergency Care	**BAF Ref: 3.3**	**Director Lead:** Richard Evans, Executive Medical Director **Assuring Committee**: Performance & Finance Committee **For Information**: Quality & Safety Committee, Workforce & OD Committee	
Risk: Risk of closure of Burns service if Burns Anaesthetic Consultant cover not sustained There is a risk that adequate Burns Consultant Anaesthetist cover will not be sustained, potentially resulting in closure to this regional service, harm to those patients would require access to it when closed and the associated reputational damage. This is caused by: • Significant reduction in Burns anaesthetic consultant numbers due to retirement and long-term sickness • Inability to recruit to substantive burns anaesthetic posts • The reliance on temporary cover by General intensive care consultants, and Consultants from the Morriston General on-call and Paediatric Anaesthesia rotas, to cover while building work is completed in order to co-locate the burns service on General ITU • Reliance on capital funding from Welsh Government to support the co-location of the service		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 4 = 16 Target: 3 x 1 = 3		**Rationale for current score:** This risk was increased due to closure of the Burns Unit due to staffing levels, and reduced from 25 to 20 having secured the agreement of the general ITU consultants to provide cross-cover while enabling capital works are completed. Propose reduce risk to 16 now and reduce to 12 when funding confirmed by WG.	
Level of Control =		**Rationale for target score:** This is a small clinical service with staff with highly specialised skills. While a small service may always be vulnerable to challenges (eg staff) the intention will be to operate a more resilient clinical model that is supported by other clinical groups.	
Date added to the HB risk register December 2021			

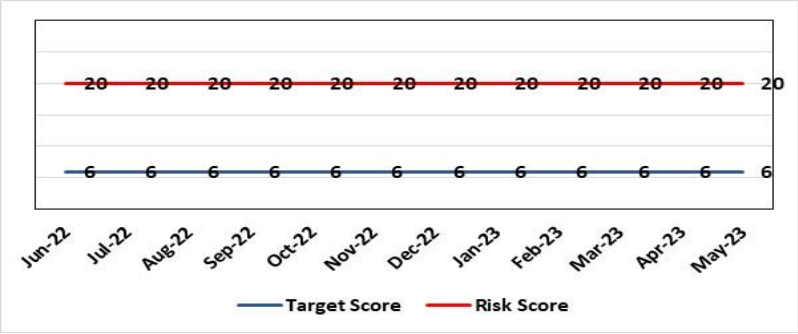
Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• The general ITU consultants, and some Consultants from the Morriston General and Paediatric Anaesthetists to support the Burns service on a temporary basis, supporting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

• WHSSC as commissioners of the service have been kept fully informed, as has the South West (UK) Regional Burns Network • Other UK burns units have ICU co-located with Burns ICU, removing the need for dual certified consultants			
Assurances (How do we know if the things we are doing are having an impact?) Effect on patients of the temporary closure of the burns service in Swansea is mitigated by maintaining an urgent assessment/stabilisation service for patients in Wales with severe burns, with onward transfer for inpatient care to another unit in the UK following the initial assessment. The service reopened fully on 14/02/2022.	**Gaps in assurance (What additional assurances should we seek?)**		
Additional Comments / Progress Notes 17.01.23 No change to consultant cover, which remains reliant on cross-cover from general critical care and anaesthetics. A business case for the strategic and capital investment of £7.3m has been completed and will be presented to the Board on the 26th January.			

Datix ID Number: 3036 **Health Care Standards: 4.1 Dignified Care, 2.1 Managing Risk & 7.1 Workforce**		**HBR Ref Number: 84** **Risk Target Date: Subject to Review**	**Current Risk Rating** **4 x 4 = 16**
Objective: Demonstrably Improved Quality, Safety & Reduced Harm	**BAF Ref: 1**	**Director Lead:** Richard Evans, Executive Medical Director **Assuring Committee:** Quality & Safety Committee	
Risk: Cardiac Surgery A Getting It Right First Time review identified concerns in respect of cardiac surgery (including patient pathway/process issues) that present risks to ensuring optimal outcomes for all patients. Potential consequences include the outlier status of the health board in respect of quality metrics, including mortality following mitral valve surgery and aortovascular surgery. This has resulted in escalation of the service by WHSSC.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 4 x 4 = 16 Target: 4 x 3 = 12		**Rationale for current score:** Service had previously been de-escalated by WHSSC from Stage 4 to Stage 3. While now de-escalated to Stage 2, score will remain pending full de-escalation. Assurance of processes in place through implementation of the improvement plan.	
Level of Control = %		**Rationale for target score:** Cardiac surgery is frequently high-risk surgery and an element of risk will remain.	
Date added to the risk register March 2022			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Invited Service Review by Royal College of Surgeons to advise on outcomes, good practice and areas for improvement; • Implementation of local action plan to address areas of concern; widespread engagement among clinicians in the department. • All surgery is now only undertaken by consultants and mitral valve repair surgery is undertaken by two mitral valve specialists; a third consultant undertakes mitral valve replacements as agreed with WHSSC. • Complex heart valve MDT established to make decisions on appropriate surgery including MV repair and MV replacement and to direct to the appropriate consultant. • Internal review of deaths following mitral valve surgery. • High Risk MDT implemented, outcome decision documented on Solus. • Dual surgeon operating mandated for complex cases (determined by the MDT) to improve outcomes. • MDT discussion to be undertaken for all patients who develop deep sternal wound infections. • Quality & Outcomes database established capture case outcome metrics in real time.	Develop actions for improvement as advised by RCS	Executive Medical Director	Complete
Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**		

• An improvement plan has been developed in conjunction with WHSSC and agreed. Progress is monitored by Gold Command arrangements. • Quality & Outcomes database established capture case outcome metrics.	Assurance sought via RCS Invited Review on outcomes and governance in the department
Additional Comments / Progress Notes 21/11/22 Report received from RCS and action plan developed. WHSSC acknowledge improvements and will consider de-escalation on receipt of the report. 17/01/22 WHSSC did not de-escalate in December 2022. Further information being provided by Executive Medical Director. 15/03/23: WHSSC have confirmed de-escalation to Stage 2.	

Datix ID Number: 2561 **Health & Care Standard: Effective Care 3.1 Safe & Clinically Effective Care**		**HBR Ref Number: 85** **Risk Target Date: 31st December 2023**	**Current Risk Rating** **4 x 5 = 20**
Objective: Children, Young People & Maternity Services	**BAF Ref: 3.6**	**Director Lead:** Christine Morrell, Director of Therapies & Health Sciences **Assuring Committee**: Quality & Safety Committee	
Risk: Non-Compliance with ALNET Act There are risks to the Health Board's ability to meet its statutory duties and establish the effective collaborative arrangements required by the ALN Act, which is being implemented through a phased approach. This risk is caused by: • Lack of staff resource needed to carry out the additional work needed to comply with the ALN Act for operational services, especially those in the PCST Service Group. The size of the gap in terms of staff resource is now better understood. • Issues around multi-agency working which may impact on levels of demand on operational services, and on existing SLAs through which the Health Board delivers some services to partner LAs. • Implementation of the Act for those of above compulsory school age (post-16) commences in September 2023, though transition planning will commence from September 2023. Significant preparedness work is required to mitigate the risks this will present. • Multiple pressures for operational services are impacting on capacity / engagement of leads within impacted services to progress tasks that need to be undertaken to mitigate the risks. • Issues with Data Quality due to pressure on ALN and Service administration teams and process issues. This means that accurate and up-to-date data regarding the Health Board's compliance is not available. Potential consequences of this risk are: parent / carer and young peoples' dissatisfaction leading to complaints, Educational Tribunals and Judicial Reviews (this is new legislation with many points of ambiguity and is highly likely to be legally 'tested'); reputational impact; and children failing to access the multi-agency support that they need with their learning needs, leading to poor outcomes.		**Date last reviewed:** May 2023 **Rationale for current score:** Risk score reflects that while controls are in place, there are multiple areas of risks (relating to compliance with legislation; governance and assurance; workforce and OD; and sustainable services); and high probability (especially given multiple risk areas) of at least one of these areas of risk being realised. Caused by implementation timetable for the ALN Act, slippage against plan and need for strengthened governance (as described in 'Risk' section).	
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 4 x 5 = 20 Target: 2 x 3 = 6		**Rationale for target score:** As the ALN Act is new legislation, there remains some ongoing likelihood of risk events during the initial phases of implementation, though with lessened consequences as a result of mitigating actions.	
Level of Control =			
Date added to the HB risk register 14/05/2022			

<table>
<tr><th colspan="2">Controls (What are we currently doing about the risk?)</th><th colspan="3">Mitigating actions (What more should we do?)</th></tr>
<tr><td colspan="2" rowspan="8">• Progressing the necessary work within an appropriate structure (see under 'ACTIONS') are constrained by financial and/or service delivery pressures.
• DECLO (Designated Educational Clinical Lead Officer) is in post - this is a statutory requirement.
• Health Board ALN Steering Group has been established, with structure agreed for Operational Group working under the governance of this
• Work is being progressed with Local Authority partners to ensure that activity relating to the ALN Act is grounded in a shared vision and principles to support collaborative working.
• Initial operational processes relating to statutory processes (through which Local Authorities access Health Board involvement) have been established and are in effect and work is being progressed with partners to refine operational approach.
• Advice has been received from WG to resolve key areas of particular ambiguity relating to Health Board duties under the Act.
• Regarding demand / capacity and staffing resource challenges, WG has a phased implementation timetable that has recently been extended from summer 2024 to summer 2025. From summer 2025, the Act will be fully in 'delivery as usual'. The phased implementation offers partial short-term mitigation of the risks.
• Awareness has been raised at Board level through Development session and thrice-yearly updates are provided to the Quality and Safety Committee.
• A multi-agency group supported by the national ALN post-16 Implementation Lead has been formed to progress key activity in relation to post-16 implementation.</td><td>Action</td><td>Lead</td><td>Deadline</td></tr>
<tr><td>Collaborative work with partners to ensure effective implementation of the Act for young people aged above 16, from September 2023.</td><td>DECLO</td><td>31/07/2023</td></tr>
<tr><td>Collaboratively with partner LAs review progress and establish ALN implementation priorities for 23/24 school year</td><td>DECLO</td><td>31/07/2023</td></tr>
<tr><td>Assess demand / capacity implications of the ALN for relevant operational children's services and produce business case if required</td><td>DECLO</td><td>31/12/2023</td></tr>
<tr><td>Work with Informatics colleagues to ensure robust data regarding compliance with statutory duties and that this is appropriately captured in HB dashboards.</td><td>DECLO</td><td>31/07/2023</td></tr>
<tr><td>Work with LA colleagues to establish future SLA arrangements for Paediatric Therapies services and to establish the impact of any changes on the Health Board.</td><td>Interim Head of Speech & Language</td><td>30/06/2023</td></tr>
<tr><td>Ensure continuation of ALN Project Management post.</td><td>DECLO</td><td>31/03/2023</td></tr>
<tr><td>Ensure a robust data capture infrastructure (for use by ALN and Service administration and clinical teams) to ensure data quality regarding the Health Board's compliance with the Act.</td><td>DECLO</td><td>31/07/2023</td></tr>
<tr><td colspan="3">Assurances (How do we know if the things we are doing are having an impact?)
• There is regular reporting in respect of the ALN Act through the Patient Safety and Compliance Group.
• ALN Steering Board has been established, ensuring oversight at a senior level within all impacted operational and corporate areas.
• DECLO meets regularly with ADOTHS / DoTHS of the 3 health boards of South-West and Mid Wales for update and assurance.
• National ALN Reform Steering Group has been formed and will include Health representation (SBU Deputy DOTHS). This will provide a national forum for consideration of risks.</td><td colspan="3">Gaps in assurance (What additional assurances should we seek?
• Extent of gap in staffing resource (gap between work required and capacity available) has been provisionally quantified, but data is imperfect and there remains some uncertainty. This is in a context where demands will increase significantly over the next year.</td></tr>
<tr><td colspan="5">Additional Comments / Progress Notes
24.01.2023 – Compliance against statutory requirements of the ALN Act remains poor, with the Health Board breaching its statutory duties in the majority of cases. Detailed ALN Project Plan has now been discussed and approved by ALN Steering Group on 24.01.2023. There is commitment to progress the workplan and that ownership of the different workstreams within the plan will be held by relevant operational leads. Work with Informatics continues to make good progress in developing accurate compliance data that is readily-visible to service leads. It is anticipated that</td></tr>
</table>

this will support improved performance. The ALN Project Management post is due to end in March 2023. If not extended, this will present significant risks to progress. Two actions closed - Finalise ALN work plan to be progressed by the ALN Operational Group, including allocation of leads to individual work streams and have plan approved through ALN Steering Group. Discussion in Steering Group to explore solutions to ongoing capacity / engagement issues that are slowing progress on tasks needed to mitigate risks.
31.03.2023 – Progress with the ALN Project Plan has improved in the last period, with a marked improvement in distributed leadership to move key work forward. Work is ongoing to secure continuation of Project Management support to help ensure that progress continues. The Health Board ALN Steering Group will be expanded to include Local Authority representatives moving forward, strengthening partnership working and shared governance arrangements. Good progress is being made regarding future SLA arrangements for Children's Therapies services, with work near completion with one Local Authority and with agreed timescales having shifted with the other Local Authority, resulting in slippage on dates. Work to conduct a detailed demand / capacity assessment of the ALN Act in operational services has been built into the IMTP. ALN GMOs with resource implications have been prioritised at 'Tier 2' level.
The Health Board's compliance with its statutory duties under the ALN Act remains poor, though data quality issues have been identified that need to be addressed. Work with Informatics colleagues is ongoing to ensure robust data is moving forward, though there has been slippage against timescales as complexities in this work have been identified.
24.04.2023 – The Project Manager post has been continued until March 2024 through the DoTHS office and a robust governance structure is in place, which provide tools for co-ordination of, and assurance on, progress. There is increased momentum within Health Board Services to fully understand the demand and capacity implications of ALN operationally. Key pieces of work which underpin compliance with the Act are being progressed in partnership with Local Authority colleagues. Issues with data quality have been identified and escalated, and a course of action has been planned with support from Health Board's Informatics colleagues.

Datix ID Number: 3100 **Health Care Standards: 4.1 Dignified Care, 2.1 Managing Risk & 7.1 Workforce**		**HBR Ref Number: 88** **Target Risk Date: 31/03/2023**	**Current Risk Rating** **4 x 5 = 20**
Objective: Networked Hospitals – A Systems Approach – Urgent & Emergency Care	**BAF Ref: 3.3**	**Director Lead:** Deb Lewis, Chief Operating Officer **Assuring Committee:** Performance & Finance Committee **For Information:** Quality & Safety Committee	
Risk: Non-delivery of AMSR programme benefits There is a risk that the Acute Medical Service Re-Design (AMSR) programme may not deliver the expected performance & financial benefits in a timely way. The principal potential causes of this risk are: workforce (OCP and recruitment requirements), capacity constraints linked to significant number of clinically optimised patients (COP), financial affordability linked to 90 beds in Singleton hospital that are due to close in Q3 2023.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 4 = 16		**Rationale for current score:** Current score reflects the size and complexity of the programme. Whilst partial benefits of the programme have been realised, operational performance fluctuates mainly due to continuous high numbers of clinically optimised patients (See risk HBR80). Sustained improvement needs to be experienced prior to reduction in score.	
Level of Control = %		**Rationale for target score:** When measures identified are implemented it is anticipated that this will increase the likelihood of success.	
Date added to the risk register July 2022			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• AMSR Programme Board reporting to UEC (Urgent & Emergency Care) Board • Dedicated workstreams & workstream leads – all work streams have weekly assurance meetings where the sub groups provide updates on their specific tasks • OCP (Organisational Change Policy) workstream – supporting staff engagement • Workforce workstream – Focus on recruitment & retention. Dedicated sub groups with recruitment trackers and action plans. • AMU (Acute Medical Unit) model workstream - focus on development of the operating policy for the AMU, including the interaction with the admitting units, WAST and specialist wards. Triage process has been agreed – system same as Emergency Department. Draft Standard Operating Procedure (SOP) created. • SDEC (Same Day Emergency Care) collaborative workstream – focus on further development of SDEC model. SOP developed, focusing on hospital pre admission, data sessions to assist with finalising pathways. • Specialist wards workstream – focus on role & operating model of specialist wards and interfaces. Agreement on patient criteria with preference of sub-acute /round rounds for singleton wards/ SOP	The costs of service transfer will be met through transformation of out of hospital pathways. Should savings not be fully identified, by December 2022, there will be an increased CIP commitment in 2023/24. Review to be undertaken in December 2022. A dedicated project to decommission contingency beds to commence in January 2023 with envisaged completion date of end September 2023. Progress to be reviewed at halfway point in May 2023.	Senior Project Director	31/05/2023
	External post-implementation review by	COO	31/03/2023

template for all wards. Future – dedicated sub group on Discharge and flow hosting a work shop to standardise process across the health board & internal flow from Morriston to Singleton and Neath. • Estates workstream focus on capital work. • Communications – Project team have employed Freshwater to assist with communications for the programme. Focusing on shop floor communication across all hospitals with use of storyboards and TV screens providing updates at main entrances. • Governance arrangements agreed for go / no go gateways via management board • Assurance to Performance & Finance Committee (PFC) and (Quality & Safety Committee (QSC) and escalation to Health Board if required.	Meridian planned to commence in February. Feedback planned for the beginning of March 2023.		
Assurances (How do we know if the things we are doing are having an impact?) Regular gateway reviews via Management Board Assurance to PFC and QSC and escalation to Health Board if required.	**Gaps in assurance (What additional assurances should we seek?)** Capacity and capability gaps to support the programme and drive forward actions and provide adequate assurance. Operational site pressures impacting on AMSR programme deliverables. Lack of progress in reducing bed occupancy for medicine patients.		
Additional Comments / Progress Notes 06/01/2023: Action complete - A go/no go gateway for AMSR was scheduled for 16th November 2022 - Decision was Go and phase 1 implemented on 5th December. Additional go/no go review happened in extraordinary Management Board on 4th January with decision to proceed with 2nd phase of AMSR – Phase 2 commenced. 07/02/2023 – Action completed - Full centralisation of acute medical take at Morriston hospital. 3rd Go/No Go meeting of Management Board on 18/01/2023 for final 3rd phase of AMSR. Since then implementation has concluded as planned.			

Datix ID Number: 3071 **Health Care Standards: 4.1 Dignified Care, 2.1 Managing Risk & 7.1 Workforce**		**HBR Ref Number: 89** **Target Risk Date: 31/03/2023**	**Current Risk Rating** **4 x 5 = 20**
Objective: Primary & Community Care	**BAF Ref: 3.1**	**Director Lead:** Gareth Howells, Executive Director of Nursing (lead) / Deb Lewis, Chief Operating Officer (support) **Assuring Committee:** Quality & Safety Committee	
Risk: Healthcare Nursing Staff Levels at HMP Swansea There is a risk that the men in HMP Swansea will not receive the appropriate standard of care. This is due to the fact that the nursing establishment within the prison no longer fully meets the changed demographics and numbers of men being detained. The maximum operational capacity of the Prison can reach circa 480 men. The Health Board investment into the Prison is based on delivering services to 250 men. This was also highlighted as a risk in the recent HIW governance review.		**Date last reviewed:** May 2023	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 2 x 2 = 4		**Rationale for current score:** Consequence major – unable to fully deliver on the recommendations of HIW due to low healthcare staffing numbers, further impacted during periods of sickness or absence as no headroom. Likelihood expected – suboptimal care provided on a daily basis.	
Level of Control = %		**Rationale for target score:** Consequence minor – With sufficient staffing numbers the prison will be able to deliver on HIW recommendations and fully implement the actions in the Health Delivery Plan. Likelihood unlikely – With full establishment and headroom, suboptimal care is less likely.	
Date added to the risk register 30/11/2022			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Daily communication with the Governor about the availability and priority of healthcare nursing staff. The prison regime may be amended to reflect numbers. Review of skill mix and Health Board policy: • Introduction of a pharmacy technician role who can administer drugs to support nursing establishment. • Training Health Care Support Workers to be 2nd checkers for CD drugs. The Health care charges can only focus on clinical aspects, performance, assurance and health promotion work is not prioritised. Bank and agency staff are used in a limited way, when skillset allows. E-rosta implemented and scrutinised with regular reporting to Quality and Safety and Prison Partnership Board. Escalation for overtime and additional hours to fill shortfalls. Short term, PCTG has identified up to £100k non recurrent money, until the 31st March to increase recruitment	Undertaking financial exercise to identify £100k across the group to support the nursing establishment uplift.	Deputy Group Nursing Director	Complete (for 2022/23 year)
	Business case developed included in IMTP and representation made to WG and HB for additional funding.	Head of Nursing & Community Services	03/04/2023
	Through Prison Partnership Board exploring opportunities to implement the recommendations of HIW and Health Delivery Plan.	Deputy Group Nursing Director	31/03/2023

in the highest risk areas and to fund absence as there is no 'head room' built into the funding to provide absence cover. This non recurrent funding ceases on 1st April 2023 and has been highlighted to the executive.			
Assurances (How do we know if the things we are doing are having an impact?) Prison feedback and complaint process Progress reporting on action plans through Health Board Q&S structures.	**Gaps in assurance (What additional assurances should we seek?)** Implementation and reporting of clinical audits. Audit framework for HMP Swansea in development.		
Additional Comments Jan 2023: Action Complete: *Undertaking financial exercise to identify £100k across the group to support the nursing establishment uplift.* The health board has approached the WG to seek additional funding for the prison. Short term, PCTG has identified up to £100k non recurrent money, until the 31st March to increase recruitment in the highest risk areas and to fund absence as there is no 'head room' built into the funding to provide absence cover. 26.02.2023 update (DON): This non recurrent funding ceases on 1st April 2023 and has been highlighted to the executive and the Service Delivery group has been tasked to work with finance colleagues to identify a way and actions of closing this short fall – completion date – April 2023. 14.04.2023: As a result of the loss of funding to support 1x Band 5 Uplift to Band 6 and 2 x Band 3 HCSW there is a risk that: The additional leadership provided and cover during weekends to the core team will be lost, which leaves the staff group and the PCTSG group vulnerable in the event of Death in Custody Capacity to undertake PDAR, Supervision and day to day charge duties by this role would also be lost The Health Promotion interventions highlighted as being needed within the HIW action plan would be a specific area of leadership for this role and this would also be lost which would mean the Health Care and Well Being Plan would falter and the recommendations not realised Risks related to losing the two Band 3 HCSW posts: The band 3 HCSW's are part of the Prison cover on the night shifts – Loss of these roles will revert back to a position where the registered nurse will on occasions have to work alone which was a criticism in one of the DIC and renders the sole registrant professionally vulnerable Loss of the band 3 HCSW's would impact on the action to address a DIC action whereby it was noted that although the nursing team conduct night time observations, there was little day time observation of new arrivals and those in withdrawal, aside from the prisoners attending the medication hatch at breakfast and tea time. The HCSW roles allow for mid-day wing face-to-face wellbeing checks to support those adjusting to substance or alcohol withdrawal or with low mood. In addition the loss would mean that capacity to support the daily checking requirements in the segregation / vulnerable prisoner unit, which is a risk and exposes the men, Prison and Health Board to criticism in the event of a further DIC Support to undertake Controlled Drugs checking would be lost and CD compliance impacted over and above what the pharmacy technician could provide. In addition controlled medication administration on G wing would have to cease which is contrary to the requirements of the men and the Prison and was one of the reasons HIW raised the nursing establishment issue The HCSW frees up the second registrant on D wing so the staff can provide a better service to the reception area, where new men are screened and real focus on identifying those likely to self harm is required. Again in the event of a DIC this paucity of workforce will be a consideration			

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