Meeting Date	**27 June 2023**	**Agenda Item**	**7.1**
Report Title	**Risk Management Report – Quality & Safety Risks**		
Report Author	Neil Thomas, Assistant Head of Risk & Assurance		
Report Sponsor	Hazel Lloyd, Interim Director of Corporate Governance Gareth Howells, Executive Director of Nursing		
Presented by	Hazel Lloyd, Interim Director of Corporate Governance		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to inform the Quality & Safety Committee (QSC) of the risks from the Health Board Risk Register (HBRR) assigned to the Quality & Safety Committee.		
Key Issues	• The QSC last received the January 2023 HBRR extract at its February 2023 meeting. This report presents the May 2023 HBRR extract. • Twenty risks are assigned to the Quality & Safety Committee for oversight. • Fifteen of these are assessed to meet or exceed the Board's risk appetite threshold. • Seven further risks are included in the register extract for information, but are overseen by other committees.		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐
Recommendations	Members are asked to: • **NOTE** the updates to the Health Board Risk Register (HBRR) relating to risks assigned to the Quality & Safety Committee. • **CONSIDER** the risks assigned to the Quality & Safety Committee, in particular those exceeding the Health Board's risk appetite. • **CONSIDER** whether the Committee work plan and agenda include sufficient information to provide assurance regarding the ongoing management of these risks.		

RISK MANAGEMENT REPORT – QUALITY & SAFETY RISKS

1. INTRODUCTION

The purpose of this report is to inform the Quality & Safety Committee of the risks from the Health Board Risk Register (HBRR) assigned to the Quality & Safety Committee for scrutiny.

2. BACKGROUND

2.1 Risk Management Framework

The Audit Committee is responsible for reviewing the establishment and maintenance of an effective system of risk management and providing assurance to the Board in that respect. While this is the case, individual risks have been assigned to other Board committees for more detailed scrutiny and assurance. The intention is that committee work programmes are aligned so that progress made to address key risks is reviewed in depth. Regular HBRR update reports are submitted to the Board and the committees of the Board to support this.

Executive Directors are responsible for managing risk within their area of responsibility. The Management Board, chaired by the Chief Executive, oversees the overall operation of the risk management framework and the management of risks within the health board risk register.

Risk Register management is supported by a Risk Management Group (RMG) which meets quarterly and is responsible for overseeing the operational management of risk, ensuring local systems and processes are in place and are operating effectively to ensure appropriate reporting and escalation. The Group last met in May 2023.

Additionally, a Risk Scrutiny Panel is responsible for ensuring there is an appropriate and robust risk management system in place and working throughout the organisation. It is responsible for moderating new risks and risks escalated to the Health Board Risk Register (HBRR) and Board Assurance Framework (BAF) and recommending and advising the Management Board on the escalation and de-escalation of risks. The Panel last met in May 2023.

2.2 Risk Appetite

The health board approved a risk appetite statement in November 2022, setting out the level of risk the Board is prepared to accept in pursuit of its objectives, according to the categorization of risk. In the context of the financial challenges facing the Health Board, the risk appetite adopted for most risk categories is described as ‘seeking’, indicating that risks assessed to be at or above a risk level of 20 will be overseen by the committees of the Board as a minimum on a quarterly basis. However, for the category of compliance risks where the risk relates to laws, regulations and standards directing the delivery of safe, high quality care, or the health and safety of the staff and public, an ‘open’ appetite will be adopted, indicating lower threshold and requiring risks scoring 16 or above to be overseen at committee level.

2.3 Health Board Risk Register (HBRR)

The Health Board Risk Register (HBRR) is intended to summarise the greatest organisational risks facing the Health Board and the actions being taken to mitigate them.

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

3. MANAGEMENT OF QUALITY & SAFETY RISKS

3.1 Action to Update the HBRR

Health Board risk register entries are circulated to lead Executive Directors monthly for review and updated where required. A consolidated, updated register is circulated to the Executive Team for agreement and final version issued. The report presents the risks as recorded in the May 2023 HBRR – the relevant risk extracts are attached at **Appendix 1**. Key changes made in the most recent monthly update are highlighted in red font.

3.2 HBRR Quality & Safety Risks

Twenty risks are assigned to the Quality & Safety Committee for oversight (an increase of four since the register was last received). This is due to the transfer of three risks to the Committee following the standing down of the former Health & Safety Committee (H&SC), and a further single risk transferred from the Audit Committee. Of the twenty risks, two risk scores have been increased and two have been reduced.

The profile of risk scores for these risks is as follows:

Risk Score	**12 & below**	**15**	**16**	**20**	**25**
Number of Risks	2	3	5	9	1

Section 2.2 above indicated the risk level thresholds associated with the health board risk appetite statement approved in November 2022. There are 15 risks currently meeting or exceeding the Health Board's appetite thresholds, for which action is required so that they may be reduced to acceptable levels. Table 1 below highlights recent changes / actions of note since the last meeting of the Committee for those risks that are currently meeting or exceeding the thresholds. The Committee should consider whether its work plan and agenda includes sufficient information to provide assurance regarding the ongoing management of these risks:

Table 1: HBRR risks assigned to the QSC which meet or exceed the risk appetite threshold

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
4 (739)	**Infection Control** Risk of patients acquiring infection as a	20	Executive Director of Nursing	The risk score currently remains unchanged.

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
	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.			Ongoing action dates changed to 31/03/24. 10/05/2023 Update: Action completed: Development of a ward to board Dashboard on key Tier 1 infections. Two new actions: Maintain National Standards of Cleanliness compliance >95%. (Target 31/03/24.) Develop a proactive schedule of IPC-related audit for Service Groups wards & services, and for IPC team. (Target 31/03/24.) Progress update on 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).
13 (841)	**H&S Compliance: Environment of Premises** Risk of failure to meet statutory health and safety requirements.	16	Director of Finance	Risk added following standing down of H&SC. Update 19/04/23: PCT Service Group have agreed to pilot recommended structures to support the estate at Cimla, this will commence May/June 2023. A Task & Finish Group was established to further develop Estates Strategy with a target of submitting a final, scrutinised Strategy to the Board in May 2023 *(Estates Strategy was*

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
				submitted to the Board in May 2023). Actions: A review is currently taking place of current PCT structures and governance arrangements for estates and H&S to cover key compliances and escalation processes. (Target 30/06/23.)
41 (1567)	**Fire Safety Compliance** Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations.	16	Director of Finance	Risk added following the standing down of H&SC. Update 18/04/23: Cladding programme monitored through cladding project board and remains on target for completion March 2024. Actions: Change in fire evacuation plans and alarm and detection cause and effect. (Target 01/11/23.) Replacing the existing cladding and insulation with alternative specifications and inserting 30 minute fire cavity barriers where appropriate. (Target 28/02/24.)
43 (1514)	**Deprivation of Liberty Safeguards (DoLS)** Due to a lack of Best Interest Assessor resource, there is a risk of failure to complete and authorise the assessments associated with Deprivation of Liberty/Liberty Protection Safeguards within the legally required timescales, exposing the health board to potential legal	20	Executive Director of Nursing	Risk score increased from 15 to 20 in February. Update 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. Two WTE band 6 Best Interest Assessors (BIA) have commenced and undertaken BIA training. Additional reoccurring funds

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
	challenge and reputational damage.			are to be made available by Welsh Government to strengthen Mental Capacity Act (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). Ongoing Action: Overtime/additional hours agreed to fund. Sign off from nurse assessor team to process the backlog assessments.
58 (146)	**Ophthalmology - Excellent Patient Outcomes** Risk of failure to provide adequate clinic capacity for follow-up patients in Ophthalmology results in a delay in treatment and potential risk of sight loss.	16	Chief Operating Officer	The risk score currently remains unchanged. Update 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. Update 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. Action: An overall Regional Sustainability Plan to be delivered (Target 31/10/23)

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
61 (1587)	**Paediatric Dental GA Service – Parkway** Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morriston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies.	16	Chief Operating Officer	The risk score currently remains unchanged. Update 20/04/2023: The current contract arrangements with Parkway will be extended for a further 12 months from June 2023.
63 (1605)	**Screening for Fetal Growth Assessment in line with Gap-Grow** There is not enough Ultrasound capacity within Swansea Bay UHB to offer all women serial ultrasound scan screening in the third trimester in line with the UK perinatal Institute Growth Assessment Programme (GAP). Welsh Government mandate fetal growth screening in line with the GAP programme. There is significant evidence of the increased risk for stillbirth or neonatal mortality/morbidity (hypoxic ischaemic encephalopathy (HIE)), where a fetus is growth restricted (IUGR) and/or small for gestational age fetus (SGA). Identification and appropriate management for IUGR/SGA in pregnancy will lead to improved outcomes for babies.	20	Executive Director of Nursing	Risk score increased from 16 to 20 in February. Update 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. Additional Actions: CPD Midwives to escalate those Midwives non-compliant with training to

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
				Deputy Head of Midwifery (Target 31/05/23) Business case to be completed to include administrative support for midwife sonographer clinics to be secured to ensure streamlined service (Target 31/05/23)
64 (2159)	**Health and Safety Infrastructure** Insufficient resource and capacity of the health, safety and fire function to maintain legislative and regulatory compliance.	20	Director of Finance	Risk added following the standing down of H&SC. Update 06/02/23: H&S and Manual Handling posts commenced in January 2023. One fire officer left end January 2023. Update 18/04/23: Commenced recruitment process for fire officer – to be completed end June 2023. No change in current risk score. Action: 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. (Target 31/03/24.)
65 (329)	**CTG Monitoring on Labour Wards** Misinterpretation of cardiotocograph and failure to take appropriate action is a leading cause for poor outcomes in obstetric care leading to high value claims. 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	20	Executive Director of Nursing	The risk score currently remains unchanged. Update 02/03/2023: Meeting with K2 (system provider) 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. Update 25/04/2023:

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
	records which makes defence of claims difficult.			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. Aiming for full implementation to K2 by July 2023. Actions completed: Project Board completion of a risk assessment to manage the changeover from paper based to electronic monitoring to ensure all risks are captured. Fetal Surveillance Midwife clinical sign off of K2 system and changes has been completed.
69 (1418)	**Safeguarding** Adolescents being admitted to adult MH wards resulting in potential safeguarding issues	20	Chief Operating Officer / Executive Director of Nursing	The risk score currently remains unchanged. The target score reflects the long term aim of the health board to create an admission facility for adolescent mental health patients. Action: Next service group review of effectiveness of current controls. (Target 01/08/23)

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
80 (1832)	**Discharge of Clinically Optimised Patients** If the health board is unable to discharge clinically optimised patients there is a risk of harm to those patients as they will decompensate, and to those patients waiting for admission.	20	Chief Operating Officer	The risk score currently remains unchanged. Update: 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. Consideration being given to further proposals for Management Board. Action completed: First meeting held of specific bed decommissioning programme to look at decommissioning of contingency beds at Singleton hospital.
81 (2788)	**Critical staffing levels – Midwifery:** Midwifery absence rates are outside of 26.9% uplift leading to difficulty in maintaining midwifery rotas in the hospital and community setting.	25	Executive Director of Nursing	The risk score currently remains unchanged. Update 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. Action complete: Review of the role and capacity of the HCSW to maximise registered midwife capacity. Update 19/04/2023: Transformation Board developed, weekly meetings commenced.

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
				Update 25/04/2023: Maternity Care Assistants appointed and commence training May 2023. Transformational Midwives completed competency assessment in preparation for training. OCP being developed for proposed changes to community and obstetric models, following approval of workforce paper at management board. Actions completed: Workforce paper completed 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 03/05/23. Further action: 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. (Target 01/06/23)
84 (3036)	**Cardiac Surgery – A Getting It Right First Time (GIRFT)** The GIRFT 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,	16	Executive Medical Director	The risk score currently remains unchanged. Update 15/03/23: WHSSC have confirmed de-escalation to Stage 2. Action complete: Development of actions for improvement as advised by Royal College of Surgeons.

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
	including mortality following mitral valve surgery and aortovascular surgery. This has resulted in escalation of the service by WHSSC.			
85 (2561)	**Non-Compliance with ALNET (Additional Learning Needs & Education Tribunal) Act** There are risks to the Health Board's ability to meet its statutory duties and establish the effective collaborative arrangements required by the ALNET Act, which is being implemented through a phased approach.	20	Director of Therapies & Health Sciences	The risk score currently remains unchanged. Update 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. Actions (targets refreshed): • Collaborative work with partners to ensure effective implementation of the Act for young people aged above 16, from September 2023. (Target 31/07/23) • Collaboratively with partner LAs review progress and establish ALN implementation priorities for 23/24 school year. (Target 31/07/23) • Assess demand / capacity implications of the ALN for relevant operational

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
				children's services and produce business case if required. (Target 31/12/2023) • Work with Informatics colleagues to ensure robust data regarding compliance with statutory duties and that this is appropriately captured in HB dashboards. (Target 31/07/23) • 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. (Target 30/06/23) • 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. (Target 31/07/23)
89 (3071)	**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	20	Executive Director of Nursing	The risk score currently remains unchanged. Update 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 (DIC). Capacity to undertake PADR, 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

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
	risk in the recent HIW governance review.			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 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

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
				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. Actions: Business case developed and included in IMTP, and representation made to WG and HB for additional funding. Through Prison Partnership Board exploring opportunities to implement the recommendations of HIW and Health Delivery Plan.

Table 2 below lists additional risks assigned to the Quality & Safety Committee whose risk levels do not meet the threshold currently set within the Health Board's risk appetite. However, when the appetite was agreed in November 2022, it was the Board's aspiration that thresholds could be reduced in the future. In view of this, these risks are presented for information:

Table 2: HBRR risks assigned to the QSC that do not currently meet the risk appetite threshold

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
57 (1799)	**Non-compliance with Home Office (HO) Controlled Drug (CD) Licensing requirements.** The Health Board (HB) currently has limited assurance regarding compliance with HO CD Licensing	12	Director of Corporate Governance	Risk score reduced from 16 to 12 in February. Update 04/04/23: Corporate Governance team exploring options that could provide a control system to ensure ongoing compliance with HO CD license requirements. Controlled

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
	requirements, nor does it have processes in place in respect of future service change compliance			Drug Accountable Officer (CDAO) continuing to work with the Director of Corporate Governance to complete review of Home Office Controlled Drug Licence requirements by the Health Board. Several notices of compliance visits received from the Home Office in response to recent CD license applications.
66 (1834)	**Access to Cancer Services** Delays in access to SACT (Systemic Anti-Cancer Therapy) treatment in Chemotherapy Day Unit	15	Executive Medical Director	The risk score currently remains unchanged. Update 09/04/23: Relocation of Clinical Decision Unit (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. Action: Relocation of SACT linked to AMSR programme and phase 2 of home care expansion case brought forward. Target 30/06/23.
67 (89)	**Risk target breaches – Radiotherapy** Clinical risk – target breeches in the provision of radical radiotherapy treatment. Due to capacity and demand issues the department is experiencing target breaches in the provision of radical radiotherapy treatment to patients.	15	Executive Medical Director	The risk score currently remains unchanged. Update 15/03/23: Looking at options around AI system to support planning pathway improvement. Update 19/04/23 CT1 (old CT) not currently in use due to absence of maintenance contract. Action:

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
				Business case for 2nd CT (capital and revenue). (Target End Quarter 3.) Currently working on business case to increase CT and Pre Treat capacity by weekend working. (Target End Quarter 2.)
74 (2595)	**Delay in Induction of Labour (IOL)** Delays in IOL can introduce avoidable risk and unnecessary intervention which can lead to poor clinical outcome for mother and/or baby. Delays in IOL lead to increased complaints and decreased patient satisfaction.	15	Executive Director of Nursing	Risk score reduced in February from 20 to 15. This risk should be read in conjunction with risk HBR81 on Critical midwifery Staffing levels for further detail on controls & actions, including work on workforce paper. Updates 16/02/2023: 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: Birthrate+ Cymru assessment completed for future workforce needs on the obstetric unit. Update 02/03/2023: Antenatal ward manager appointed - advised the need to collate data regarding delayed IOL due to staffing or acuity. Update 12/05/2023: Incidents continue to be reported on a monthly basis. Escalation policy sent to

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
				senior management for review.
78 (2521)	**Nosocomial Transmission** Nosocomial transmission in hospitals could cause patient harm; increase staff absence and create wider system pressures (and potential for further harm) due to measures that will be required to control outbreaks	12	Executive Medical Director	The risk score currently remains unchanged. Update 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 of progress reported monthly to NHS Wales Delivery Unit. Contact with families of patients whose cases have been reviewed at Scrutiny Panel has commenced. Action: Nosocomial Death Reviews using national toolkit ongoing. Need to ensure outcomes are reported to the Executive team and Service Groups with lessons learnt – this will be ongoing until conclusion of reviews. (Target 31/03/24) *This risk is currently being reviewed to separate the risk of nosocomial transmission of infection from the risks associated with completion of case reviews.*

3.3 Risks Assigned to Other Committees

There are seven risks which are assigned to other Committees in terms of overseeing actions to mitigate the risks, as outlined in table 2 below, noted here for information. As noted earlier, the detailed HBRR entries are also included in Appendix 1 for information. In view of the consequence to patients if the risks materialise, the Committees have requested that the Quality & Safety Committee be made aware of these risks as well.

Table 3: Risks Assigned to Other Committees with Referral to Q&S Committee for Information

Ref	Description of Risk Identified (Summarised)	Exec Lead	Committee	Current Score
1 (738)	**Access to Unscheduled Care Service** If we fail to provide timely access to Unscheduled Care then this will have an impact on quality & safety of patient care as well as patient and family experience and achievement of targets. There are challenges with capacity/staffing across the Health and Social care sectors.	Chief Operating Officer	P&F Committee	25
16 (840)	**Access to Planned Care** There is a risk of harm to patients if we fail to diagnose and treat them in a timely way.	Chief Operating Officer	P&F Committee	20
36 (1043)	**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.	Director of Digital	Workforce & OD Committee	16
48 (1563)	**CAMHS** Failure to sustain Child and Adolescent Mental Health Services (CAHMS).	Director of Strategy	P&F Committee	12
50 (1761)	**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.	Chief Operating Officer	P&F Committee	25
82 (2554)	**Risk of Closure of Burns Service** There is a risk that adequate Burns Consultant Anaesthetist cover will not be sustained, potentially resulting in closure to this regional service and the associated reputational damage.	Executive Medical Director	P&F Committee	16
88 (3100)	**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	Chief Operating Officer	P&F Committee	20

Ref	Description of Risk Identified (Summarised)	Exec Lead	Committee	Current Score
	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.			

3.4 Operational Quality & Safety Risks

Each Service Group and Directorate hold their own risk registers, which outline the operational risks facing each Service Group/directorate.

Operational risks relating to quality and safety that may need to be escalated for inclusion on the HBRR are brought to the attention of the Risk Management Group and/or Risk Scrutiny Panel for review and where appropriate added to, or linked to existing risks in, the Health Board Risk Register.

4. GOVERNANCE AND RISK

This report and appendix present information on each of the risks assigned to the Committee for oversight. Within the report, particular attention is drawn to those risks exceeding the Board's appetite, together with updates on action being taken to treat them by lead Directors and management.

5. FINANCIAL IMPLICATIONS

This report does not present any matters for decision with financial implications. There may be financial implications arising from actions required to improvement the treatment of risks entered on the HBRR. Where this is the case they are highlighted within individual risk register entries for information.

6. RECOMMENDATION

Members are asked to:

- **NOTE** the updates to the Health Board Risk Register (HBRR) relating to risks assigned to the Quality & Safety Committee.

- **CONSIDER** the risks assigned to the Quality & Safety Committee, in particular those exceeding the Health Board's risk appetite.

- **CONSIDER** whether the Committee work plan and agenda include sufficient information to provide assurance regarding the ongoing management of these risks.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
Quality, Safety and Patient Experience		
Ensuring the organisation has robust risk management arrangements that ensure organisational risks are captured, assessed, monitored and managed, supports the quality, safety & experience of patients receiving care and staff working in the UHB.		
Financial Implications		
This report does not present any matters for decision with financial implications. There may be financial implications arising from actions required to improvement the treatment of risks entered on the HBRR. Where this is the case they are highlighted within individual risk register entries for information.		
Legal Implications (including equality and diversity assessment)		
It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks faced by the organisation, as failure to do so could have legal implications for the UHB.		
Staffing Implications		
All staff have a responsibility for promoting risk management, adhering to SBUHB policies and have a personal responsibility for patients' safety as well as their own and colleague's health and safety. Executive Directors/Service Group Directors are responsible for the review of their operational risks and escalation of those requiring board-level oversight SBUHB.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
The HBRR sets out the framework for how SBUHB will make an assessment of existing and future emerging risks, and how it will plan to manage and prepare for those risks.		
Report History	• This report provides an update on the risk profile reported to QSC in February 2023.	
Appendices	• Appendix 1 – Health Board Risk Register (HBRR) Risks Assigned to the Quality & Safety Committee	