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

HEALTH BOARD RISK REGISTER (HBRR)

RISKS ASSIGNED TO THE QUALITY & SAFETY COMMITTEE

March 2021

Datix ID Number: 739 **Health & Care Standard: 2.4 Infection Prevention & Control & Decontamination**	**HBR Ref Number: 4** **Target Date: 31st March 2021**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Christine Williams, Interim Director of Nursing and Patient Experience **Assuring Committee:** Quality and Safety Committee
Risk: Failure to achieve **infection control** targets set by Welsh Government, increase risk to patients and increased costs associated with length of stays.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 =12	**Rationale for current score:** Currently under targeted intervention for rates of infection, achievement of targets are variable with monthly fluctuations
Level of Control = 40%	**Rationale for target score:**
Date added to the HB risk register January 2016	Once the infection control team is fully recruited to, ICNet is functioning to its full capability the infection control team will be able to support the clinical areas more and drive service improvements. In addition, a negative pressure isolation facility is being built into the new emergency department at Morriston hospital providing another facility to appropriately manage patients at the front door. Review and implementation of a robust clean of patient rooms following an infection will reduce the risk of cross infection.

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• Regular monitoring on infection rates • Policies, procedures and guidelines in place • Regular reporting through internal processes • ICNet information management system for infections is in place • Infection control team support the clinical teams for issues relating to infection control • A permanent infection control doctor has been recruited • Recruitment is ongoing and the decontamination lead and assistant director of nursing in infection control have been appointed • Bug stop quality improvement programme • Incident reporting	Ongoing infection control team involvement in site level estates projects to ensure appropriate isolation facilities are factored in from the outset	Senior Infection Control Matron	1st May 2021

Assurances **(How do we know if the things we are doing are having an impact?)** • Ongoing monitoring of infection control rates and feedback provided to delivery units • Infection Control Committee monitors infection rates and identifies key actions to drive improvement • Sub groups to the infection control committee such as the decontamination group provide the	**Gaps in assurance** **(What additional assurances should we seek?)** ICNet provides information linked with PAS relating to patients who have been inpatients since the connection was made therefore additional manual records are maintained by the infection control team creating additional work and some duplication.

assurances and operationally drive key areas of work. • Clear assurance framework in place at Corporate level with Health Board Infection Prevention & Control Committee, Health Board C. difficile Infection Improvement Group; Corporate Infection Prevention & Control Nursing Team; Water Safety Group; and Directly Managed Unit Infection Prevention & Control Groups. • Incident reporting • Root Cause Analysis to ensure monitoring and lessons continued to be learned from HCAI.	
Current Risk Rating **5 x4 = 20**	

Additional Comments

Significant progress to date however trajectory not met overall. Work underway on recruitment to IPC, a work plan to improve practice and improved information available for reporting, oversite and also investigation.

13/06/19 Continue to make progress against annual IMTP profiles, however, incidence within the Health Board remains above that for the NHS in Wales. Recruitment to Matron IPC post on 03/06/19. Work in progress to improve incident reporting in relation to infections and pilot to commence on post infection review process.

Appropriate environmental decontamination resource to be identified and staff trained in its appropriate use.

Compliance with IPC standard precautions and ANTT training and competence needs to be improved.

A review of cleaning of shared equipment such as beds, commodes is required to reduce risks of transmission.

Increase in cleaning hours across the Units is required to meet national minimum standards. Dedicated protected decant facilities are required for each Unit to ensure appropriate cleaning.

Sufficient isolation rooms required to manage patient's appropriately.

Estate needs to be updated and maintained to reduce risks.

IPCC resources required to support community and primary care.

Increase numbers of Piis on the last two months. HB over trajectory on a number of the TI Tier 1 targets. Increased level of risk due to insufficient domestic hours at Singleton hospital and significant vacancies at Morrison, lack of decant facilities, over occupancy in bays. Approved for increase in establishment at IBG in October 2019. 4 new posts approved. Now within VCP Process plus 1 existing band 6 vacancy. All 5 posts to be advertised in January 2020.

Although there has been some improvement against TI Tier 1 targets, it is challenging to sustain. PII currently at Morriston Hospital. Reduction initiatives are compromised by over-crowding of wards as a result of increased activity, over-occupancy, staff vacancies, and where activity levels are such that it is not possible to decant bays to effectively clean patient areas where there have been infections. From an All Wales perspective, not yet achieving NHS Wales Infection Reduction Expectations. 26.05.20 - Incidence of C. difficile infection has been increasing over the last 7 months from an average of 11 cases per month to an average of 13 cases per month. The Welsh Government target is <8 cases per month. There has been an improvement in E. coli and Klebsiella bacteraemia cases, but these are still above the Welsh Government targets.

09.07.20 - incidence of C. difficile has increase further to an average of 16 cases per month in the first quarter (this is double the Welsh Government monthly expectation). The incidence of Staph. aureus bacteraemia also is higher than Welsh Government expectations, however, there continues to be reductions in E. coli and Klebsiella bacteraemia cases.

Public Health Wales will make C. difficile genomic results available to the Health Board (current anticipated date Sept. 2020). This may facilitate a better understanding of the epidemiology of this infection within the Health Board.

18.08.20 - recruitment now complete. All staff now in post and on induction.

3.11.20 - In the Written Statement: Escalation and Intervention Arrangements on 7th October 2020, Minister for Health & Social Services, VG, announced that there has been a clearer approach to performance and an improvement in some of the measures under consideration, including infections. As a consequence of improved performance in a number of the TI areas, SBUHB has been de-escalated to 'enhanced monitoring'.

It is challenging to attain improvements in reduction of targeted infections. However, there has been year-on-year improvement in the following key infections: Staph. aureus, E. coli, Klebsiella, and Pseudomonas aeruginosa bacteraemia cases. Of concern, there has been an approximate 75% year-on-year increase in C. difficile cases.

COVID has led to increased compliance with training for PPE. Increased ICN presence clinically supporting DUs with the increase in resource and a full 7 day ICN service.

29/01/21 - the rate of increase in C. difficile cases has slowed, from a 75% increase year-on-year in November, to an approximate 20% increase in January 2021. There has been an improvement in Staph. aureus, E-coli and Pseudomonas aeruginosa bacteraemia, but a worsening of position in relation to Klebsiella spp. bacteraemia.
Increased clinical presence of ICNs on wards, the extension of the service to include Primary Care and a 7 day service continues, DD
26.02.2021 - With Covid nosocomial transmissions reducing, a greater emphasis on the Tier 1 targets will be made. Some in depth scrutiny working with microbiology to commence for Klebsiella. LH
12/04/21 - Progress in relation to E. coli and Pseudomonas bacteraemia, however, failed to achieve Tier 1 targets for C. difficile, Staph. aureus and Klebsiella

Datix ID Number: 737 **Health & Care Standard: Staying Healthy 1.1 Health Promotion**	**HBR Ref Number: 15** **Target Date: 31st March 2021**
Objective: Partnerships for Improving Health and Wellbeing	**Director Lead:** Keith Reid, Director of Public Health **Assuring Committee:** Quality and Safety Committee
Risk: If we fail to achieve **population health improvement targets** leading to an increase in preventable disease amongst the population resulting in increased morbidity impacting on operational and financial pressures.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 4 = 20 Target: 3 x 3 = 9	**Rationale for current score:** If we fail to prevent a serious outbreak by effectively achieving herd immunity in the population through immunisation and vaccination programmes, or to effectively manage an outbreak by disrupting the spread, this will result in serious harm to individual, maybe death, and pressure on health services, disruption to flow, business continuity and reputational damage to the health board and public health team.
Level of Control = 60%	**Rationale for target score:**
Date added to the HB risk register 26.01.16	Manage preventable disease

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Deliver immunisation awareness training for pre-school settings to promote key vaccination messages	Consultant Public Health Medicine	31st March 2021
Contribute to the implementation of recommendations made in the "MMR Immunisation: process mapping of the child's journey" report.	Consultant Public Health Medicine	31st March 2021
Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins	Consultant Public Health Medicine	31st March 2021

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

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

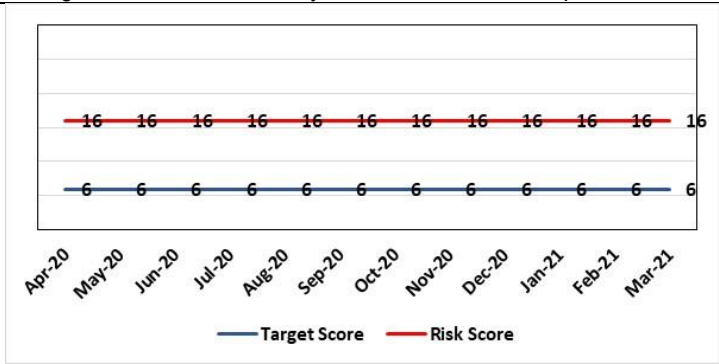
Gaps in assurance
(What additional assurances should we seek?)
The need to deliver sustained service.

Current Risk Rating
5 x 4 = 20

Additional Comments
Scrutiny by internal audit, raise awareness, encourage uptake, target population. Co-production work with the public.
The impact of COVID-19 has been to disrupt usual population health activities. This disruption is ongoing.

	Control measures have had a mixed impact on behaviours associated with health eg ability to undertake exercise has been negatively affected. There will be a legacy of adverse psychological effects which will require community-based approaches to mitigate. This is likely to require a sustained response over several years. COVID-19 has had a disproportionate impact on those with existing poor health or underlying risk factors and also impacted more severely on those areas of high deprivation. Overall inequities in health are likely to increase as a consequence. The risk rating probably needs to be increased to 20 – likelihood is probably 5 and impact 4 – it will require the development of a mitigation strategy in response.

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



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

- Supervisory body signatories increased from 3 to 7
- BIA rota now implemented
- 2 x substantive BIA posts and additional admin post advertised
- DoLS database updated and DoLS dashboard devised to enable more accurate monitoring and reporting
- Regular reporting to Mental Health and Legislative Committee (MHLC)(Nov 20)
- QIA completed for re-introduction of DoLS BIAs attending Ward as part of Reset and Recovery Sept 2020
- QIA reviewed and service stood down in light of increased COVID incidence Oct 2020
- Managing and supporting all referrals remotely
- New legislation changes expected in 21/22 which will require a different service model, business case to meet existing and future requirements will be progressed March 21.

Mitigating actions (What more should we do?)

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

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

- Regular scrutiny at Safeguarding Committee and by DoLS Internal Audit; monitoring via DoLS Dashboard which is due to be rolled out imminently and will provide real-time accurate data.
- Update report to MHLC regarding quarter 1 and 2 activity 2020, impact of COVID and focus on urgent cases via virtual process and plan to progress business case by year end.

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

Current Risk Rating
4 x 4 = 16

Additional Comments
All actions attributable to safeguarding completed and Internal Audit aware.

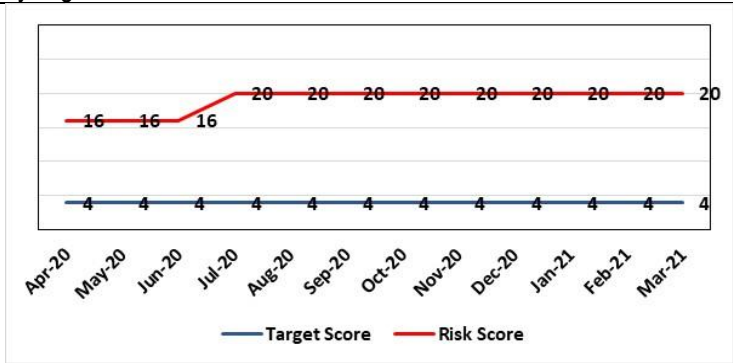
	DoLS and MCA Training provided to doctors and managers by Solicitor from Legal & Risk Services in January and February 2021.

Datix ID Number: 922 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**HBR Ref Number: 49** **Target Date: 31st March 2021**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Richard Evans, Medical Director **Assuring Committee:** Quality and Safety Committee
Risk: Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI)	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 4 x 5 =20 Target: 3 x 4 = 12 **Level of Control** = 50% **Date added to the HB risk register** July 2016		**Rationale for current score:** • External review undertaken by Royal College of Physicians which will likely indicate that patients have come to serious harm as a result of excessive waits. • Remains significant reputational risk to the Health Board **Rationale for target score:** External review by the Royal College of Physicians will provide a view on improvement required immediately and for sustainability.

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

Assurances **(How do we know if the things we are doing are having an impact?)** Reduction in waiting times for TAVI. Executive Medical Director Oversight of improvement plans. Development of Quality and Safety Dashboard. Oversight and scrutiny by Quality and Safety Committee	**Gaps in assurance** **(What additional assurances should we seek?)**
Current Risk Rating **4 x 4 = 16**	**Additional Comments** Business case for WHSSC funding has been agreed. There is considerable reputational risk to the organisation on the outcome of the Royal College of Physicians review. RCP reports received for first cohort casenote reviews and site visit. Action plans implemented. All posts identified as essential in the RCP reports have been appointed to. Improvement activity continues to have oversight of the Executive Medical Director at fortnightly Gold Command meetings. Extensive validation of pathway start dates for cardiothoracic and TAVI patients from external health boards.

	Regular briefings and reports are provided to key stakeholders including WHSSC, Welsh Government and Hywel Dda UHB. The service has felt some impact from COVID, particularly at peaks of COVID prevalence, but the service has continued to operate. The RCP have undertaken a review of a second cohort of casenotes and their report is awaited. Actions completed 08.03.21: • Commission external review of the service by the Royal College of Physicians • Commission further case note review by the Royal College of Physicians WHSSC informed the Health Board of its decision to de-escalate the TAVI service from its current Stage 3 to Stage 2 of the WHSSC Escalation process, having recognised that the service has delivered a significant improvement in the overall quality of the TAVI programme including the reduction in waiting times despite the pandemic. RCP 2nd report received which is positive. Clearly defined pathways now established, TAVIs being undertaken twice weekly. Managed by 2 independent TAVI nurses. Only 1 or 2 patients now waiting >25 weeks with reasons for this.

Datix ID Number: 146 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**CRR Ref Number: 58** **Target Date: 31st March 2021**
Objective: Excellent Patient Outcomes	**Director Lead**: Rab McEwan, Chief Operating Officer **Assuring Committee**: Quality and Safety Committee
Risk: There is a failure to provide adequate clinic capacity to support follow-up patients within the **Ophthalmology** specialty. The consequence of this failure is a delay in patients with chronic eye conditions accessing ongoing secondary care monitoring of diagnosed conditions with the potential risk of permanently impairing eyesight.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 4 x 5 = 20 Target: 4 x 1 = 4 **Level of Control** = 40% **Date added to the HB risk register** December 2014		**Rationale for current score:** Sustainable plans underway - short term measures in process of being implemented. Serious incidents being reported to WG. Gold Command exec-led oversight established November 2018. Risk rating increased to 25 January 2019 as instructed by Gold Command. LJ advised change risk score to 16, 03/04/2019 as Probable x Major. Risk rating increased to 20 in July 2020 due to Covid-19 pandemic. **Rationale for target score:**

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• All patients are categorised by condition in order to quantify issue. Second glaucoma consultant appointed November 2018. • Additional accommodation secured to increase capacity; implementation plan under development. Welsh government funding secured for 2019/20 to employ additional activity and deliver some services in a community setting. Virtual clinics established. • Service Manager for Ophthalmology providing regular updates via Planned Care Programme.	An overall Sustainability Plan to be delivered (Gold Command in place)	Service Group Manager Surgical Specialties	31st March 2021 (Monthly Ongoing)

Assurances **(How do we know if the things we are doing are having an impact?)** • A Welsh Government pilot programme was implemented in June 2014. The purpose of the HES project is to use clinic capacity to assess, review and treat patients within clinical priority rather than prioritising new patients based on their waiting time. A Project Management Lead was in post to deliver on the HES objectives.	**Gaps in assurance** **(What additional assurances should we seek?)** Extended waiting times for patients requiring routine clinical intervention, but these are still listed as per RTT guidance.
Current Risk Rating **4 x 5 = 20**	**Additional Comments** Additional Glaucoma practitioner (temporary for 12 months) commenced in post 11/06/2018. 2nd Glaucoma Consultant started 05/11/2018. Accommodation in Corridor 3 reconfigured 08/02/2019. Further work needed on

	accommodation and additional rooms required. Ongoing discussions continue with Singleton Unit so that space can be created to house a co-located Ophthalmology Department Middle grade doctor to commence in post April 2019. Monthly tracker of glaucoma backlog patients indicates reduction of over 800 patients to end of January 2019. Diabetic Retinopathy Virtual Review clinics are to be increased via a WG funded successful bid. Reviewed by AD& PT Sustainable plans are under way and are on target against follow up trajectory backlog. 20/21 sustainable plans are currently being drafted. Risk score reviewed to maintain at 20. Although routine outpatients appointment are not being undertaken due to COVID-19 those patients at high risk i.e. wet AMD are still being seen and receiving treatment and those patients in other high risk specialties such as glaucoma are being reviewed virtually and if deemed necessary attending for urgent appointments. Since the advent of the Covid-19 outbreak only the following essential Eye services have been maintained during Covid 19. • AMD treatments • Retina services • Rapid Access Eye clinic (RACE - Eye Casualty) As a consequence the progress made through the previous eye care initiatives has been reversed. During the pandemic the following has been achieved: • Paediatric – 2 consultants have started with a post Covid timetable covering Hywel Dda sessions under SLA contract. • Diabetic Retina – Band 4 Coordinator appointed from interview 19th June 2020. • Glaucoma – Strawberry Place ODTC clinics to resume for 3 months from July 2020 while we look for alterative accommodation. Some clinically urgent Cataract operations have been undertaken through May and June 2020 The progress made in reducing follow up patients has been reversed due to significant reduction in capacity during pandemic. Revised action plans to recover the position have been developed but are reliant on post Covid activity levels being restored. 14.04.21 - Additional glaucoma clinic capacity now available in Wellbeing Centre, Swansea University, but overall capacity is still below pre-COVID levels due to social distancing requirements and the theatre capacity only being allocated to Priority 2 patients. Gold Command process in place to regularly review recovery plans. Work ongoing with Hywel Dda HB on regional solutions.

Datix ID Number: 1587 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**	**HBR Ref Number: 61** **Target Date: 31st March 2021**
Objective: Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morriston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies.	**Director Lead:** Rab McEwan, Chief Operating Officer **Assuring Committee:** Quality and Safety Committee/Strategy Planning and Commissioning Committee
Risk: Paediatric dental GA/Sedation services provided under contract from Parkway Clinic, Swansea. Medical Safety risk GAs performed on children outside of an acute hospital setting.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 4 x 4 = 16 Target: 4 x 2 = 8 **Level of Control** = 60% **Date added to the HB risk register** 4th July 2018		**Rationale for current score:** There is no immediate access to crash team/ICU facilities in in Parkway Clinic – the client group are undergoing G/A/sedation. Paediatric GA/Sedation services provided under contract from Parkway Clinic, Swansea continue due to lack of capacity for these patients to be accommodated in Secondary Care. **Rationale for target score:** Relocation of the paediatric GA service [provided by Parkway Clinic] to a hospital site being treated as a priority

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Transfer of services from Parkway.	Interim Head of Primary Care	31st May 2021

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

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

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

Current Risk Rating
4 X 4 = 16

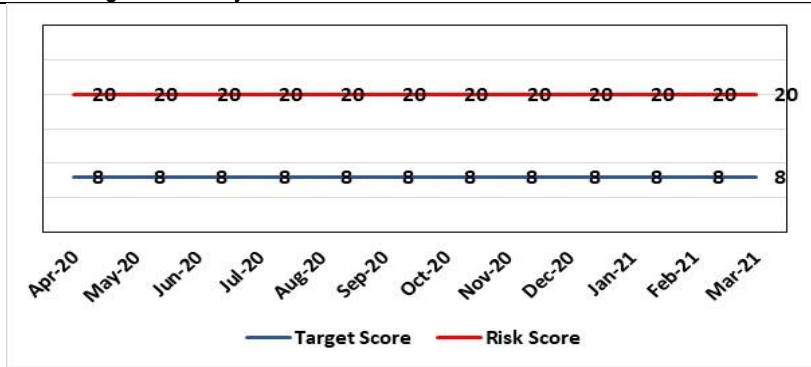
Additional Comments
Task & Finish Group continue to progress transfer of service to Morriston.
Action moved to May 2021 due to Covid pressures. However, PWC have now given the Health Board notice that they wish to terminate the contract at the end of January 2021.

	Transfer of this service to Morriston is not feasible by the end of January and given the limitations on staffing and theatre capacity is not achievable by May 2021 therefore T&F Group are looking at the other options available to deliver the service which, includes extending the contract with PWC through to March 2022 or transferring the service the NPTH. A paper setting the options will be presented the Senior Leadership on 18 November 2020. Risk remains - for review in November following meeting with Senior Leadership on 18th November 2020. Task and Finish Group re-established first meeting on 1st December to progress transfer to Morriston Hospital by 31st May 2021. However, the limited theatre capacity available due to Covid restrictions has resulted in an extension of the contract with Parkway until June 2022 being negotiated.

Datix ID Number: 1605 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**	**HBR Ref Number: 63** **Target Date: 31st December 2020**
Objective: Screening for Fetal Growth Assessment in line with Gap-Grow (G&G)	**Director Lead**: Christine Williams, Interim Director of Nursing and Patient Experience **Assuring Committee:** Quality and Safety Committee
Risk: There is evidence a growth restricted/small for gestational age fetus (SGA), has an increased risk of intra-uterine death before or during the intrapartum period. Identification and appropriate management for SGA in pregnancy should lead to improved outcomes. GAP & Grow standards were implemented to contribute to the reduction of stillbirth rates in wales. Obstetric USS scan appointments are at capacity leading to delays in obtaining required appointments. In addition the guidance from Gap & Grow is for women requiring serial scanning with a risk factor for a growth restricted baby must have 3 weekly scans from 28 to 40 week gestation. Due to the scanning capacity there are significant challenges in achieving this standard.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 5 = 20 Target: 3 x 4 = 12 **Level of Control** = 60% **Date added to the HB risk register** 1st August 2019	
	Rationale for current score: CSFM's leading on audit reviewing records of all women where SGA not identified in antenatal period. Scanning capacity under increasing pressure. Meeting arranged with radiology management to discuss introduction of midwife sonographer third trimester scanning. Staff to be informed to submit Datix incident where scan not available in line with standards.
	Rationale for target score: Compliance with Gap & Grow requirements.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
All staff have received training on Gap & Grow and detection of small for gestational babies. Obstetric scanning capacity across the HB is being reviewed and compliance with criteria for scanning is being monitored. Ultrasound are assisting with finding capacity wherever possible in order to meet standards for screening and complying with Gap & grow recommendations.	Adherence to Gap/Grow Standards	Deputy Head of Midwifery	31st December 2021
Assurances **(How do we know if the things we are doing are having an impact?)** Audit of compliance with guidance being undertaken, detection rates of babies born below the 10th centile is being monitored via datix and audited by the service. Ultrasound are assisting with finding capacity wherever possible in order to meet standards for screening and complying with Gap & grow recommendations.	**Gaps in assurance** **(What additional assurances should we seek?)**		
Current Risk Rating **4 X 5 = 20**	**Additional Comments** Meeting took place with Deputy Head of Therapies for the HB. Arrangement to meet in January 2020 to review radiology capacity and plan future service needs. This will form part of the antenatal clinic review. Audit of missed cases themes and trends to be presented to the MDT in February 2020. Approval from health board to progress training and recruitment of midwife		

	sonographers. Working group in place chaired by exec lead for therapies. Oct20 - awaiting advert for MW sonographer roles. G&G training compliance monitored. Rescheduled scan frequency during COVID. Forthcoming interviews on 11.12.2020 for midwife trainee sonographers with a view to commence training in January 2021. Working with radiology to provide training opportunities with antenatal clinics. Midwife Trainee Sonographers have commenced training. Continue to work with radiology to provide a trainer for the trainees. Recruitment for a fixed term 2 year role for a sonographer trainer will commence February 2021. Training currently being provided by appropriately trained obstetrician the two trainee midwife sonographers are making good progress in their university course and practical skills training. An ultrasound machine has been purchased from capital funds and will be installed by 31/03/2021 for midwife sonographer service use. relocation of some gynaecology clinics will free up space for a dedicated room in the antenatal clinic environment.

Datix ID Number: 329 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**	**HBR Ref Number: 65** **Target Date: 31st January 2021**
Objective: Digitally enabled Care	**Director Lead**: Christine Williams, Interim Director of Nursing and Patient Experience **Assuring Committee:** Quality & Safety Committee
Risk: Risk associated with misinterpreting abnormal cardiotocography readings in the delivery room. A central monitoring station would enable multi-disciplinary viewing and discussion of the readings to take place, and reduce the risk of a concerning CTG trace going unidentified. Provisionally scored C4 (irrecoverable injury) x L3= 12. The central monitoring system has a facility to archive the CTG recordings: currently these tracings are only available as a paper copy, which can be lost from the maternity records. There is also a concern that the paper tracings fade over time which makes defending claims very difficult.	**Date last reviewed:** March 2021 **Rationale for current score:** Meeting with K2, IT, finance, procurement and midwifery team on 30/09/2019. System viewed and IT needs identified. Final costing to be assessed prior to resubmission to IBG in Oct or November 2019.
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 5 = 20 Target: 4 x 2 = 8 **Level of Control** = 50% **Date added to the HB risk register** 31st December 2011	
	Rationale for target score:
Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**
Current controls include all staff undertaking RCOG CTG training and competency assessment. Protocol in place for an hourly "fresh eyes" on 'intrapartum CTG's' and jump call procedures. CTG prompting stickers have been implemented to correctly categorise CTG recordings. Central monitoring is also expected to strengthen the HB's position in defending claims. K2 fetal monitoring system has been identified as the best option for a central monitoring system.	**Action**: Business case prepared for Central monitoring system to store CTG recordings of fetal heart rate in electronic format. **Lead**: Deputy Head of Midwifery **Deadline**: 31st December 2021
Assurances **(How do we know if the things we are doing are having an impact?)** All Wales Fetal Surveillance Standards for 6hrs Fetal Surveillance Training per year	**Gaps in assurance** **(What additional assurances should we seek?)**
Current Risk Rating **4 X 5 = 20**	**Additional Comments** Submission to IGB in January 2019. CTG envelopes placed in every set of records for safe storage of CTG. Business case completed by maternity service and multi-professional team. Remaining issue outstanding is the financial detail from IT. To ensure submission of case in January 2020. Initial capital funding has been agreed. Meeting held with delivery unit finance director, head of IT and procurement to agree if tendering process required. Paper submitted to describe what specifications are required. Decision awaited from procurement lead if

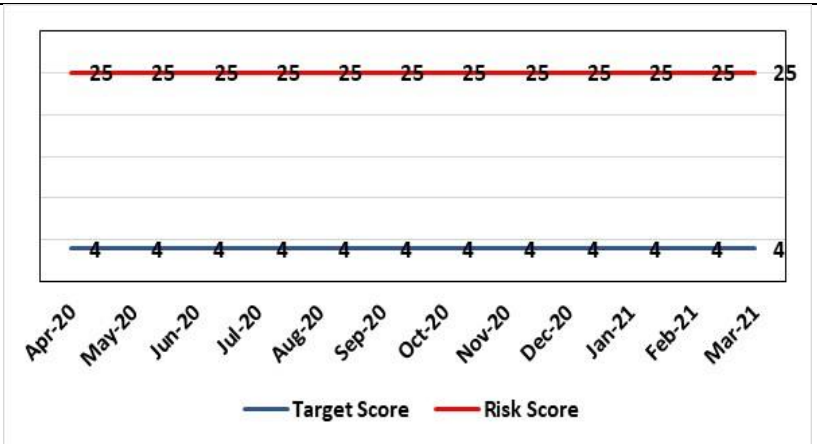
	tendering process is required. Tenders have been received, Narrowed down to one suitable provider. Procurement are continuing with the process. Chosen provider for central monitoring system agreed. The chosen monitoring system will include a computerised analysis algorithm as recommended by HIW. Funding for central monitoring approved for 2021/22 Meeting to be arranged with provider and key stakeholders in SBU to commence the project toward installation and training.

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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Review of CDU by improvement science practitioner Increase nursing staff x 1 at risk, to ensure all nurses are working appropriately. Review of scheduling by staff to ensure all chairs used appropriately. Options appraisal to be completed for SSDU senior management team by service group	Expansion of home care delivery and additional chair capacity - SACT group	Service Manager Surgical Services	1st April 2021

Assurances **(How do we know if the things we are doing are having an impact?)** Extra nurse in place reliant on agency. Senior team meeting to review findings of service review paper. Additional funding agreed to support increase in nurse establish to appropriately run the unit during their main opening hours	**Gaps in assurance** **(What additional assurances should we seek?)**
Current Risk Rating **5 X 5 = 25**	**Additional Comments** Additional staffing in place from Dec 19 to allow full use of chairs but capacity gap remains. Looking at options around use of additional SACT capacity via Tenovus. Also working with MSD/GE around potential partnership agreement to look at C&D mapping and best practice elsewhere with visit to Leeds being arranged by MSD colleagues. Covid has impact on demand WT continue to improve average wait for Chair time at present is 11days - decrease from 21days. Some of this links to Covid changes, as part of recovery plan need to understand better the future need. Currently lost 3chairs due to Covid-19 and waiting times at 15days at end of June 2020. Meeting with GE/MSD - taking place waiting on partnership agreement paperwork to take through legal team to ensure robust will then start with project plan that we are drafting while paperwork is being finalised between HB and MSD/GE. 13.01.21 Work has identified significant gap in our chair capacity- current shortfall 7, with an additional

	10 chairs required by 2023/24, based on current horizon scanning. Final report confirming this is outstanding. Working on project plan around how we deliver the increased 7 chairs. 03.03.21 - Action closed - Options appraisal paper to be produced for SSDU senior team by service group. Continuing to working with GE/B Braun around modelling work around gap. There some issues with report from GE. However work has identified 2 areas of work: 1. Infrastructure for expansion of home care delivery for low risk drugs- Joint paper between pharmacy and cancer team under development. 2. Scoping up option of 7 additional chairs initially (exact number TBC) in NPTH.

Datix ID Number: 89 **Health & Care Standard: 5.1 Timely Care**	**HBR Ref Number: 67** **Target Date: 31st March 2021**
Objective: Best values outcomes from high quality care	**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee:** Quality and Safety Committee
Risk: Clinical risk-target breeches in the provision of radical radiotherapy treatment. Due to capacity and demand issues the department is experiencing target breeches in the provision of radical radiotherapy treatment to patients.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 5 = 25 Target: 2 x 2 = 4 **Level of Control** = **Date added to the HB risk register** 30/11/2019	
	Rationale for current score: Waiting times deteriorating for elective delays patients, particularly prostates discussed in Oncology business meeting.
	Rationale for target score:

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

Assurances **(How do we know if the things we are doing are having an impact?)** Performance and activity data is being monitored and monthly data shared with radiotherapy management meeting and cancer board. It is also now included in scorecard.	**Gaps in assurance** **(What additional assurances should we seek?)**
Current Risk Rating **5 X 5 = 25**	**Additional Comments** Radiotherapy waiting times continue to cause concerns, new COSC guidelines launched this year mean we now reporting Rx waiting times to WG. Sept Performance has been added to this risk. Options to increase our capacity and include in PBC for SWWCC which is being developed and internal efficiency work with QI colleagues is also being reviewed. Rx Performance is discussed in Radiotherapy management meeting and papers are chased in Cancer Board. Agreement has been reached around outsourcing 12 prostate radiotherapy cases per month for 6 months to Rutherford. Commencing in January 2020. While case for extended day is further reviewed. Contract signed off by Executive Team Jan 2020. Patients are being approached to attend Rutherford Cancer Centre and patient details being sent to Rutherford Cancer

	Centre. Seen improvement in some WT performance in RT due to cases being referred to Rutherford and due to changes in practice due to Covid-19. Due to machine breakdowns and covid capacity has been effected to deliver RT. however outsourcing has mitigated some of this but not all. New action agreed 07/07/20- RT Covid Recovery plan is being developed that will include options around, further outsourcing, bringing back SBAR work from VCC, changes to fractions on BREAST and PROSTATE and how we could use this freed up machine capacity differently. This plan is to go to Reset and Recovery meeting as part of Essential Services Covid Recovery plans for Cancer. RT recovery plan (part 1 Breast Hypofractionations) when to Reset and Recovery on 01.09.20 and was approved. 04.01.21 - Delay due to covid in finalising recovery plan. Recovery plan for Breast hypofraction work that releases capacity was agreed and staff being appointed to. Working to start date of Feb 21 for these additional staff. Prostate Case is being finalised plan to go to Reset and Recover end Jan 21/Mid Feb 21. Working with surgeons to finalise pathway. Action closed – Review of patient pathway. Number of projects around hypo fractionation treatments have been developed and are being developed. Breast hypo fractionation has been agreed and additional resources were given in Qtr 3-4 to support this. Recruitment to posts is just been finalised. Work for hypo fractionation in prostate in partnership with Urology teams in SBU and HD is in development stage and is included as priority in annual plan. Clinical fellow to support hypo fractionation development work in pancreas has also been supported on fixed term basis and is due to commence in April/May 21. Case for Lung Hypo fractionation has also been developed and is with WHSSC for consideration. Without investment unless we see drop in demand risk will not be reduced.

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

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

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

5 X 4 = 20	Pandemic plans invoked Command, Control and Coordination arrangements in place with Strategic, Tactical and bronze Groups in place to ensure Health Board wide engagement and instigate required planning including: o Patient flow pathway scenarios for unwell patients and well patients that may self-present in both acute and Primary and Community Care o Appropriate PPE kit and training o Appropriate support service pathways for cleaning, decontamination, waste and linen management o Multi-agency engagement o Community Testing arrangements o Workforce review • Identified isolation facilities. Pandemic was declared. Health Board stood up 3CF structures and response on 31 January 2020. System wide response in place. Lockdown established 23rd March. Current levels of demand are containable within existing capacity. Expectations that initial peak of infections has been managed within capacity. 08.03.21 - Current Score reduced as per e-mail EMD

Datix ID Number: 1418 **Health & Care Standard: 5.1 Timely Access**	**HBR Ref Number: 69** **Target Date: 31st March 2021**
Objective: Best values outcomes from high quality care	**Director Lead**: Rab McEwan, Chief Operating Officer/Christine Williams, Interim Director of Nursing and Patient Experience **Assuring Committee:** Performance and Finance Committee
Risk: Risk issues Related to **adolescent patients being admitted to Adult MH inpatient wards**- Inappropriate settings resulting in 'Safeguarding Issues' The WG has requested that HBs identify Secondary Care in -patient facilities for the care of adolescents- in Swansea Bay University Health Board Ward F NPT hospital is the dedicated receiving facility with one bed identified.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 2 x 3 = 6 Current: 4 x 4 = 16 Target: 2 x 3 = 4 **Level of Control** = **Date added to the HB risk register** 27/02/2020		**Rationale for current score:** Risk score heightened after a DU wide RR meeting to review scores. **Rationale for target score:**

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	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.	Review of Service by Swansea Bay Youth	Assistant Head of Operations MH	30th April 2021
	Learning event to be held facilitated by the Serious Incident Team to review a number of recommendations eg location of the crisis assessment.	Deputy Director of Nursing	31st March 2021

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 DU legislative Committee of the HB.	**Gaps in assurance** **(What additional assurances should we seek?)**
Current Risk Rating **4 X 4 = 16**	**Additional Comments** Action Completed - Revised pathway and guidance for the management of CYP with emotional well- being issues presenting in the ED in Morriston has been developed in conjunction with CAMH service. A paper presented to and approved by Safeguarding Committee on 9th December 2020.