



HEALTH BOARD RISK REGISTER (HBRR)

RISKS ASSIGNED TO THE QUALITY & SAFETY COMMITTEE

November 2020

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: December 2020																																								
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 = 12	<table border="1"> <caption>Chart Data</caption> <thead> <tr> <th>Month</th> <th>Target Score</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Dec-19</td><td>12</td><td>20</td></tr> <tr><td>Jan-20</td><td>12</td><td>20</td></tr> <tr><td>Feb-20</td><td>12</td><td>20</td></tr> <tr><td>Mar-20</td><td>12</td><td>20</td></tr> <tr><td>Apr-20</td><td>12</td><td>20</td></tr> <tr><td>May-20</td><td>12</td><td>20</td></tr> <tr><td>Jun-20</td><td>12</td><td>20</td></tr> <tr><td>Jul-20</td><td>12</td><td>20</td></tr> <tr><td>Aug-20</td><td>12</td><td>20</td></tr> <tr><td>Sep-20</td><td>12</td><td>20</td></tr> <tr><td>Oct-20</td><td>12</td><td>20</td></tr> <tr><td>Nov-20</td><td>12</td><td>20</td></tr> </tbody> </table>	Month	Target Score	Risk Score	Dec-19	12	20	Jan-20	12	20	Feb-20	12	20	Mar-20	12	20	Apr-20	12	20	May-20	12	20	Jun-20	12	20	Jul-20	12	20	Aug-20	12	20	Sep-20	12	20	Oct-20	12	20	Nov-20	12	20	Rationale for current score: Currently under targeted intervention for rates of infection, achievement of targets are variable with monthly fluctuations	
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Level of Control = 40%	Rationale for target score: 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.																																									
Date added to the HB risk register January 2016	Controls (What are we currently doing about the risk?)																																									
<ul style="list-style-type: none"> 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 		Mitigating actions (What more should we do?)																																								
		<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Ongoing infection control team involvement in site level estates projects to ensure appropriate isolation facilities are factored in from the outset</td> <td>Senior Infection Control Matron</td> <td>31st March 2021</td> </tr> </tbody> </table>	Action	Lead	Deadline	Ongoing infection control team involvement in site level estates projects to ensure appropriate isolation facilities are factored in from the outset	Senior Infection Control Matron	31 st March 2021																																		
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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	31 st March 2021																																								
Assurances (How do we know if the things we are doing are having an impact?) <ul style="list-style-type: none"> 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 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 		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.																																								

<ul style="list-style-type: none"> Root Cause Analysis to ensure monitoring and lessons continued to be learned from HCAI. <p style="text-align: center;">Current Risk Rating 5 x 4 = 20</p>	<p style="text-align: center;">Additional Comments</p> <p>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, oversight 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.</p> <p>Appropriate environmental decontamination resource to be identified and staff trained in its appropriate use.</p> <p>Compliance with IPC standard precautions and ANTT training and competence needs to be improved.</p> <p>A review of cleaning of shared equipment such as beds, commodes is required to reduce risks of transmission.</p> <p>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.</p> <p>Sufficient isolation rooms required to manage patient's appropriately.</p> <p>Estate needs to be updated and maintained to reduce risks.</p> <p>IPCC resources required to support community and primary care.</p> <p>Increase numbers of PIs 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.</p> <p>Although there has been some improvement against TI Tier 1 targets, it is challenging to sustain. PII currently at Morrison 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.</p> <p>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.</p>
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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.

Datix ID Number: 737 Health & Care Standard: Staying Healthy 1.1 Health Promotion		HBR Ref Number: 15 Target Date: 31st March 2020																																									
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: December 2020																																									
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 3 = 15 Target: 3 x 3 = 9	<table border="1"> <caption>Risk Rating Data</caption> <thead> <tr> <th>Month</th> <th>Target Score</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Dec-19</td><td>9</td><td>15</td></tr> <tr><td>Jan-20</td><td>9</td><td>15</td></tr> <tr><td>Feb-20</td><td>9</td><td>15</td></tr> <tr><td>Mar-20</td><td>9</td><td>15</td></tr> <tr><td>Apr-20</td><td>9</td><td>15</td></tr> <tr><td>May-20</td><td>9</td><td>15</td></tr> <tr><td>Jun-20</td><td>9</td><td>15</td></tr> <tr><td>Jul-20</td><td>9</td><td>15</td></tr> <tr><td>Aug-20</td><td>9</td><td>15</td></tr> <tr><td>Sep-20</td><td>9</td><td>15</td></tr> <tr><td>Oct-20</td><td>9</td><td>15</td></tr> <tr><td>Nov-20</td><td>9</td><td>15</td></tr> </tbody> </table>	Month	Target Score	Risk Score	Dec-19	9	15	Jan-20	9	15	Feb-20	9	15	Mar-20	9	15	Apr-20	9	15	May-20	9	15	Jun-20	9	15	Jul-20	9	15	Aug-20	9	15	Sep-20	9	15	Oct-20	9	15	Nov-20	9	15	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.		
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Level of Control = 60%	Rationale for target score: Manage preventable disease																																										
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?)																																									
<ul style="list-style-type: none"> 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 		<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Deliver immunisation awareness training for pre-school settings to promote key vaccination messages</td> <td>Consultant Public Health Medicine</td> <td>29th January 2021</td> </tr> <tr> <td>Contribute to the implementation of recommendations made in the "MMR Immunisation: process mapping of the child's journey" report.</td> <td>Consultant Public Health Medicine</td> <td>29th January 2021</td> </tr> <tr> <td>Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins</td> <td>Consultant Public Health Medicine</td> <td>29th January 2021</td> </tr> </tbody> </table>	Action	Lead	Deadline	Deliver immunisation awareness training for pre-school settings to promote key vaccination messages	Consultant Public Health Medicine	29 th January 2021	Contribute to the implementation of recommendations made in the "MMR Immunisation: process mapping of the child's journey" report.	Consultant Public Health Medicine	29 th January 2021	Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins	Consultant Public Health Medicine	29 th January 2021																													
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Assurances (How do we know if the things we are doing are having an impact?) <ul style="list-style-type: none"> School imms target is over 70%, we are the 2nd highest in Wales. All other childhood imms targets below trajectory. 		Gaps in assurance (What additional assurances should we seek?) The need to deliver sustained service.																																									
Current Risk Rating 5 x 3 = 15		Additional Comments Scrutiny by internal audit, raise awareness, encourage uptake, target population. Co-production work with the public.																																									

Datix ID Number: 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: December 2020																																								
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 3 x 2 = 6	<table border="1"> <caption>Risk Rating Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr><td>Dec-19</td><td>16</td><td>6</td></tr> <tr><td>Jan-20</td><td>16</td><td>6</td></tr> <tr><td>Feb-20</td><td>16</td><td>6</td></tr> <tr><td>Mar-20</td><td>16</td><td>6</td></tr> <tr><td>Apr-20</td><td>16</td><td>6</td></tr> <tr><td>May-20</td><td>16</td><td>6</td></tr> <tr><td>Jun-20</td><td>16</td><td>6</td></tr> <tr><td>Jul-20</td><td>16</td><td>6</td></tr> <tr><td>Aug-20</td><td>16</td><td>6</td></tr> <tr><td>Sep-20</td><td>16</td><td>6</td></tr> <tr><td>Oct-20</td><td>16</td><td>6</td></tr> <tr><td>Nov-20</td><td>16</td><td>6</td></tr> </tbody> </table>	Month	Risk Score	Target Score	Dec-19	16	6	Jan-20	16	6	Feb-20	16	6	Mar-20	16	6	Apr-20	16	6	May-20	16	6	Jun-20	16	6	Jul-20	16	6	Aug-20	16	6	Sep-20	16	6	Oct-20	16	6	Nov-20	16	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.	
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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?)		Mitigating actions (What more should we do?)																																								
<ul style="list-style-type: none"> 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 Process in place within P&C Unit for management of authorisations and identifications of breaches in timescales. The Corporate Safeguarding Team is monitoring this. 31.07.19 2 WTE BIA's and a Band 4 Administrator have been appointed since April 2019. These individuals are managed by the Interim Head of Long Term Care, Primary & Community Service Delivery Unit 		<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Delivery of DOLS Action plan reviewed monthly (change coding above also)</td> <td>Director Primary & Community</td> <td>Monthly Review</td> </tr> <tr> <td>DoLS dashboard in place, monitoring applications and breaches via dedicated BIAs and Admin.</td> <td>UND Primary and Community</td> <td>Monthly Review</td> </tr> <tr> <td>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</td> <td>UND Primary and Community</td> <td>Monthly Review</td> </tr> <tr> <td>Business case for revised service model</td> <td>UND Primary and Community</td> <td>March 2021</td> </tr> </tbody> </table>		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																								
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Assurances (How do we know if the things we are doing are having an impact?)		Gaps in assurance (What additional assurances should we seek?)																																								
<ul style="list-style-type: none"> 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 MHLIC 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. 																																										
Current Risk Rating 4 x 4 = 16		Additional Comments All actions attributable to safeguarding completed and Internal Audit aware.																																								

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: December 2020																																								
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<ul style="list-style-type: none"> TAVI Recovery Plan implemented and backlog has been cleared.. Plan is supported with Executive oversight at fortnightly TAVI OG meeting. TAVI has been prioritised in next year's WHSSC ICP for 2020/21. The UHB has commissioned the Royal College of Physicians to undertake a review of the service. Final report awaited, but anticipated that this will indicate that patients have come to serious harm 		<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Commission external review of the service by the Royal College of Physicians (Awaiting report)</td> <td>Directorate Manager</td> <td>30th November 2020</td> </tr> </tbody> </table>	Action	Lead	Deadline	Commission external review of the service by the Royal College of Physicians (Awaiting report)	Directorate Manager	30 th November 2020																																		
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Assurances (How do we know if the things we are doing are having an impact?) Reduction in waiting times for TAVI. Appointment to key posts (medical & nursing).		Gaps in assurance (What additional assurances should we seek?)																																								
Current Risk Rating 4 x 5 = 20		Additional Comments Business case for WHSSC funding has been agreed. There is considerable reputational risk to the organisation on the outcome of the Royal College of Physicians review. Medical director in receipt of RCP report which will be shared widely in due course. Extensive validation of pathway start dates for cardiothoracic and TAVI patients from external health boards has taken place (in line with recommendations from DU report). Patients are now reported with true reflection of actual wait which has resulted in a reported position of 5 patients waiting >36 weeks. All patients will have TCI date before end of December 2019. As part of external review, we have employed the 2nd TAVI nurse. The service remains challenging due to unscheduled care pressures particularly around cardiac short stay and also DDW has in recent weeks been closed to Norovirus. We are as a service soon to hit a 100 patient procedures as per contract base with WHSSC which leaves us with any new patient who presents in Feb/March with a plan to undertake their procedures from a financial perspective. Update from Service Group Manager/Snr Matron 30/6/20 - Service is currently commissioned to undertake 100 procedures per annum ie, one list a week. Demands on service mean that currently two lists per week as being undertaken																																								

through an amended weekly timetable for team. Service has been asked by RE, Medical Director, that they support 3 lists per week.

Senior Matron, advises currently enough nursing budget on DDW to run two TAVI lists per week, however at present it is difficult to meet the nursing demands for the service due to COVID pandemic (clean and dirty pathway for patients). Pathways for TAVI are now correct having been reviewed in depth over the last one year.

Service Group Manager, advises a new business case needs to be considered through weekly Gold Command meetings chaired by Medical Director

Risk at the moment can be reduced to 16.

Cardiac Regional Service are trying to provide elective planned service and emergency service across a wider clinical area. JT meeting with Matron (LM), Anwen, Gwen 7/7/20 to agree what nursing is required (1:3 PACU type acuity - can cause some pressures on green / red pathways).

Update from Senior Matron - It has been agreed that the staffing ration for patients will be 1:3 – current staffing on DDW allows for 2 lists per week to be provided.

Any additional patients who are done or who are done on the red pathway will were possible be recovered in CCU. If bed not available there will be a risk assessment undertaken of the patients post procedure care needs, and the acuity of the other patients on the ward. Based on this an additional nurse may be required for the day and possibly the night shift. This is not funded and to note currently DDW can accommodate 2 lists per week but only one of these is funded.

Datix ID Number: 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: Chris White. Chief Operating Officer Assuring Committee: Quality and Safety Committee																																								
Risk: There is a failure to provide adequate clinic capacity to support follow-up patients within the Ophthalmology specialty. The consequence of this failure is a delay in patients with chronic eye conditions accessing ongoing secondary care monitoring of diagnosed conditions with the potential risk of permanently impairing eyesight.		Date last reviewed: December 2020																																								
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 4 x 5 = 20 Target: 4 x 1 = 4	<table border="1"> <caption>Risk Score History</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr><td>Dec-19</td><td>20</td><td>4</td></tr> <tr><td>Jan-20</td><td>20</td><td>4</td></tr> <tr><td>Feb-20</td><td>20</td><td>4</td></tr> <tr><td>Mar-20</td><td>12</td><td>4</td></tr> <tr><td>Apr-20</td><td>16</td><td>4</td></tr> <tr><td>May-20</td><td>16</td><td>4</td></tr> <tr><td>Jun-20</td><td>16</td><td>4</td></tr> <tr><td>Jul-20</td><td>20</td><td>4</td></tr> <tr><td>Aug-20</td><td>20</td><td>4</td></tr> <tr><td>Sep-20</td><td>20</td><td>4</td></tr> <tr><td>Oct-20</td><td>20</td><td>4</td></tr> <tr><td>Nov-20</td><td>20</td><td>4</td></tr> </tbody> </table>			Month	Risk Score	Target Score	Dec-19	20	4	Jan-20	20	4	Feb-20	20	4	Mar-20	12	4	Apr-20	16	4	May-20	16	4	Jun-20	16	4	Jul-20	20	4	Aug-20	20	4	Sep-20	20	4	Oct-20	20	4	Nov-20	20	4
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Nov-20	20	4																																								
Level of Control = 40%	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.																																									
Date added to the HB risk register December 2014	Rationale for target score:																																									
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																																								
<ul style="list-style-type: none"> 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. 		<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>An overall Sustainability Plan to be delivered</td> <td>Service Group Manager Surgical Specialties</td> <td>30th November 2020</td> </tr> </tbody> </table>		Action	Lead	Deadline	An overall Sustainability Plan to be delivered	Service Group Manager Surgical Specialties	30 th November 2020																																	
Action	Lead	Deadline																																								
An overall Sustainability Plan to be delivered	Service Group Manager Surgical Specialties	30 th November 2020																																								
Assurances (How do we know if the things we are doing are having an impact?) <ul style="list-style-type: none"> 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. 2 nd 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 alternative accommodation.

Some clinically urgent Cataract operations have been undertaken through May and June 2020

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 Morrision Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies.		Director Lead: Chris White, Chief Operating Officer Assuring Committee: Quality and Safety Committee/Strategy Planning and Commissioning Committee																																								
Risk: Paediatric dental GA/Sedation services provided under contract from Parkway Clinic, Swansea. Medical Safety risk GAs performed on children outside of an acute hospital setting.		Date last reviewed: December 2020																																								
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 4 x 4 = 16 Target: 4 x 2 = 8	<table border="1"> <caption>Score Data</caption> <thead> <tr> <th>Month</th> <th>Target Score</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Dec-19</td><td>8</td><td>16</td></tr> <tr><td>Jan-20</td><td>8</td><td>16</td></tr> <tr><td>Feb-20</td><td>8</td><td>16</td></tr> <tr><td>Mar-20</td><td>8</td><td>16</td></tr> <tr><td>Apr-20</td><td>8</td><td>16</td></tr> <tr><td>May-20</td><td>8</td><td>16</td></tr> <tr><td>Jun-20</td><td>8</td><td>16</td></tr> <tr><td>Jul-20</td><td>8</td><td>16</td></tr> <tr><td>Aug-20</td><td>8</td><td>16</td></tr> <tr><td>Sep-20</td><td>8</td><td>16</td></tr> <tr><td>Oct-20</td><td>8</td><td>16</td></tr> <tr><td>Nov-20</td><td>8</td><td>16</td></tr> </tbody> </table>		Month	Target Score	Risk Score	Dec-19	8	16	Jan-20	8	16	Feb-20	8	16	Mar-20	8	16	Apr-20	8	16	May-20	8	16	Jun-20	8	16	Jul-20	8	16	Aug-20	8	16	Sep-20	8	16	Oct-20	8	16	Nov-20	8	16	Rationale for current score: There is no immediate access to crash team/ICU facilities 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.
Month	Target Score	Risk Score																																								
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Nov-20	8	16																																								
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 4 th July 2018	Controls (What are we currently doing about the risk?) <ul style="list-style-type: none"> Consultant Anaesthetist present for every General Anaesthetic clinic. Assurance Documentation supplied by Parkway Clinic including confirmation of arrangements in place with WAST and Morrision 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 																																									
Assurances (How do we know if the things we are doing are having an impact?) <ul style="list-style-type: none"> 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 		Mitigating actions (What more should we do?) <table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Transfer of services from Parkway.</td> <td>Interim Head of Primary Care</td> <td>31st May 2021</td> </tr> </tbody> </table>		Action	Lead	Deadline	Transfer of services from Parkway.	Interim Head of Primary Care	31 st May 2021																																	
Action	Lead	Deadline																																								
Transfer of services from Parkway.	Interim Head of Primary Care	31 st May 2021																																								
Current Risk Rating 4 X 4 = 16		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 Task & Finish Group continue to progress transfer of service to Morrision. 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 Morrision 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 2020.

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 Date last reviewed: December 2020																																								
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.																																										
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 5 = 20 Target: 3 x 4 = 12	<table border="1"> <caption>Score Data</caption> <thead> <tr> <th>Month</th> <th>Target Score</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Dec-19</td><td>12</td><td>20</td></tr> <tr><td>Jan-20</td><td>12</td><td>20</td></tr> <tr><td>Feb-20</td><td>12</td><td>20</td></tr> <tr><td>Mar-20</td><td>12</td><td>20</td></tr> <tr><td>Apr-20</td><td>12</td><td>20</td></tr> <tr><td>May-20</td><td>12</td><td>20</td></tr> <tr><td>Jun-20</td><td>12</td><td>20</td></tr> <tr><td>Jul-20</td><td>12</td><td>20</td></tr> <tr><td>Aug-20</td><td>12</td><td>20</td></tr> <tr><td>Sep-20</td><td>12</td><td>20</td></tr> <tr><td>Oct-20</td><td>12</td><td>20</td></tr> <tr><td>Nov-20</td><td>12</td><td>20</td></tr> </tbody> </table>	Month	Target Score	Risk Score	Dec-19	12	20	Jan-20	12	20	Feb-20	12	20	Mar-20	12	20	Apr-20	12	20	May-20	12	20	Jun-20	12	20	Jul-20	12	20	Aug-20	12	20	Sep-20	12	20	Oct-20	12	20	Nov-20	12	20	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.	
Month	Target Score	Risk Score																																								
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Nov-20	12	20																																								
Level of Control = 60%		Rationale for target score: Compliance with Gap & Grow requirements.																																								
Date added to the HB risk register 1 st August 2019																																										
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																																								
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.		Action	Lead																																							
		Deadline																																								
		Adherence to Gap/Grow Standards	Deputy Head of Midwifery																																							
		31 st December 2020																																								
Assurances (How do we know if the things we are doing are having an impact?) Audit of compliance with guidance being undertaken, detection rates of babies born below the 10th centile is being monitored via datix and audited by the service. Ultrasound are assisting with finding capacity wherever possible in order to meet standards for screening and complying with Gap & grow recommendations.		Gaps in assurance (What additional assurances should we seek?)																																								
Current Risk Rating 4 X 5 = 20		Additional Comments																																								
		Meeting took place with Deputy Head of Therapies for the HB. Arrangement to meet in January 2020 to review radiology capacity and plan future service needs. This will form part of the antenatal clinic review. Audit of missed cases themes and trends to be presented to the MDT in February 2020. Approval from health board to progress training and recruitment of midwife sonographers. Working group in place chaired by exec lead for therapies.																																								

Oct20 - awaiting advert for MW sonographer roles. G&G training compliance monitored. Rescheduled scan frequency during COVID.

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 cardiocography 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: December 2020 Rationale for current score: Meeting with K2, IT, finance, procurement and midwifery team on 30/09/2019. System viewed and IT needs identified. Final costing to be assessed prior to resubmission to IBG in Oct or November 2019.																																								
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 5 = 20 Target: 4 x 2 = 8	<table border="1"> <caption>Risk Rating Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr><td>Dec-19</td><td>20</td><td>8</td></tr> <tr><td>Jan-20</td><td>20</td><td>8</td></tr> <tr><td>Feb-20</td><td>20</td><td>8</td></tr> <tr><td>Mar-20</td><td>20</td><td>8</td></tr> <tr><td>Apr-20</td><td>20</td><td>8</td></tr> <tr><td>May-20</td><td>20</td><td>8</td></tr> <tr><td>Jun-20</td><td>20</td><td>8</td></tr> <tr><td>Jul-20</td><td>20</td><td>8</td></tr> <tr><td>Aug-20</td><td>20</td><td>8</td></tr> <tr><td>Sep-20</td><td>20</td><td>8</td></tr> <tr><td>Oct-20</td><td>20</td><td>8</td></tr> <tr><td>Nov-20</td><td>20</td><td>8</td></tr> </tbody> </table>	Month	Risk Score	Target Score	Dec-19	20	8	Jan-20	20	8	Feb-20	20	8	Mar-20	20	8	Apr-20	20	8	May-20	20	8	Jun-20	20	8	Jul-20	20	8	Aug-20	20	8	Sep-20	20	8	Oct-20	20	8	Nov-20	20	8	Rationale for target score:	
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Level of Control = 50%	Date added to the HB risk register 31 st December 2011																																									
Controls (What are we currently doing about the risk?) 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.		Mitigating actions (What more should we do?)																																								
		<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Business case prepared for Central monitoring system to store CTG recordings of fetal heart rate in electronic format.</td> <td>Deputy Head of Midwifery</td> <td>31st December 2020</td> </tr> </tbody> </table>	Action	Lead	Deadline	Business case prepared for Central monitoring system to store CTG recordings of fetal heart rate in electronic format.	Deputy Head of Midwifery	31 st December 2020																																		
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Business case prepared for Central monitoring system to store CTG recordings of fetal heart rate in electronic format.	Deputy Head of Midwifery	31 st December 2020																																								
Assurances (How do we know if the things we are doing are having an impact?) All Wales Fetal Surveillance Standards for 6hrs Fetal Surveillance Training per year		Gaps in assurance (What additional assurances should we seek?)																																								
Current Risk Rating 4 X 5 = 20		Additional Comments Submission to IGB in January 2019. CTG envelopes placed in every set of records for safe storage of CTG. Business case completed by maternity service and multi-professional team. Remaining issue outstanding is the financial detail from IT. To ensure submission of case in January 2020																																								

Datix ID Number: 1834 Health & Care Standard: 5.1 Timely Care		HBR Ref Number: 66 Target Date: 31st March 2022																																								
Objective: Best values outcomes from high quality care		Director Lead: Richard Evans, Executive Medical Director Assuring Committee: Quality and Safety Committee																																								
Risk: Unacceptable delays in access to SACT treatment in Chemotherapy Day Unit		Date last reviewed: December 2020																																								
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 5 = 25 Target: 2 x 2 = 4	<table border="1"> <caption>Risk Rating and Level of Control Data</caption> <thead> <tr> <th>Month</th> <th>Risk Rating</th> <th>Level of Control</th> </tr> </thead> <tbody> <tr><td>Dec-19</td><td>25</td><td>4</td></tr> <tr><td>Jan-20</td><td>25</td><td>4</td></tr> <tr><td>Feb-20</td><td>25</td><td>4</td></tr> <tr><td>Mar-20</td><td>25</td><td>4</td></tr> <tr><td>Apr-20</td><td>25</td><td>4</td></tr> <tr><td>May-20</td><td>25</td><td>4</td></tr> <tr><td>Jun-20</td><td>25</td><td>4</td></tr> <tr><td>Jul-20</td><td>25</td><td>4</td></tr> <tr><td>Aug-20</td><td>25</td><td>4</td></tr> <tr><td>Sep-20</td><td>25</td><td>4</td></tr> <tr><td>Oct-20</td><td>25</td><td>4</td></tr> <tr><td>Nov-20</td><td>25</td><td>4</td></tr> </tbody> </table>	Month	Risk Rating	Level of Control	Dec-19	25	4	Jan-20	25	4	Feb-20	25	4	Mar-20	25	4	Apr-20	25	4	May-20	25	4	Jun-20	25	4	Jul-20	25	4	Aug-20	25	4	Sep-20	25	4	Oct-20	25	4	Nov-20	25	4	Rationale for current score: Increased risk to 25 as waiting times starting to re-increase for Long chair regimes, discussed at oncology business meeting.	
Month		Risk Rating	Level of Control																																							
Dec-19		25	4																																							
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Date added to the HB risk register 30/11/2019																																										
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																																								
Review of CDU by improvement science practitioner Increase nursing staff x 1 at risk, to ensure all nurses are working appropriately. Review of scheduling by staff to ensure all chairs used appropriately. Options appraisal to be completed for SSDU senior management team by service group		Action	Lead	Deadline																																						
		Options appraisal paper to be produced for SSDU senior team by service group	Service Manager Surgical Services	30 th November 2020																																						
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																																								

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 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: December 2020																																								
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 5 = 25 Target: 2 x 2 = 4	<table border="1"> <caption>Chart Data</caption> <thead> <tr> <th>Month</th> <th>Target Score</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Dec-19</td><td>4</td><td>20</td></tr> <tr><td>Jan-20</td><td>4</td><td>25</td></tr> <tr><td>Feb-20</td><td>4</td><td>25</td></tr> <tr><td>Mar-20</td><td>4</td><td>25</td></tr> <tr><td>Apr-20</td><td>4</td><td>25</td></tr> <tr><td>May-20</td><td>4</td><td>25</td></tr> <tr><td>Jun-20</td><td>4</td><td>25</td></tr> <tr><td>Jul-20</td><td>4</td><td>25</td></tr> <tr><td>Aug-20</td><td>4</td><td>25</td></tr> <tr><td>Sep-20</td><td>4</td><td>25</td></tr> <tr><td>Oct-20</td><td>4</td><td>25</td></tr> <tr><td>Nov-20</td><td>4</td><td>25</td></tr> </tbody> </table>		Month	Target Score	Risk Score	Dec-19	4	20	Jan-20	4	25	Feb-20	4	25	Mar-20	4	25	Apr-20	4	25	May-20	4	25	Jun-20	4	25	Jul-20	4	25	Aug-20	4	25	Sep-20	4	25	Oct-20	4	25	Nov-20	4	25	Rationale for current score: Waiting times deteriorating for elective delays patients, particularly prostates discussed in Oncology business meeting.
Month	Target Score	Risk Score																																								
Dec-19	4	20																																								
Jan-20	4	25																																								
Feb-20	4	25																																								
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Oct-20	4	25																																								
Nov-20	4	25																																								
Level of Control =			Rationale for target score:																																							
Date added to the HB risk register 30/11/2019																																										
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																																							
		Additional risk capacity	Service Manager Surgical Services	Deadline 31 st December 2020																																						
		Review of patient pathway	Assistant General Manager – Cancer Services	31 st December 2020																																						
Assurances (How do we know if the things we are doing are having an impact?) Performance and activity data is being monitored and monthly data shared with radiotherapy management meeting and cancer board. It is also now included in scorecard.		Gaps in assurance (What additional assurances should we seek?)																																								
Current Risk Rating 5 X 5 = 25		Additional Comments Radiotherapy waiting times continue to cause concerns, new COSC guidelines launched this year mean we now reporting Rx waiting times to WG. Sept Performance has been added to this risk. Options to increase our capacity and include in PBC for SWWCC which is being developed and internal efficiency work with QI colleagues is also being reviewed. Rx Performance is discussed in Radiotherapy management meeting and papers are chased in Cancer Board. Agreement has been reached around outsourcing 12 prostate radiotherapy cases per month for 6 months to Rutherford. Commencing in January 2020. While case for extended day is further reviewed.																																								

Contract signed off by Executive Team Jan 2020. Patients are being approached to attend Rutherford Cancer Centre and patient details being sent to Rutherford Cancer Centre.

Seen improvement in some WT performance in RT due to cases being referred to Rutherford and due to changes in practice due to Covid-19.

Due to machine breakdowns and covid capacity has been effected to deliver RT. however outsourcing has mitigated some of this but not all.

New action agreed 07/07/20- RT Covid Recovery plan is being developed that will include options around, further outsourcing, bringing back SBAR work from VCC, changes to fractions on BREAST and PROSTATE and how we could use this freed up machine capacity differently. This plan is to go to Reset and Recovery meeting as part of Essential Services Covid Recovery plans for Cancer.

Datix ID Number: 2299 Health & Care Standard: 2.4 Infection Prevention and Control (IPC) and Decontamination		HBR Ref Number: 68 Target Date: 31st March 2021																																								
Objective: Best Value Outcomes from High Quality Care Risk: Risk of declared pandemic due to Coronavirus Infectious Disease outbreak 2020 leading to disruption to Health Board activities.		Director Lead: Keith Reid, Executive Medical Director Assuring Committee: Quality and Safety Committee Date last reviewed: December 2020																																								
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 5 x 5 = 25 Target: 3 x 2 = 6	<table border="1"> <caption>Risk Rating Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr><td>Dec-19</td><td>20</td><td>6</td></tr> <tr><td>Jan-20</td><td>20</td><td>6</td></tr> <tr><td>Feb-20</td><td>20</td><td>6</td></tr> <tr><td>Mar-20</td><td>20</td><td>6</td></tr> <tr><td>Apr-20</td><td>20</td><td>6</td></tr> <tr><td>May-20</td><td>20</td><td>6</td></tr> <tr><td>Jun-20</td><td>20</td><td>6</td></tr> <tr><td>Jul-20</td><td>25</td><td>6</td></tr> <tr><td>Aug-20</td><td>25</td><td>6</td></tr> <tr><td>Sep-20</td><td>25</td><td>6</td></tr> <tr><td>Oct-20</td><td>25</td><td>6</td></tr> <tr><td>Nov-20</td><td>25</td><td>6</td></tr> </tbody> </table>	Month	Risk Score	Target Score	Dec-19	20	6	Jan-20	20	6	Feb-20	20	6	Mar-20	20	6	Apr-20	20	6	May-20	20	6	Jun-20	20	6	Jul-20	25	6	Aug-20	25	6	Sep-20	25	6	Oct-20	25	6	Nov-20	25	6	Rationale for current score: Separate risk register capturing the specific Covid-19 risks which the Health Board are managing with high risks relating to: <ul style="list-style-type: none"> • COVID Equipment – inc PPE • COVID Workforce • COVID Medicines • COVID Capacity 	
Month	Risk Score	Target Score																																								
Dec-19	20	6																																								
Jan-20	20	6																																								
Feb-20	20	6																																								
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Oct-20	25	6																																								
Nov-20	25	6																																								
Level of Control =	Rationale for target score:																																									
Date added to the HB risk register 27/02/2020	Controls (What are we currently doing about the risk?)																																									
<ul style="list-style-type: none"> • HB Response now in place. • Command and Control structure stood up. • Non-COVID19 activity curtailed. • Staff exclusions and testing in place. • PPE guidance in place. • Engagement with all Wales planning and delivery functions. • Field hospitals developed and commissioned. • Primary Care models adapted to current situation. • Work with local authorities on maintaining care sector. • Acting in concert with Local Resilience Forum to manage wider community risks. 		Mitigating actions (What more should we do?) <table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Pandemic Plans invoked</td> <td>Director of Public Health Wales</td> <td>Monthly Ongoing</td> </tr> </tbody> </table>		Action	Lead	Deadline	Pandemic Plans invoked	Director of Public Health Wales	Monthly Ongoing																																	
Action	Lead	Deadline																																								
Pandemic Plans invoked	Director of Public Health Wales	Monthly Ongoing																																								
Assurances (How do we know if the things we are doing are having an impact?) <ul style="list-style-type: none"> • 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 5 X 5 = 25		Additional Comments Mitigation as follows to identify and reduce risks of spread of infection: Pandemic plans invoked																																								

Command, Control and Coordination arrangements in place with Strategic, Tactical and bronze Groups in place to ensure Health Board wide engagement and instigate required planning including:

- o Patient flow pathway scenarios for unwell patients and well patients that may self-present in both acute and Primary and Community Care
- o Appropriate PPE kit and training
- o Appropriate support service pathways for cleaning, decontamination, waste and linen management
- o Multi-agency engagement
- o Community Testing arrangements
- o Workforce review
 - Identified isolation facilities.

Pandemic was declared. Health Board stood up 3CF structures and response on 31 January 2020. System wide response in place. Lockdown established 23rd March. Current levels of demand are containable within existing capacity. Expectations that initial peak of infections has been managed within capacity.

Datix ID Number: 1418 Health & Care Standard: 5.1 Timely Access		HBR Ref Number: 69 Target Date: 31st March 2021																																									
Objective: Best values outcomes from high quality care		Director Lead: Chris White, Chief Operating Officer/Christine Williams, Interim Director of Nursing and Patient Experience Assuring Committee: Performance and Finance Committee																																									
Risk: Risk issues Related to adolescent patients being admitted to Adult MH inpatient wards- Inappropriate settings resulting in 'Safeguarding Issues' The WG has requested that HBs identify Secondary Care in -patient facilities for the care of adolescents- in Swansea Bay University Health Board Ward F NPT hospital is the dedicated receiving facility with one bed identified.		Date last reviewed: December 2020																																									
Risk Rating (consequence x likelihood): Initial: 2 x 3 = 6 Current: 4 x 5 = 20 Target: 2 x 3 = 4	<table border="1"> <caption>Chart Data</caption> <thead> <tr> <th>Month</th> <th>Target Score</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Dec-19</td><td>6</td><td>20</td></tr> <tr><td>Jan-20</td><td>6</td><td>20</td></tr> <tr><td>Feb-20</td><td>6</td><td>20</td></tr> <tr><td>Mar-20</td><td>6</td><td>20</td></tr> <tr><td>Apr-20</td><td>6</td><td>20</td></tr> <tr><td>May-20</td><td>6</td><td>20</td></tr> <tr><td>Jun-20</td><td>6</td><td>20</td></tr> <tr><td>Jul-20</td><td>6</td><td>20</td></tr> <tr><td>Aug-20</td><td>6</td><td>20</td></tr> <tr><td>Sep-20</td><td>6</td><td>20</td></tr> <tr><td>Oct-20</td><td>6</td><td>20</td></tr> <tr><td>Nov-20</td><td>6</td><td>20</td></tr> </tbody> </table>	Month	Target Score	Risk Score	Dec-19	6	20	Jan-20	6	20	Feb-20	6	20	Mar-20	6	20	Apr-20	6	20	May-20	6	20	Jun-20	6	20	Jul-20	6	20	Aug-20	6	20	Sep-20	6	20	Oct-20	6	20	Nov-20	6	20	Rationale for current score: Risk score heightened after a DU wide RR meeting to review scores.		
Month		Target Score	Risk Score																																								
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Level of Control =	Rationale for target score:																																										
Date added to the HB risk register 27/02/2020	Controls (What are we currently doing about the risk?)																																										
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.		Mitigating actions (What more should we do?)																																									
		Action	Lead	Deadline																																							
		Review of Service by Swansea Bay Youth	Assistant Head of Operations MH	31 st December 2020																																							
		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	31 st December 2020																																							
		Revised pathway and guidance for the management of CYP with emotional well- being issues presenting in the ED in Morriston has been developed in conjunction with CAMH service. A paper is being presented to Safeguarding Committee.	Deputy COO	31 st December 2020																																							
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?)																																									
		Additional Comments																																									

Current Risk Rating

$$4 \times 5 = 20$$