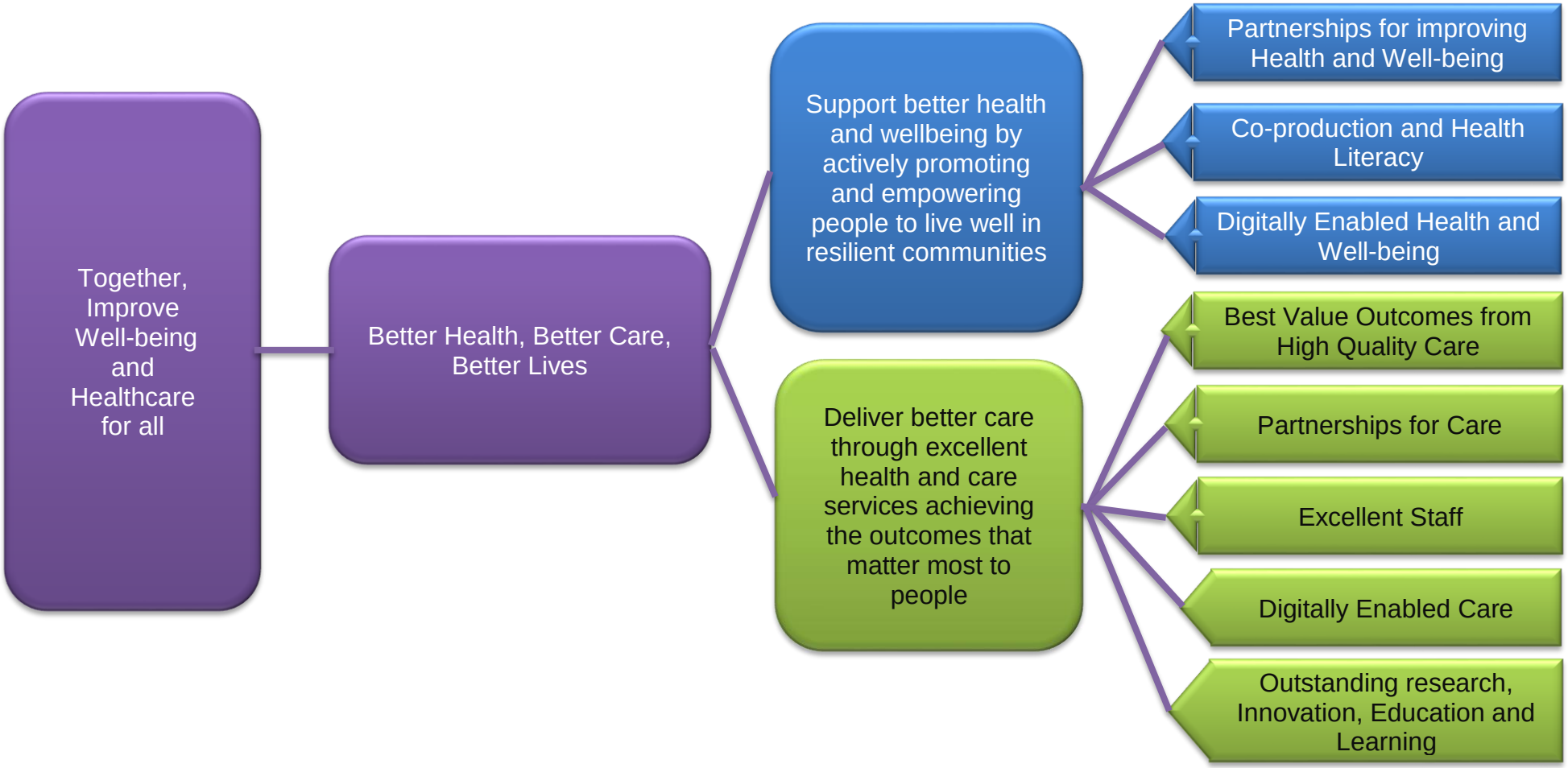
GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Bae Abertawe | Swansea Bay University Health Board

Health Board Risk Register:
Entries for Quality & Safety Committee
May 2020

Aligning Risk with Swansea Bay University Health Board (SBUHB) Strategy

The Swansea Bay University Health Board (SBUHB) strategy is outlined in the figure below and all risks identified for inclusion on the Health Board Risk Register are mapped to our enabling objectives.



HEALTH BOARD RISK REGISTER

DASHBOARD OF ASSESSED RISKS – May 2020

Impact/Consequences						
5				**51:** Compliance with Nurse Staffing Levels (Wales) Act 2016 **4:** Infection Control **49:** TAVI Service **63:** Screening for Fetal Growth Assessment in line with Gap-Grow (G&G) **65:** CTG Monitoring in Labour Wards **69:** Adolescents being admitted to Adult MH wards **70:** Data Centre outages **03:** Workforce Recruitment of Medical and Dental Staff	**67:** Target breeches to Radical Radiotherapy Treatment **66:** SACT Treatment **16:** Access to Planned Care Services **50:** Access to Cancer Services **68:** Coronavirus Pandemic
4				**01:** Access to Unscheduled Care Service **11:** Healthcare Model for Aging Population **43:** DOLS Authorisation and Compliance with Legislation **45**: Discharge information **48:** Child & Adolescence Mental Health Services **37**: Operational and strategic decisions are not data informed **57:** Non-compliance with Home Office Controlled Drug Licensing requirements **61:** Paediatric Dental GA Service - Parkway **58:** Ophthalmology Clinic Capacity	**64:** H&S Infrastructure **39:** IMTP Statutory Responsibility **62:** Sustainable Corporate Services **60:** Cyber Security
3				**13:** Environment of Health Board Premises **36:** Electronic Patient Record **27:** Sustainable Clinical Services for Digital Transformation **41:** Fire Safety Regulation Compliance **52**: Engagement & Impact Assessment Requirements	**15:** Population Health Improvement **54:** No Deal Brexit **53:** Compliance with Welsh Language Standards
2					
1					
C X L	**1**	**2**	**3**	**4**	**5**
	Likelihood				

Risk Register Dashboard

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend	Controls	Last Reviewed	Scrutiny Committee
Best Value Outcomes from High Quality Care	1 (738)	**Access to Unscheduled Care Service** Failure to comply with Tier 1 target for Unscheduled Care could impact on patient and family experience of care.	25	16	→	↓	April 2020	Performance and Finance Committee
	4 (739)	**Infection Control** Failure to achieve infection control targets set by Welsh Government could impact on patient and family experience of care.	20	20	→	→	April 2020	Quality and Safety Committee
	11 (837)	**Ageing Population** Failure to provide an appropriate healthcare model for the ageing population over the next 20 years.	16	16	→	→	April 2020	Quality and Safety Committee
	13 (814)	**Environment of HB Premises** Failure to meet statutory health and safety requirements.	16	12	↓	↑	April 2020	Health and Safety Committee
	64 (2159)	**Health and Safety Infrastructure** Insufficient resource and capacity of the health, safety and fire function to maintain legislative and regulatory compliance.	20	20	→	→	April 2020	Health and Safety Committee
	16 (840)	**Access to Planned Care** Failure to achieve compliance with waiting times, there is a risk that patients may come to harm. Also, financial risk not achieving targets.	16	25	↑	↑	April 2020	Performance and Finance Committee
	37 (1217)	**Information Led Decisions** Operational and strategic decisions are not data informed.	16	16	→	→	April 2020	Audit Committee

39 (1297)	**Approved IMTP – Statutory Compliance** If the Health Board does not have an approved IMTP signed off by Welsh Government, primarily due to the inability to align performance and financial plans it will remain in escalation status, currently "targeted intervention".	16	20	↑	→	April 2020	Performance and Finance Committee
41 (1567)	**Fire Safety Compliance** Fire Safety notice received from the Fire Authority – MH&LD Unit. Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance.re safety regulations.	12	12	→	→	April 2020	Health and Safety Committee
43 (1514)	**DoLS** If the Health Board is unable to complete timely completion of DoLS Authorisation then the Health Board will be in breach of legislation and claims may be received in this respect.	16	16	→	→	April 2020	Quality and Safety Committee
48 (1563)	**CAMHS** Failure to sustain Child and Adolescent Mental Health Services (CAHMS).	16	16	→	→	April 2020	Performance and Finance Committee
49 (922)	**Trans-catheter Aortic Valve Implementation (TAVI)** Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI)	25	20	↓	→	April 2020	Quality and Safety Committee

	63 (1605)	**Screening for Fetal Growth Assessment in line with Gap-Grow** Due to the scanning capacity there are significant challenges in achieving this standard.	20	20	→	→	April 2020	Quality and Safety Committee
	50 (1761)	**Access to Cancer Services** Failure to sustain services as currently configured to meet cancer targets could impact on patient and family experience of care.	20	25	→	↑	April 2020	Performance and Finance Committee
	57 (1799)	**Controlled Drugs** Non-compliance with Home Office Controlled Drug Licensing requirements.	20	16	↓	→	April 2020	Audit Committee
	66 (1834)	**Access to Cancer Services** Delays in access to SACT treatment in Chemotherapy Day Unit	25	25	→	→	April 2020	Quality and Safety Committee
	67 (89)	**Risk target breeches – Radiotherapy** Clinical risk – Target breeches of radical radiotherapy treatment	16	25	→	→	April 2020	Quality and Safety Committee
	69 (1418)	**Safeguarding** Adolescents being admitted to adult MH wards	16	20	→	→	April 2020	Quality & Safety Committee
Excellent Staff	3 (843)	**Workforce Recruitment** Failure to recruit medical & dental staff	20	20	↓	↑	April 2020	Workforce and OD Committee
	51 (1759)	**Nurse Staffing (Wales) Act** Risk of Non Compliance with the Nurse Staffing (Wales) Act	16	20	↓	↑	April 2020	Workforce and OD Committee

	62 (2023)	**Sustainable Corporate Services** Health Board's Annual Plan and organisational strategy, and with the skills, capability, behaviours and tools to successfully deliver in support of the whole organisation, and to do so in a way which respects and promotes the health and well-being of our staff and their work-life balance.	20	20	→	→	April 2020	Workforce and OD Committee
Digitally Enabled Care	27 (1035)	**Sustained Clinical Services** Inability to deliver sustainable clinical services due to lack of digital transformation.	16	12	↓	↓	April 2020	Audit Committee
	36 (1043)	**Storage of Paper Records** Failure to provide adequate storage facilities for paper records then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if	20	12	↓	↓	April 2020	Audit Committee
	45 (1565)	**Discharge Information** If patients are discharged from hospital without the necessary discharge information this may have an impact on their care	20	16	↓	↓	April 2020	Quality and Safety Committee
	60 (2003)	**Cyber Security – High level risk** The level of cyber security incidents is at an unprecedented level and health is a known target.	20	20	→	→	April 2020	Audit Committee
	65 (329)	**CTG Monitoring on Labour Wards** Risk associated with misinterpreting abnormal CTG readings in delivery rooms.	20	20	→	→	April 2020	Information Governance Board

	70 (2245)	**National Data Centre Outages** The failure of national systems causes severe disruption across NHS Wales, affecting Primary and secondary care services.	20	20	➔	➔	April 2020	Audit Committee

Partnerships for Improving Health and Wellbeing	58 (146)	**Ophthalmology - Excellent Patient Outcomes** There is a failure to provide adequate clinic capacity to support follow-up patients within the Ophthalmology specialty.	12	16	➔	↑	April 2020	Quality and Safety Committee
	15 (737)	**Population Health Targets** Failure to achieve population health improvement targets leading to an increase in preventable disease amongst the population resulting in increased morbidity impacting on operational and financial pressures.	15	15	➔	➔	April 2020	Quality and Safety Committee
	68 (2299)	**Pandemic Framework** Risk of declared pandemic due to Coronavirus Infectious Disease outbreak 2020.	20	25	➔	↑	April 2020	Quality and Safety Committee
	61 (1587)	**Paediatric Dental GA Service – Parkway** Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morriston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies.	15	16	↑	➔	April 2020	Quality and Safety Committee

Partnerships for Care	52 (1763)	**Statutory Compliance** The Health Board does not have sufficient resource in place to undertake engagement & impact assess in line with Statutory Duties	16	12	↓	↑	April 2020	Performance & Finance Committee
	53 (1762)	**Welsh Language Standards** Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.	15	15	→	→	April 2020	Health Board (Welsh Language Group)
	54 (1724)	**Brexit** Failure to maintain services as a result of the potential no deal Brexit	15	15	→	→	April 2020	Health Board (Emergency Preparedness Resilience and Response Group)

Risk Schedules

Datix ID Number: 738 **Health & Care Standard: 5.1 Timely Care**	**HBR Ref Number: 1**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Quality and Safety Committee
Risk: If we fail to comply with Tier 1 target – **Access to Unscheduled Care** then this will have an impact on patient and family experience. Challenges with capacity /staffing across the Health and Social care sectors.	**Date last reviewed:** April 2020

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

Rationale for current score:
Due to current measures related to COVID 19 including the cancelled all non-urgent activity, Emergency Department and MIU attendance have reduced by nearly 50%, red call performance is at 65% and 4hr handover for the last 3 weeks has been in excess of 75%. Both Morriston and Singleton have been risk level 1 for the past 2 weeks. It is recognised that this is not likely to be maintained and therefore remains a high risk.

Level of Control = 50%

Rationale for target score:

Date added to the HB risk register 26.01.16

The service delivery units have been implementing models of care that reflect National priorities and there is evidence that these are starting to impact positively on patient flow, length of stay and demand management. Workforce capacity issues continue to be challenging in some key specialty areas.

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

- Programme management arrangements in place to improve Unscheduled Care performance.
- Daily Health Board wide conference calls/ escalation process in place.
- Regular reporting to Executive Team, Executive Board and Health Board/Quality and Safety Committee.
- Increased reporting as a result of escalation to targeted intervention status.
- Targeted unscheduled care investment to support changes to front door service models/ workforce redesign/ patient flow.
- Weekly unscheduled care meeting implemented, led by COO and attended by Service Directors

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Bed utilisation audit being undertaken to support USC system redesign programme in NPT and Swansea.	Deputy Chief Operating Officer	30th June 2020
Implement findings of Kendall Bluck report once supported by Executive Team	Chief Operating Officer	30th June 2020

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

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

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

Current Risk Rating
4 x 4 = 16

Additional Comments
Due to current measures related to COVID 19 including the cancelled all non-urgent activity, Emergency Department and MIU attendance have reduced by

	nearly 50%, red call performance is at 65% and 4hr handover for the last 3 weeks has been in excess of 75%. Both Morriston and Singleton have been risk level 1 for the past 2 weeks. It is recognised that this is not likely to be maintained and therefore remains a high risk. 23.4.20

Datix ID Number: 739 Health & Care Standard: 2.4 Infection Prevention & Control & Decontamination	HBR Ref Number: 4
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Gareth Howells, 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:** April 2020

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

Level of Control = 40%

Date added to the HB risk register January 2016

Rationale for current score:
Currently under targeted intervention for rates of infection, achievement of targets are variable with monthly fluctuations

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.

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

- Regular monitoring on infection rates
- Policies, procedures and guidelines in place
- Regular reporting through internal processes
- ICNet information management system for infections is in place
- Infection control team support the clinical teams for issues relating to infection control
- A permanent infection control doctor has been recruited
- Recruitment is ongoing 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?)

Action	Lead	Deadline
Recruitment to ensure the team is fully established with the right skills and experience	Assist Dir Nursing Infection Control	30th June 2020
Ongoing infection control team involvement in site level estates projects to ensure appropriate isolation facilities are factored in from the outset	Senior Infection Control Matron	30th June 2020
HPV/UV cleaning post infection to be implemented	Assist Dir Nursing Infection Control	30th June 2020

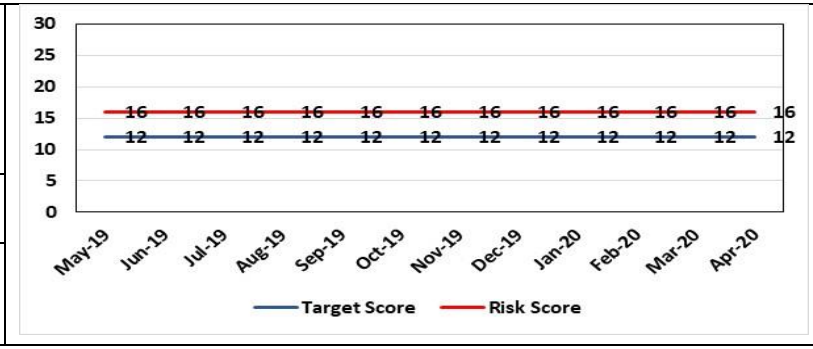
Assurances
(How do we know if the things we are doing are having an impact?)

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

Gaps in assurance
(What additional assurances should we seek?)
ICNet provides information linked with PAS relating to patients who have been inpatients since the connection was made therefore additional manual records are maintained by the infection control team creating additional work and some

• 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.	duplication.
Current Risk Rating **5 x 4 = 20**	**Additional Comments** Significant progress to date however trajectory not met overall. Work underway on recruitment to IPC, a work plan to improve practice and improved information available for reporting, oversite and also investigation. 13/06/19 Continue to make progress against annual IMTP profiles, however, incidence within the Health Board remains above that for the NHS in Wales. Recruitment to Matron IPC post on 03/06/19. Work in progress to improve incident reporting in relation to infections and pilot to commence on post infection review process. Appropriate environmental decontamination resource to be identified and staff trained in its appropriate use. Compliance with IPC standard precautions and ANTT training and competence needs to be improved. A review of cleaning of shared equipment such as beds, commodes is required to reduce risks of transmission. Increase in cleaning hours across the Units is required to meet national minimum standards. Dedicated protected decant facilities are required for each Unit to ensure appropriate cleaning. Sufficient isolation rooms required to manage patient's appropriately. Estate needs to be updated and maintained to reduce risks. IPCC resources required to support community and primary care. Increase numbers of Piis on the last two months. HB over trajectory on a number of the TI Tier 1 targets. Increased level of risk due to insufficient domestic hours at Singleton hospital and significant vacancies at Morrison, lack of decant facilities, over occupancy in bays. Approved for increase in establishment at IBG in October 2019. 4 new posts approved. Now within VCP Process plus 1 existing band 6 vacancy. All 5 posts to be advertised in January 2020. Although there has been some improvement against TI Tier 1 targets, it is challenging to sustain. PII currently at Morriston Hospital. Reduction initiatives are compromised by over-crowding of wards as a result of increased activity, over-occupancy, staff vacancies, and where activity levels are such that it is not possible to decant bays to effectively clean patient areas where there have been infections. From an All Wales perspective, not yet achieving NHS Wales Infection Reduction Expectations.

Datix ID Number: 837 Health & Care Standard: Staying Healthy 1.1 Health Promotion & Protection & Improvement	HBR Ref Number: 11
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Gareth Howells, Director of Nursing and Patient Experience **Assuring Committee:** Quality and Safety Committee
Risk: If we fail to provide an appropriate **healthcare model for aging population** over next 20 years care resident population will see a 24% increase in people of a pensionable age and 15% increase in people of non-working age. Providing services to enable citizens to live independently at home is a major challenge.	**Date last reviewed:** April 2020
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 =16 Target: 4 x 3 = 12	**Rationale for current score:** New Hospital to Home Service Module, Good Care at Home.
Level of Control = 70%	**Rationale for target score:** New models of care will reduce the risk to be at an acceptable level for timely discharges reducing lengthy harmful patient delays from hospital.
Date added to the HB risk register January 2013	

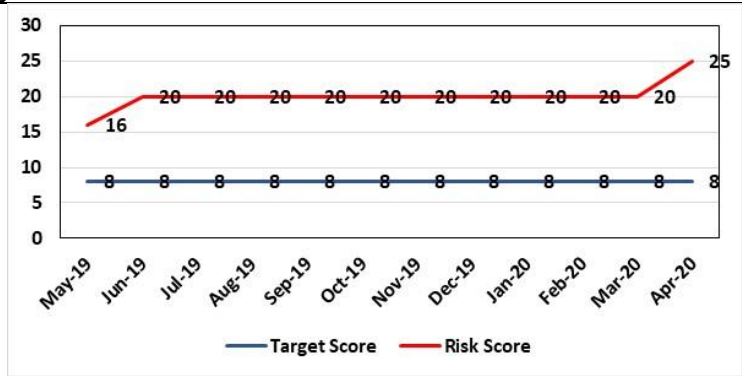


Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
• Twelve standards of care for older people in hospital have been developed jointly by clinical staff, patient groups and voluntary sector organisations. • The 'See It Say It' campaign was established to make it easier for staff, patients and visitors to raise concerns – anonymously if they wish – by phone, text or email • Introduction of the '15 Step Challenge' to improve the first impression patients and visitors get when they enter a ward • Close monitoring of the implementation plan via Health Board Clinical Redesign Group • Restructured Dementia Care Steering Group (July 2019) to review and monitor services for those living with Dementia within the Health Board population. • New models of working to commence as phased approach December 2019 – Hospital to Home essentially aims to increase the quality of patient care and patient experiences due to timely discharges from hospital through primarily a Reablement home-based home support using a Trusted Assessor model. Current hospital based assessment will shift to home based assessment which is strengths based and takes place when the person (patient) is not in crisis (in hospital). Jointly developed with Local Authority and Health.	**Action**	**Lead**	**Deadline**
	Move to a balanced service model with bed provision reducing over time, development of community OPMH Hubs, community development and essential infrastructure services such as support & stay, care home support, memory clinics and Day Services.	Corporate Head of Nursing	31st May 2020

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
Current Risk Rating **4 x 4 = 16**	**Additional Comments** Commenced Hospital to home service December 2019. Updated safer patient flow and discharge policy October.

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

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



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

Level of Control
= 90%

Rationale for target score:

Date added to the HB risk register
January 2013

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

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

- Weekly RTT meetings in place
- Outsourcing additional capacity
- NHS Wales Delivery Unit support provided in house and also support to the RTT meetings
- Treat in Turn tools operationalised
- Cohort tools operationalised
- Support from Cwm Taf re backfill
- Support from NPTH re additional orthopaedic waiting lists
- Theatre group considering how to increase throughout through theatres
- Additional staff training and recruitment (along with short term agency) to increase resilience of Morriston elective theatre

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Escalation and scrutiny to Performance and finance Committee for off profile specialties	Associate Director Performance	Monthly
Develop sustainability plans for specialties through the emerging Clinical Services Plan	Head of IMPT Development	30th June 2020

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

- Recover of specialties to profiled levels
- Outsourcing volumes confirmed by providers
- Increased Treat in Turn rates and cohort appointment
- Reduction in overall waiting long waiting volumes

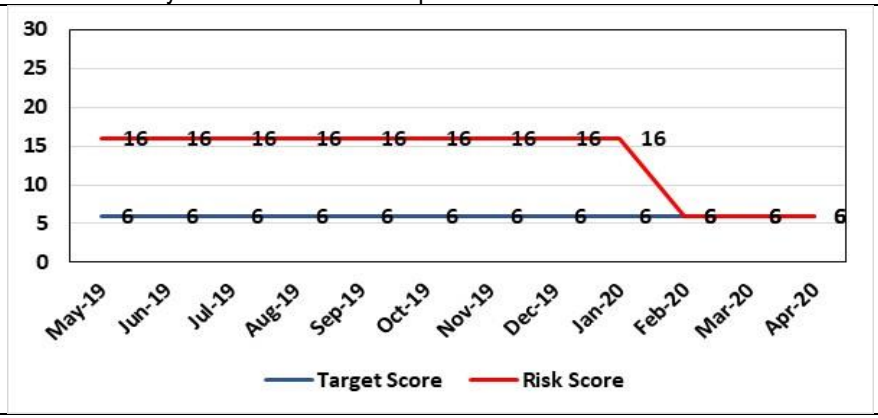
Gaps in assurance
(What additional assurances should we seek?)

Current Risk Rating

Additional Comments

5 x 5 = 25	The cancellation of all non-urgent activity due to COVID-19 has increased the backlog of planned care cases across the organisation. Whilst mitigating measures such as virtual clinics have been put in place new referrals are still being accepted which is adding to the outpatient volumes. The significant reduction in theatre activity is obviously increasing the number of patients now breaching 36 and 52 week thresholds.

Datix ID Number: 1514 Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety	HBR Ref Number: 43
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Gareth Howells, 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:** April 2020

Risk Rating (consequence x likelihood): Initial: 4 x 4 =16 Current: 2 x 3 = 6 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?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• 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	Delivery of DOLS Action plan reviewed monthly	Head of Safeguarding	Monthly Review

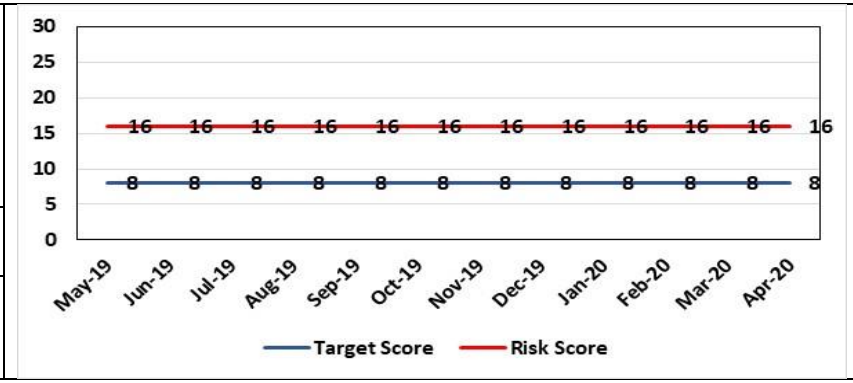
Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
• Regular scrutiny at Safeguarding Committee and by DoLS Internal Audit; monitoring via DoLS Dashboard which is due to be rolled out imminently and will provide real-time accurate data.	
Current Risk Rating **4 x 4 = 16**	**Additional Comments** All actions attributable to safeguarding completed and Internal Audit aware.

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

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

Level of Control
= 50%

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



Rationale for current score:
The specialist CAMHS Network is delivered by Cwm Taf University Health Board on behalf of ABMU. Cwm Taf have confirmed that they will not meet the 28 day target by the end of March 2018. This is as a result of pressures across the entire CAMHS network in relation to demand & capacity and recruitment & retention.

Rationale for target score:

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Implementation of the Choice and Partnership Approach (CAPA) started on 1st November 2017 and being closely monitored	CAMHS network	29th June 2020
Additional investment expected - from Welsh Government is supporting the delivery of Waiting List Initiative clinics to support the position.	CAMHS network	29th June 2020
The Network is seeking to recruit agency staff to fill existing and upcoming vacancies to ensure that core capacity is maximised.	CAMHS network	29th June 2020

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

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

Current Risk Rating
4 x 4 = 16

Additional Comments
The service is now in the 2nd cycle of CAPA with new job plans agreed from January, with updated demand & capacity mapping. WLI Clinics initiated at POW Hospital, Bridgend which enabled the 80% target to be achieved by end of end March. This was also achieved for NPT area. However Swansea had a significant

	backlog, which is starting to be addressed with waiting list initiatives from March 2018. Primary & specialist CAMHS services are delivered by Cwm Taf University Health Board on behalf of ABMU (although this will only be for Swansea & NPT from 1/4/19). Cwm Taf achieved the non-urgent 28 day target for specialist CAMHS by the end of March 2019. Their ability to sustain this performance is dependent on consistency and availability of staff which due to the small numbers in the various CAMHS teams can affect achievement of waiting times significantly. Target achieved in March 2019, then missed for a number of months, but achieved from September 2019. However performance is still inconsistent, and will remain so until the existing 3 teams have been integrated into one service across West Glamorgan. New service model being implemented from June 2020 which will stabilise service. A new pathway for CAMHS patients is currently being developed which provides advice on the appropriate actions for dealing with these children and young people and will reduce the need to hold them in the Emergency Department at Morriston.

Datix ID Number: 922 Health & Care Standard: Effective Care 3.1 Clinically Effective Care	HBR Ref Number: 49
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:** April 2020

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?)

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

Mitigating actions (What more should we do?)

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

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

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

Current Risk Rating
4 x 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

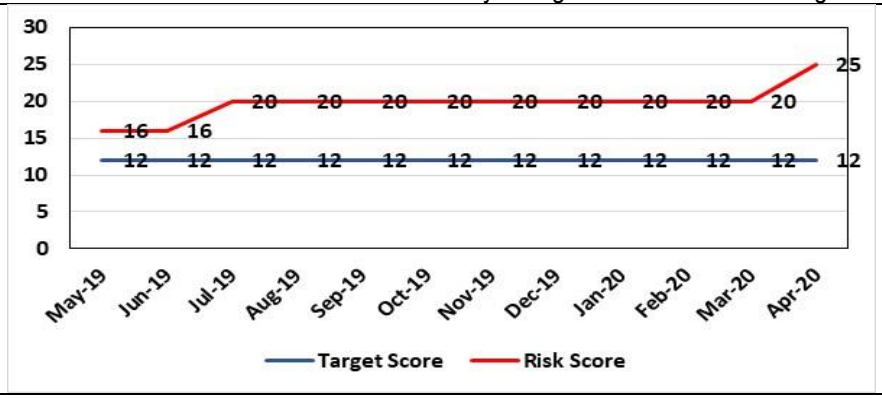
	procedures as per contract base with WHSSC which leaves us with any new patient who presents in Feb/March with a plan to undertake their procedures from a financial perspective.

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

Risk Rating
(consequence x likelihood):
Initial: 4 x 5 = 20
Current: 5 x 5 = 25
Target: 4 x 3 = 12

Level of Control
= 70%

Date added to the HB risk register
April 2014



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

Rationale for target score:

Target score reflects the challenge this area of work present the Board and where small numbers of patients impact on the potential to breach target

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

- Tight management processes to manage each individual case on the unscheduled care (USC) Pathway.
- Initiatives to protect surgical capacity to support USC pathways have been put in place in RGH and PCH to protect core activity.
- Prioritised pathway in place to fast track USC patients.
- Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies.
- Overall Cancer target performance plateau at around 90% with ongoing monitoring of related actions in place at F,P&W Committee.
- Small numbers of patients breaching which is impacting on sustained delivery of the 31 and 62 day target.
- Rapid Diagnostic Clinic established at Neath Port Talbot Hospital. Discussions are ongoing with regard to patient flow and the boundary changes. Discussions are being held with the Executive team regarding the future direction and provision of the RDC service. Work is also ongoing to roll out the concept of the RDC across Wales.
- Delivery Units have Cancer Trackers to closely monitor and 'pull' patients through their pathways. Weekly cancer performance meetings are held at both Singleton and Morriston Delivery Units. Also a weekly HB Cross Unit Cancer performance meeting is held. This meeting is led by the Cancer Lead Manager/Cancer Information Team and the Units are challenged on delays and service issues.
- The tumour sites of concern across the HB for breaches are now Breast, Gynaecological and Lower GI. Forecast performance remains a significant risk until sustainable solutions are identified for these tumour sites and new staff appointments to support tracking and pathways are fully embedded within services.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Introduction of revised models for rapid diagnostic review / assessment in cancer pathways being introduced.	Service Director	30th June 2020
Continue close monitoring of each patient on the USC pathways to ensure rapid flow of patients through the pathway.	Service Director	30th June 2020
Some speciality challenges remain in Lung and Urology - Action plans in place, along with monitoring.	Service Director	30th June 2020

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

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

General improvement (sustained) trajectory. Need to continue improvement actions and close monitoring. Early diagnosis pathway launched and impact being closely monitored.	Clear current funding gap.
Current Risk Rating **5 x 5 = 25**	**Additional Comments** The need to deliver sustained performance. Whilst every effort is being made to maintain cancer treatment, surgical cancer activity in particular is being impacted upon by both the reduction in elective theatre capacity and availability in critical care beds due to the COVID-19 outbreak.

Datix ID Number: 146 Health & Care Standard: Effective Care 3.1 Clinically Effective Care	CRR Ref Number: 58
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:** April 2020
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 4 x 4 = 16 Target: 4 x 1 = 4	**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.
Level of Control = 40%	**Rationale for target score:**
Date added to the HB risk register December 2014	

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	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	Service Group Manager Surgical Specialties	30th June 2020

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
• 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.	Extended waiting times for patients requiring routine clinical intervention, but these are still listed as per RTT guidance.
Current Risk Rating **4 x 4 = 16**	**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.

Datix ID Number: 737 Health & Care Standard: Staying Healthy 1.1 Health Promotion	HBR Ref Number: 15
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:** April 2020

Risk Rating (consequence x likelihood):
Initial: 5 x 3 = 15
Current: 5 x 3 = 15
Target: 3 x 3 = 9

Level of Control = 60%

Date added to the HB risk register 26.01.16

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

Rationale for target score:

Manage preventable disease

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Deliver immunisation awareness training for pre-school settings to promote key vaccination messages	Consultant Public Health Medicine	31st May 2020
Contribute to the implementation of recommendations made in the "MMR Immunisation: process mapping of the child's journey" report.	Consultant Public Health Medicine	31st May 2020
Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins	Consultant Public Health Medicine	31st May 2020

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

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

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

Current Risk Rating
5 x 3 = 15

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

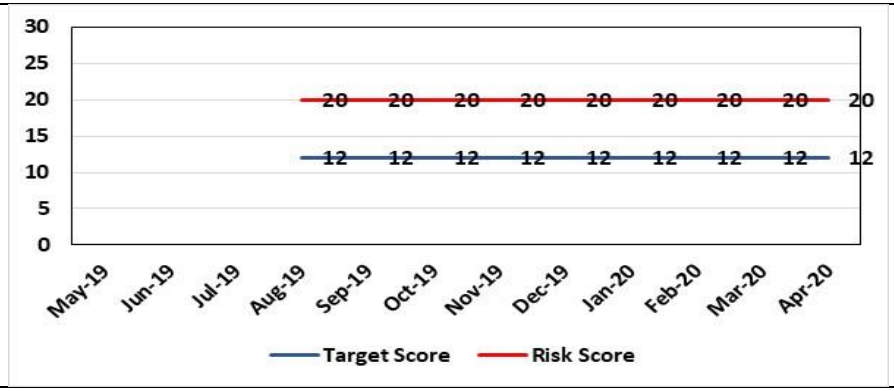
Datix ID Number: 1587 Health & Care Standard: 3.1 Safe and Clinically Effective Care	HBR Ref Number: 61
Objective: Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morriston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies.	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** 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:** April 2020

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

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• 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	Transfer of services from Parkway.	Interim Head of Primary Care	30th June 2020

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
• 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	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.

Datix ID Number: 1605 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**	**HBR Ref Number: 63**
Objective: Screening for Fetal Growth Assessment in line with Gap-Grow (G&G)	**Director Lead**: Gareth Howells, 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:** April 2020
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 5 = 20 Target: 3 x 4 = 12 **Level of Control** = 60% **Date added to the HB risk register** 1st August 2018	**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?)**		
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	29th May 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		

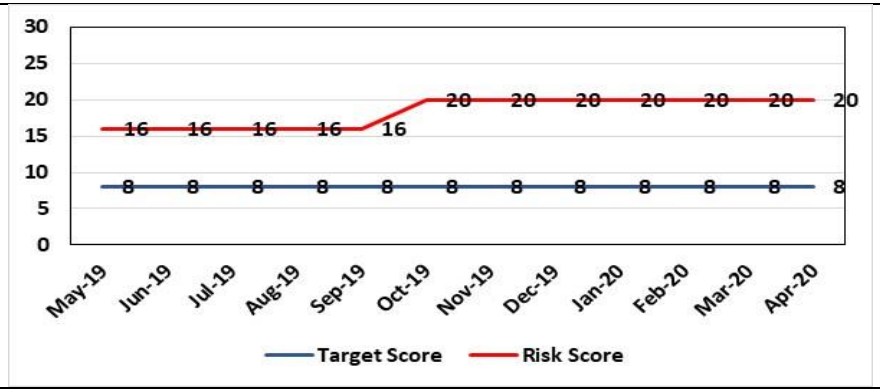
	February 2020

Datix ID Number: 329 Health & Care Standard: 3.1 Safe and Clinically Effective Care	HBR Ref Number: 65
Objective: Digitally enabled Care	**Director Lead**: Gareth Howells, 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:** April 2020 **Rationale for current score:** Meeting with K2, IT, finance, procurement and midwifery team on 30/09/2019. System viewed and IT needs identified. Final costing to be assessed prior to resubmission to IBG in Oct or November 2019.

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

Level of Control = 50%

Date added to the HB risk register 31st December 2011

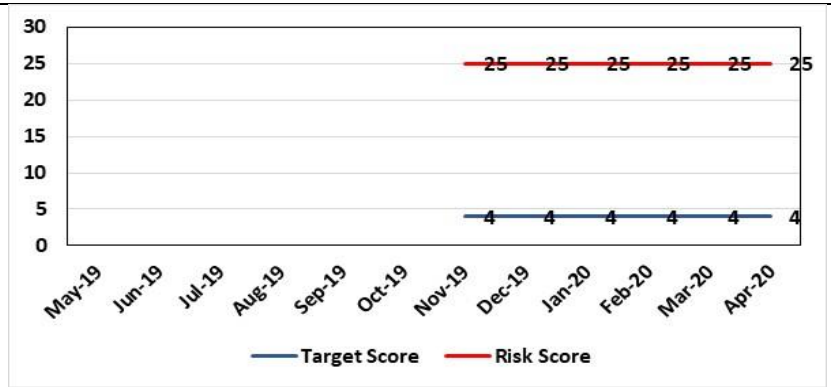


Rationale for target score:

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
Current controls include all staff undertaking RCOG CTG training and competency assessment. Protocol in place for an hourly "fresh eyes" on 'intrapartum CTG's' and jump call procedures. CTG prompting stickers have been implemented to correctly categorise CTG recordings. Central monitoring is also expected to strengthen the HB's position in defending claims. K2 fetal monitoring system has been identified as the best option for a central monitoring system.	Business case prepared for Central monitoring system to store CTG recordings of fetal heart rate in electronic format.	Deputy Head of Midwifery	29th May 2020
	Identified need for midwife for fetal surveillance training and support to improve knowledge through increased support and training in the clinical areas as well as support for the formal training programme within SBUHB.	Deputy Head of Midwifery	29th May 2020

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
All Wales Fetal Surveillance Standards for 6hrs Fetal Surveillance Training per year	
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
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:** April 2020

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

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
Review of CDU by improvement science practitioner Increase nursing staff x 1 at risk, to ensure all nurses are working appropriately. Review of scheduling by staff to ensure all chairs used appropriately. Options appraisal to be completed for SSDU senior management team by service group	**Action**	**Lead**	**Deadline**
	Options appraisal paper to be produced for SSDU senior team by service group	Service Manager Surgical Services	31sy May 2020

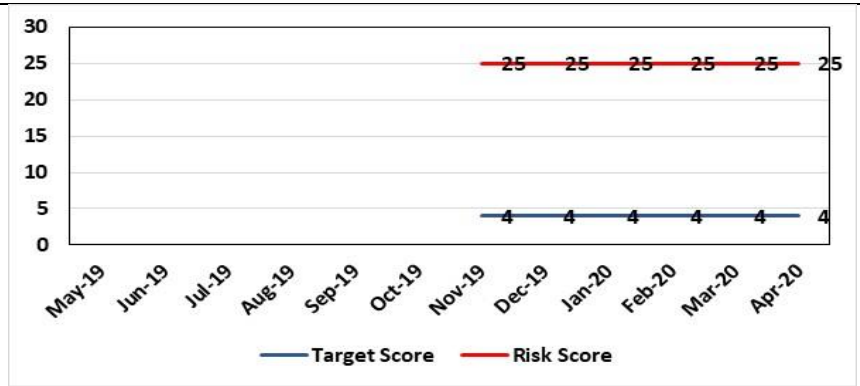
Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Extra nurse in place reliant on agency Senior team meeting to review findings of service review paper. Additional funding agreed to support increase in nurse establish to appropriately run the unit during their main opening hours	
Current Risk Rating **5 X 5 = 25**	**Additional Comments** Additional staffing in place from Dec 19 to allow full use of chairs but capacity gap remains. Looking at options around use of additional SACT capacity via Tenovus. Also working with MSD/GE around potential partnership agreement to look at C&D mapping and best practice elsewhere with visit to Leeds being arranged by MSD colleagues.

Datix ID Number: 89 **Health & Care Standard: 5.1 Timely Care**	**HBR Ref Number: 67**
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:** April 2020

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

Level of Control =

Date added to the HB risk register 30/11/2019



Rationale for current score:
Waiting times deteriorating for elective delays patients, particularly prostates discussed in Oncology business meeting.

Rationale for target score:

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
Requests for treatment and treatment dates monitored by senior management team.	**Action**	**Lead**	**Deadline**
	Additional risk capacity	Service Manager Surgical Services	31st May 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.

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

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

No HB Policy in place but HB would seek guidance from WG, PHE and PHW. However, the HB Pandemic Framework will be invoked if mass vaccination is required in response to an outbreak of an infectious disease.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Pandemic Plans invoked	Director of Public Health Wales	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
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 o Identified isolation facilities.

Datix ID Number: 1418 Health & Care Standard: 5.1 Timely Access	HBR Ref Number: 69
Objective: Best values outcomes from high quality care	**Director Lead**: Chris White, Chief Operating Officer/Gareth Howells, 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:** April 2020

Risk Rating (consequence x likelihood):
Initial: 2 x 3 = 6
Current: 4 x 5 = 20
Target: 2 x 3 = 4

Level of Control =

Date added to the HB risk register 27/02/2020

Rationale for current score:
Risk score heightened after a DU wide RR meeting to review scores.

Rationale for target score:

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	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 June 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	27th March 2020

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
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.	
Current Risk Rating **4 X 5 = 20**	**Additional Comments**

Risk Score Calculation

For each risk identified, the LIKELIHOOD & CONSEQUENCE mechanism will be utilised. Essentially this examines each of the risks and attempts to assess the likelihood of the event occurring (PROBABLILITY) and the effect it could have on the Health Board (IMPACT). This process ensures that the Health Board will be focusing on those risks which require immediate attention rather than spending time on areas which are, relatively, a lower priority.

Risk Matrix	LIKELIHOOD (*)				
CONSEQUENCE (**)	1 - Rare	2 - Unlikely	3 - Possible	4 - Probable	5 - Expected
1 - Negligible	1	2	3	4	5
2 - Minor	2	4	6	8	10
3 - Moderate	3	6	9	12	15
4 - Major	4	8	12	16	20
5 - Catastrophic	5	10	15	20	25