



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Bae Abertawe
Swansea Bay University
Health Board

HEALTH BOARD RISK REGISTER SEPTEMBER 2021

(Revised to reflect updates to mid-October)

RISKS ASSIGNED TO THE QUALITY & SAFETY COMMITTEE

Datix ID Number: 738 Health & Care Standard: 5.1 Timely Care		HBR Ref Number: 1 Target Date: 31st March 2022		Current Risk Rating 5 x 5 = 25																																								
Objective: Best Value Outcomes from High Quality Care		Director Lead: Janet Williams, Interim Director of Operations Assuring Committee: Performance and Finance Committee For Information: Quality & 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: September 2021																																										
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4.5 x 4.5 = 20.25 Target: 3 x 4 = 12		<table border="1"> <caption>Risk and Target Scores</caption> <thead> <tr> <th>Month</th> <th>Target Score</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Oct-20</td><td>12</td><td>16</td></tr> <tr><td>Nov-20</td><td>12</td><td>16</td></tr> <tr><td>Dec-20</td><td>12</td><td>16</td></tr> <tr><td>Jan-21</td><td>12</td><td>16</td></tr> <tr><td>Feb-21</td><td>12</td><td>16</td></tr> <tr><td>Mar-21</td><td>12</td><td>16</td></tr> <tr><td>Apr-21</td><td>12</td><td>16</td></tr> <tr><td>May-21</td><td>12</td><td>16</td></tr> <tr><td>Jun-21</td><td>12</td><td>16</td></tr> <tr><td>Jul-21</td><td>12</td><td>16</td></tr> <tr><td>Aug-21</td><td>12</td><td>16</td></tr> <tr><td>Sep-21</td><td>12</td><td>25</td></tr> </tbody> </table>		Month	Target Score	Risk Score	Oct-20	12	16	Nov-20	12	16	Dec-20	12	16	Jan-21	12	16	Feb-21	12	16	Mar-21	12	16	Apr-21	12	16	May-21	12	16	Jun-21	12	16	Jul-21	12	16	Aug-21	12	16	Sep-21	12	25	Rationale for current score: Post wave 2 of COVID 19 Murrison and Singleton have experienced a steady increase in emergency demand to pre-covid levels. Capacity is limited due to covid response and therefore remains a high risk. Current score raised due to increasing pressures.	
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Sep-21	12	25																																										
Level of Control = 50%		Rationale for target score: Our annual plan is to implement models of care that reflect best practice. This will improve patient flow, length of stay and reduce emergency demand.																																										
Date added to the HB risk register 26.01.16																																												
Controls (What are we currently doing about the risk?)			Mitigating actions (What more should we do?)																																									
<ul style="list-style-type: none"> Programme management office in place to improve Unscheduled Care. Daily Health Board wide conference calls/ escalation process in place. Regular reporting to Executive and Health Board/Quality and Safety Committee. Increased reporting as a result of escalation to targeted intervention status. Targeted unscheduled care investment of £8.5m in the annual plan, including a new Acute Medical Model focused on increasing ambulatory care. Development of a Phone First for ED model in conjunction with 111 to reduce demand. 			<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Implementation of Phone First for ED as one the initiatives set out in the National Unscheduled Care Programme – six goals.</td> <td>Chief Operating Officer</td> <td>31st October 2021</td> </tr> <tr> <td>Phased implementation of the Acute Medical Services Redesign. Business case for ambulatory care element of service redesign submitted WG.</td> <td>Chief Operating Officer</td> <td>31st October 2021</td> </tr> </tbody> </table>			Action	Lead	Deadline	Implementation of Phone First for ED as one the initiatives set out in the National Unscheduled Care Programme – six goals.	Chief Operating Officer	31 st October 2021	Phased implementation of the Acute Medical Services Redesign. Business case for ambulatory care element of service redesign submitted WG.	Chief Operating Officer	31 st October 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"> New Urgent & Emergency Care Board to meet monthly 			Gaps in assurance (What additional assurances should we seek?) The need to deliver sustained service.																																									
Additional Comments																																												
Risk transferred to Urgent & Emergency Care Board to task 11.05.2021.																																												

Datix ID Number: 739 Health & Care Standard: 2.4 Infection Prevention & Control & Decontamination		HBR Ref Number: 4 Target Date: 31st March 2022		Current Risk Rating 4 x 5 = 20																																								
Objective: Best Value Outcomes from High Quality Care		Director Lead: Gareth Howells, Director of Nursing & Patient Experience Assuring Committee: Quality and Safety Committee																																										
Risk: Failure to achieve Welsh Government infection reduction goals, and a higher incidence of Tier 1 infections than average for NHS Wales. Risk of nosocomial transmission of infection.		Date last reviewed: September 2021																																										
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 = 12 Level of Control = 40% Date added to the HB risk register January 2016		<table border="1"> <caption>Target and Risk Scores (Oct-20 to Sep-21)</caption> <thead> <tr> <th>Month</th> <th>Target Score</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Oct-20</td><td>12</td><td>16</td></tr> <tr><td>Nov-20</td><td>12</td><td>16</td></tr> <tr><td>Dec-20</td><td>12</td><td>16</td></tr> <tr><td>Jan-21</td><td>12</td><td>16</td></tr> <tr><td>Feb-21</td><td>12</td><td>16</td></tr> <tr><td>Mar-21</td><td>12</td><td>16</td></tr> <tr><td>Apr-21</td><td>12</td><td>16</td></tr> <tr><td>May-21</td><td>12</td><td>16</td></tr> <tr><td>Jun-21</td><td>12</td><td>16</td></tr> <tr><td>Jul-21</td><td>12</td><td>16</td></tr> <tr><td>Aug-21</td><td>12</td><td>16</td></tr> <tr><td>Sep-21</td><td>12</td><td>16</td></tr> </tbody> </table>				Month	Target Score	Risk Score	Oct-20	12	16	Nov-20	12	16	Dec-20	12	16	Jan-21	12	16	Feb-21	12	16	Mar-21	12	16	Apr-21	12	16	May-21	12	16	Jun-21	12	16	Jul-21	12	16	Aug-21	12	16	Sep-21	12	16
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Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																																										
<ul style="list-style-type: none"> • Policies, procedures, protocols and guidelines supplement the National Infection Control Manual. • Seven-day infection prevention & control service provides advice and support HB staff. • Medical microbiology & infectious diseases team provides expertise and support. • Infection Prevention & Control related training provided programmes. • Surveillance of infections, with early identification of increased incidence, and instigation of controls. • Provision of cleaning service to meet National Standards of Cleanliness. • Engineering controls for water safety, ventilation, and decontamination. 		<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Ensure maintained, clean and safe patient care environments, equipment/devices.</td> <td>Facilities, Support Services & Service Group Directors</td> <td>31st March 2022</td> </tr> <tr> <td>Review feasibility of increasing single room capacity.</td> <td>SGD, Operational Services & Patient Flow</td> <td>31st March 2022</td> </tr> <tr> <td>Reduce bed occupancy & patient moves.</td> <td>SGD, Operational Services & Patient Flow</td> <td>31st March 2022</td> </tr> <tr> <td>Use timely data to drive QI programmes.</td> <td>HoN IPC, Digital Intelligence & SGD</td> <td>31st March 2022</td> </tr> </tbody> </table>			Action	Lead	Deadline	Ensure maintained, clean and safe patient care environments, equipment/devices.	Facilities, Support Services & Service Group Directors	31st March 2022	Review feasibility of increasing single room capacity.	SGD, Operational Services & Patient Flow	31st March 2022	Reduce bed occupancy & patient moves.	SGD, Operational Services & Patient Flow	31st March 2022	Use timely data to drive QI programmes.	HoN IPC, Digital Intelligence & SGD	31st March 2022																									
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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"> • Clear Corporate and Service Group IPC Assurance Framework in place. • Ongoing monitoring of infection control rates, with weekly feedback corporately & to Service Groups. 		Gaps in assurance (What additional assurances should we seek?) Review single room capacity. Poor condition of hospital estate requires investment. High activity limits access for planned preventative maintenance and necessary HTM validation/compliance checks. Seek improved Corporate and Service Group																																										

<ul style="list-style-type: none"> • Infection Control Committee receives assurance reports, monitors infection rates, and identifies key actions to drive improvement. • Training compliance. • IPC, antimicrobial, decontamination and cleaning audit programmes. • Compliance and validation systems for water safety, ventilation systems and decontamination. 	<p>oversight of compliance with ventilation, water safety, decontamination & cleaning checks. Challenge to sustain cleaning workforce to achieve National Minimum Standards of Cleanliness. Review plans to reduce bed occupancy rates and patient multi-ward moves. Investment in ESR Self-service to provide data on IPC-related training compliance. Investment in digital intelligence systems to provide Board to Ward oversight of infection, antimicrobial, cleanliness, and training data.</p>
<p>Additional Comments</p> <p>17/05/21 - The Health Board continues to have amongst the highest incidence of the Tier 1 infections in Wales. When improvements have been achieved, it has been challenging to sustain these improvements. Clinical teams require renewed focus on:</p> <ul style="list-style-type: none"> • Antimicrobial stewardship - prudent use of broad-spectrum antibiotics; compliance with 72 hour review; reduction in overall use. • prudent use of, and monitoring of continued need for, invasive devices, including evidence of compliance with insertion & maintenance bundles. <p>This risk has been reviewed and revised post-COVID, and has taken into account 2020/21 Tier 1 HCAI performance. Improvement will require IPC-related quality priorities to be integrated into crosscutting service plans. Register content has been refreshed substantially by the Head of Nursing (Infection, Prevention & Control).</p> <p>05/10/21 – Current service pressures are high, and surge capacity is being utilised, leading to instances of over-occupancy, which increases risks. Currently ventilation in majority of clinical wards does not provide the recommended 6 air changes per hour, particularly required in areas where patients with viral respiratory infections are cared for. Mitigation currently has to be by the use of natural ventilation, facilitated by opening windows where possible. This may reduce environmental temperatures for patients, to potentially uncomfortable levels. Lack of isolation facilities is exacerbated over winter months due to the increased incidence of seasonal viral infections, such as Influenza, Respiratory Syncytial Virus, and Norovirus. Increased length of stay and staff shortages increase potential infection risks.</p>	

Datix ID Number: 840 Health & Care Standard: 5.1 Timely Care		HBR Ref Number: 16 Target Date: 31st March 2022		Current Risk Rating 5 x 5 = 25																																								
Objective: Best Value Outcomes from High Quality Care		Director Lead: Janet Williams, Interim Director of Operations Assuring Committee: Performance and Finance Committee For Information: Quality & Safety Committee																																										
Risk: Access and Planned Care. There is a risk of harm to patients if we fail to diagnose and treat them in a timely way.		Date last reviewed: September 2021																																										
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 5 = 25 Target: 4 x 2 = 8		<table border="1"> <caption>Risk Score and Target Score Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr><td>Oct-20</td><td>25</td><td>8</td></tr> <tr><td>Nov-20</td><td>25</td><td>8</td></tr> <tr><td>Dec-20</td><td>25</td><td>8</td></tr> <tr><td>Jan-21</td><td>25</td><td>8</td></tr> <tr><td>Feb-21</td><td>25</td><td>8</td></tr> <tr><td>Mar-21</td><td>25</td><td>8</td></tr> <tr><td>Apr-21</td><td>25</td><td>8</td></tr> <tr><td>May-21</td><td>25</td><td>8</td></tr> <tr><td>Jun-21</td><td>25</td><td>8</td></tr> <tr><td>Jul-21</td><td>25</td><td>8</td></tr> <tr><td>Aug-21</td><td>25</td><td>8</td></tr> <tr><td>Sep-21</td><td>25</td><td>8</td></tr> </tbody> </table>		Month	Risk Score	Target Score	Oct-20	25	8	Nov-20	25	8	Dec-20	25	8	Jan-21	25	8	Feb-21	25	8	Mar-21	25	8	Apr-21	25	8	May-21	25	8	Jun-21	25	8	Jul-21	25	8	Aug-21	25	8	Sep-21	25	8	Rationale for current score: All non-urgent activity was cancelled due to response to the Covid-19 pandemic and has increased the backlog of planned care cases across the organisation. Whilst mitigating measures such as virtual clinics have been put in place new referrals are still being accepted which is adding to the outpatient backlog particularly in Ophthalmology and Orthopaedics. The significant reduction in theatre activity is obviously increasing the number of patients now breaching 36 and 52 week thresholds.	
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Sep-21	25	8																																										
Level of Control = 90%		Rationale for target score: There is scope to reduce the likelihood score to reduce the Risk to an acceptable level																																										
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?)																																									
<ul style="list-style-type: none"> Post Covid 19 the focus is on minimising harm by ensuring that the patients with the high clinical priority are treatment first. The Health Board is following the Royal College of Surgeons guidance for all surgical procedures and patients on the waiting list have been categorised accordingly. There is a bi-weekly Recovery meeting for assurance on the recovery of our elective programme. The annual plan is based on specialty level capacity and demand models at specialty level that set out the baseline capacity and identify solutions to bridge the gap. Non-recurring pump – prime funding is available to support initial recovery measures. Monthly performance reviews track progress against delivery. A focused intervention is in train support to the 10 specialties with the longest waits. 			<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Develop and implement a full range of ‘treat while you wait’ interventions at specialty level to minimise harm.</td> <td>Service Directors</td> <td>30th September 2021</td> </tr> </tbody> </table>	Action	Lead	Deadline	Develop and implement a full range of ‘ treat while you wait ’ interventions at specialty level to minimise harm.	Service Directors	30 th September 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"> Weekly meetings in place to ensure patients with greatest clinical need are treated first. 			Gaps in assurance (What additional assurances should we seek?)																																									
Additional Comments 23.04.2021 – Action closed - Development of a whole system model for NPTH as a centre for Orthopaedic and Spinal services, to include the scoping of ambulant trauma options and capital requirements - Strategic Outline Case submitted to WG awaiting outcome. 15.07.2021 - Theatre activity has now increased to over 85% pre-Covid levels and further sessions will be commissioned with support from an insourcing companies for staff. In addition outsourcing to independent hospital has commenced with the further provision of theatre sessions to be utilised by surgeons and anaesthetics from Sept 2021. Update 13.10.21 Theatre activity has now increased to pre-Covid levels across the three sites and further sessions are planned (in orthopaedics initially) with support from an insourcing companies for staff and additional elective sessions in Singleton Hospital. In addition, outsourcing to independent hospital has commenced with the further provision of theatre sessions in private facilities to be utilised by surgeons and anaesthetics from November onwards.																																												

Datix ID Number: 1514 Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety		HBR Ref Number: 43 Target Date: 31st March 2022		Current Risk Rating 4 x 4 = 16																																								
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: September 2021																																										
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 and Target Scores over time</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr><td>Oct-20</td><td>16</td><td>6</td></tr> <tr><td>Nov-20</td><td>16</td><td>6</td></tr> <tr><td>Dec-20</td><td>16</td><td>6</td></tr> <tr><td>Jan-21</td><td>16</td><td>6</td></tr> <tr><td>Feb-21</td><td>16</td><td>6</td></tr> <tr><td>Mar-21</td><td>16</td><td>6</td></tr> <tr><td>Apr-21</td><td>16</td><td>6</td></tr> <tr><td>May-21</td><td>16</td><td>6</td></tr> <tr><td>Jun-21</td><td>16</td><td>6</td></tr> <tr><td>Jul-21</td><td>16</td><td>6</td></tr> <tr><td>Aug-21</td><td>16</td><td>6</td></tr> <tr><td>Sep-21</td><td>16</td><td>6</td></tr> </tbody> </table>		Month	Risk Score	Target Score	Oct-20	16	6	Nov-20	16	6	Dec-20	16	6	Jan-21	16	6	Feb-21	16	6	Mar-21	16	6	Apr-21	16	6	May-21	16	6	Jun-21	16	6	Jul-21	16	6	Aug-21	16	6	Sep-21	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?)																																									
Supervisory body signatories in place BIA rota now implemented but limited uptake due to inability to release staff 2 x substantive BIA posts and additional admin post in place DoLS database updated and DoLS dashboard devised to enable more accurate monitoring and reporting Regular reporting to Mental Health and Legislative Committee (MHLC) (Nov 20) QIA completed for re-introduction of DoLS BIAs attending Ward as part of Reset and Recovery April 2021 QIA reviewed and service stood down in light of increased COVID incidence Oct 2020, service recommenced April 2021 Managing and supporting all referrals remotely New legislation changes expected in April 2022 which will require a different service model, business case to meet existing and future requirements will be progressed March 21. Expertise, advice and support available to wards via substantive BIAs			<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.</td> <td>UND Primary and Community</td> <td>Monthly Review</td> </tr> <tr> <td>Business case for revised service model. Report around changes from DoLS to LPS on track. Discussions with Corporate Nursing in progress to agree next steps</td> <td>UND Primary and Community</td> <td>31st July 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.	UND Primary and Community	Monthly Review	Business case for revised service model. Report around changes from DoLS to LPS on track. Discussions with Corporate Nursing in progress to agree next steps	UND Primary and Community	31 st July 2021																								
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Assurances (How do we know if the things we are doing are having an impact?) Regular scrutiny at Safeguarding Committee and by DoLS Internal Audit; monitoring via DoLS Dashboard this will provide real-time accurate data. Update report to MHLC, impact of COVID and focus on urgent cases via virtual process and plan to progress business case by year end.			Gaps in assurance (What additional assurances should we seek?)																																									
Additional Comments																																												

All actions attributable to safeguarding completed and Internal Audit aware. DoLS and MCA Training provided to doctors and managers by Solicitor from Legal & Risk Services in January and February 2021.

Progress in implementing / reinstating controls has been updated and future dates refreshed, including an extension to the target date for the business case for the revised service model.

Datix ID Number: 1563 Health & Care Standard: Safe Care 5.1 Access		HBR Ref Number: 48 Target Date: 31st March 2022		Current Risk Rating 4 x 4 = 16																																								
Objective: Best Value Outcomes from High Quality Care		Director Lead: Sian Harrop-Griffiths, Director of Strategy Assuring Committee: Performance and Finance Committee, Health Board For Information: Quality & Safety Committee																																										
Risk: Failure to sustain Child and Adolescent Mental Health Services		Date last reviewed: September 2021																																										
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 4 x 2 = 8		<table border="1"> <caption>Risk Score and Target Score Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr><td>Oct-20</td><td>16</td><td>8</td></tr> <tr><td>Nov-20</td><td>16</td><td>8</td></tr> <tr><td>Dec-20</td><td>16</td><td>8</td></tr> <tr><td>Jan-21</td><td>16</td><td>8</td></tr> <tr><td>Feb-21</td><td>16</td><td>8</td></tr> <tr><td>Mar-21</td><td>16</td><td>8</td></tr> <tr><td>Apr-21</td><td>16</td><td>8</td></tr> <tr><td>May-21</td><td>16</td><td>8</td></tr> <tr><td>Jun-21</td><td>16</td><td>8</td></tr> <tr><td>Jul-21</td><td>16</td><td>8</td></tr> <tr><td>Aug-21</td><td>16</td><td>8</td></tr> <tr><td>Sep-21</td><td>16</td><td>8</td></tr> </tbody> </table>		Month	Risk Score	Target Score	Oct-20	16	8	Nov-20	16	8	Dec-20	16	8	Jan-21	16	8	Feb-21	16	8	Mar-21	16	8	Apr-21	16	8	May-21	16	8	Jun-21	16	8	Jul-21	16	8	Aug-21	16	8	Sep-21	16	8	Rationale for current score: Difficulties with sustainable staffing affecting performance.	
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Apr-21	16	8																																										
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Jun-21	16	8																																										
Jul-21	16	8																																										
Aug-21	16	8																																										
Sep-21	16	8																																										
Level of Control = 50%		Rationale for target score: New service model and improved performance																																										
Date added to HB the risk register 31/05/2018																																												
Controls (What are we currently doing about the risk?)			Mitigating actions (What more should we do?)																																									
<ul style="list-style-type: none"> Performance Scrutiny - is undertaken at monthly commissioning meetings between Swansea Bay & Cwm Taf Morgannwg University Health Boards. Improved governance -ensures that issues and concerns are discussed by all interested parties including local authorities to support the network identify local solutions. New Service Model agreed and being established by Summer 2019 which should give further stability to service. 			<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Additional investment expected - from Welsh Government</td> <td>CAMHS network</td> <td>30th September 31st March 2022</td> </tr> <tr> <td>Staffing of service being strengthened & supplemented by agency staff</td> <td>CAMHS network</td> <td>30th September 31st December 2021</td> </tr> </tbody> </table>			Action	Lead	Deadline	Additional investment expected - from Welsh Government	CAMHS network	30th September 31 st March 2022	Staffing of service being strengthened & supplemented by agency staff	CAMHS network	30th September 31 st December 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?)																																									
Additional Comments Cwm Taf achieved the non-urgent 28 day target for specialist CAMHS and primary CAMHS in 2020, with performance deteriorating due to staff being relocated to Ty Llydiard to support 763pandemic. Performance has improved in 2021 towards achievement of targets. 01.04.21 – Action update – Additional demands as a result of Covid expected and will need additional investment either from MH development monies or from direct Welsh Government funding. 04.10.21 - CAMHS services have experienced increases in demand due to the pandemic. Plans are in place to address the backlog of cases but are dependent on agreement with CTM to use additional staff time / payments which is outstanding. Progress expected by end of December 2021.																																												

Datix ID Number: 922 Health & Care Standard: Effective Care 3.1 Clinically Effective Care		HBR Ref Number: 49 Target Date: 31st July 2021		Current Risk Rating 4 x 3 = 12																																								
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: September 2021																																										
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 4 x 3 = 12 Target: 3 x 4 = 12		<table border="1"> <caption>Risk Score and Target Score Data</caption> <thead> <tr> <th>Month</th> <th>Target Score</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Oct-20</td><td>12</td><td>16</td></tr> <tr><td>Nov-20</td><td>12</td><td>16</td></tr> <tr><td>Dec-20</td><td>12</td><td>16</td></tr> <tr><td>Jan-21</td><td>12</td><td>16</td></tr> <tr><td>Feb-21</td><td>12</td><td>16</td></tr> <tr><td>Mar-21</td><td>12</td><td>16</td></tr> <tr><td>Apr-21</td><td>12</td><td>16</td></tr> <tr><td>May-21</td><td>12</td><td>16</td></tr> <tr><td>Jun-21</td><td>12</td><td>12</td></tr> <tr><td>Jul-21</td><td>12</td><td>12</td></tr> <tr><td>Aug-21</td><td>12</td><td>12</td></tr> <tr><td>Sep-21</td><td>12</td><td>12</td></tr> </tbody> </table>		Month	Target Score	Risk Score	Oct-20	12	16	Nov-20	12	16	Dec-20	12	16	Jan-21	12	16	Feb-21	12	16	Mar-21	12	16	Apr-21	12	16	May-21	12	16	Jun-21	12	12	Jul-21	12	12	Aug-21	12	12	Sep-21	12	12	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.	
Month	Target Score	Risk Score																																										
Oct-20	12	16																																										
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Jul-21	12	12																																										
Aug-21	12	12																																										
Sep-21	12	12																																										
Level of Control = 50%		Rationale for target score: External review by the Royal College of Physicians will provide a view on improvement required immediately and for sustainability.																																										
Date added to the HB risk register July 2016																																												
Controls (What are we currently doing about the risk?)		Mitigating actions (What more should we do?)																																										
<ul style="list-style-type: none"> TAVI Recovery Plan implemented and backlog has been cleared. Plan is supported with Executive oversight at fortnightly TAVI has been prioritised in next year's WHSSC ICP for 2020/21. Royal College of Physicians have provided reports on the service and action plans have been developed and implemented 		<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Continued oversight of outcomes by the Executive Medical Director, reporting to Quality and Safety committee regularly</td> <td>Executive Medical Director</td> <td>30th Sept 2021</td> </tr> </tbody> </table>		Action	Lead	Deadline	Continued oversight of outcomes by the Executive Medical Director, reporting to Quality and Safety committee regularly	Executive Medical Director	30 th Sept 2021																																			
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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. Executive Medical Director Oversight of improvement plans. Development of Quality and Safety Dashboard. Oversight and scrutiny by Quality and Safety Committee		Gaps in assurance (What additional assurances should we seek?)																																										
Additional Comments																																												
Reports now received from RCP on (1) initial casenote review (2) site visit in July 2019 (3) second cohort casenote review; action plans implemented in response Improvement activity continues to have oversight of the Executive Medical Director at fortnightly Gold Command meetings. Regular briefings and reports are provided to key stakeholders including WHSSC, Welsh Government and Hywel Dda UHB. WHSSC have de-escalated the TAVI service from its current Stage 3 to Stage 2, in recognition of significant improvement in the service. Recommend reduction in risk score from 16 to 12. Update 04.10.21 - Notification from WHSSC today that they have formally de-escalated TAVI; RCP have also formally signed-off and ended their involvement. The risk score is now at the target score and it's been agreed that risk can now close.																																												

Datix ID Number: 1761 Health & Care Standard: Timely Care 5.1 Access		HBR Ref Number: 50 Target Date: 31st March 2022		Current Risk Rating 5 x 4 = 20																																								
Objective: Best Value Outcomes from High Quality Care		Director Lead: Janet Williams, Interim Director of Operations Assuring Committee: Performance and Finance Committee For Information: Quality & Safety Committee																																										
Risk: Access to Cancer Services – There is a risk of harm to patients with cancer due to delayed presentation, referral, diagnosis or treatment. A backlog of patients now presenting with suspected cancer has accumulated during the pandemic, creating an increase in referrals into the health board which is greater than the current capacity for prompt diagnosis and treatment. Because of this there is a risk of delay in diagnosing patients with cancer, and consequent delay in commencement of treatment, which could lead to poor patient outcomes and failure to achieve targets.		Date last reviewed: September 2021																																										
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 5 x 4 = 20 Target: 4 x 3 = 12		<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>Oct-20</td><td>12</td><td>25</td></tr> <tr><td>Nov-20</td><td>12</td><td>25</td></tr> <tr><td>Dec-20</td><td>12</td><td>25</td></tr> <tr><td>Jan-21</td><td>12</td><td>25</td></tr> <tr><td>Feb-21</td><td>12</td><td>25</td></tr> <tr><td>Mar-21</td><td>12</td><td>25</td></tr> <tr><td>Apr-21</td><td>12</td><td>25</td></tr> <tr><td>May-21</td><td>12</td><td>25</td></tr> <tr><td>Jun-21</td><td>12</td><td>25</td></tr> <tr><td>Jul-21</td><td>12</td><td>25</td></tr> <tr><td>Aug-21</td><td>12</td><td>20</td></tr> <tr><td>Sep-21</td><td>12</td><td>20</td></tr> </tbody> </table>		Month	Target Score	Risk Score	Oct-20	12	25	Nov-20	12	25	Dec-20	12	25	Jan-21	12	25	Feb-21	12	25	Mar-21	12	25	Apr-21	12	25	May-21	12	25	Jun-21	12	25	Jul-21	12	25	Aug-21	12	20	Sep-21	12	20	Rationale for current score: There has been a reduction in presentation and referrals for cancer. The cancer backlog has increased and treatment times have got longer due to Covid-19 related reductions in surgical capacity. Enhanced monitoring & weekly monitoring of action plans for top 6 tumour sites in place.	
Month	Target Score	Risk Score																																										
Oct-20	12	25																																										
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Jun-21	12	25																																										
Jul-21	12	25																																										
Aug-21	12	20																																										
Sep-21	12	20																																										
Level of Control = 70%		Rationale for target score: Target score reflects the challenge this area of work present the Board and where small numbers of patients impact on the potential to breach target																																										
Date added to the HB risk register April 2014																																												
Controls (What are we currently doing about the risk?)			Mitigating actions (What more should we do?)																																									
<ul style="list-style-type: none"> Tight management processes to manage each individual case on the unscheduled care (USC) Urgent Suspected Cancer Pathway. Enhanced monitoring & weekly monitoring of action plans for top 6 tumour sites. Initiatives to protect surgical capacity to support USC pathways have been put in place in RGH and PCH to protect core activity. Additional investment in MDT consideration, with 5 cancer trackers appointed in April 2021. Prioritised pathway in place to fast track USC patients. Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. Weekly cancer performance meetings are held at both Singleton and Morriston Delivery Units. The tumour sites of concern is in development. One of the areas is Lower GI where clinic capacity has increased by 4 times in April. Endoscopy contract has been extended. 			<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Phased and sustainable solution for the required uplift in endoscopy capacity that will be key to supporting both the Urgent Suspected Cancer backlog and future cancer diagnostic demand on Endoscopy Services. Harm review process to be implemented.</td> <td>Service Group Manager</td> <td>1st November 2021</td> </tr> <tr> <td>To explore the possibility of offering SABR RT for high risk lung cancer patients in SWWCC. Business case with WHSCC – expect response by end Nov 2021</td> <td>Service Manager Surgical Services</td> <td>30th September 2021 30th November 2021</td> </tr> </tbody> </table>			Action	Lead	Deadline	Phased and sustainable solution for the required uplift in endoscopy capacity that will be key to supporting both the Urgent Suspected Cancer backlog and future cancer diagnostic demand on Endoscopy Services. Harm review process to be implemented.	Service Group Manager	1 st November 2021	To explore the possibility of offering SABR RT for high risk lung cancer patients in SWWCC. Business case with WHSCC – expect response by end Nov 2021	Service Manager Surgical Services	30 th September 2021 30 th November 2021																														
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To explore the possibility of offering SABR RT for high risk lung cancer patients in SWWCC. Business case with WHSCC – expect response by end Nov 2021	Service Manager Surgical Services	30 th September 2021 30 th November 2021																																										
Assurances (How do we know if the things we are doing are having an impact?) General improvement (sustained) trajectory. Need to continue improvement actions and close monitoring.			Gaps in assurance (What additional assurances should we seek?) Clear current funding gap.																																									

~~Early diagnosis pathway launched and impact being closely monitored.~~ Backlog trajectory accepted at Management Board on 15th September and trajectory will be monitored in weekly enhanced monitoring meetings.

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.

Covid screening is in place for all patients starting their 1st cycle of SACT and for all Lung RT patients.

Action - Establishment of mobile unit to carry out PET/CT scans for Swansea and South West Wales patients. – Completed

Action - Continue to expand our Surgery capacity to allow our complex cancer surgeries to deal with any backlog of patients – Completed

01.03.21: Action Completed – Introduce COVID testing for Oncology and Haematology

15.07.2021: The analysis of cases in top six cancer sites has been completed and a plan to resolve these was agreed in Management Board on 7th July 2021.

Datix ID Number: 146 Health & Care Standard: Effective Care 3.1 Clinically Effective Care		CRR Ref Number: 58 Target Date: 31st March 2022		Current Risk Rating 4 x 5 = 20																																									
Objective: Excellent Patient Outcomes		Director Lead: Janet Williams, Interim Director of Operations Assuring Committee: Quality and Safety Committee																																											
Risk: Failure to provide adequate clinic capacity for follow-up patients Ophthalmology results in a delay in treatment and potential risk of sight loss.		Date last reviewed: September 2021																																											
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 5 = 20 Target: 4 x 1 = 4	<table border="1"> <caption>Target and Risk Scores</caption> <thead> <tr> <th>Month</th> <th>Target Score</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Oct-20</td><td>4</td><td>4</td></tr> <tr><td>Nov-20</td><td>4</td><td>4</td></tr> <tr><td>Dec-20</td><td>4</td><td>4</td></tr> <tr><td>Jan-21</td><td>4</td><td>4</td></tr> <tr><td>Feb-21</td><td>4</td><td>4</td></tr> <tr><td>Mar-21</td><td>4</td><td>4</td></tr> <tr><td>Apr-21</td><td>4</td><td>4</td></tr> <tr><td>May-21</td><td>4</td><td>4</td></tr> <tr><td>Jun-21</td><td>4</td><td>4</td></tr> <tr><td>Jul-21</td><td>4</td><td>20</td></tr> <tr><td>Aug-21</td><td>4</td><td>20</td></tr> <tr><td>Sep-21</td><td>4</td><td>20</td></tr> </tbody> </table>		Month	Target Score	Risk Score	Oct-20	4	4	Nov-20	4	4	Dec-20	4	4	Jan-21	4	4	Feb-21	4	4	Mar-21	4	4	Apr-21	4	4	May-21	4	4	Jun-21	4	4	Jul-21	4	20	Aug-21	4	20	Sep-21	4	20	Rationale for current score: Risk rating increased to 20 in July 2020 due to Covid-19 pandemic backlog has continued to grow.			
			Month	Target Score	Risk Score																																								
			Oct-20	4	4																																								
Nov-20	4	4																																											
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Jul-21	4	20																																											
Aug-21	4	20																																											
Sep-21	4	20																																											
Level of Control = 40%		Rationale for target score: Mitigation plan via outsourcing will reduce the backlog to pre-covid levels.																																											
Date added to the HB risk register December 2014																																													
Controls (What are we currently doing about the risk?)			Mitigating actions (What more should we do?)																																										
<ul style="list-style-type: none"> All patients are categorised by condition in order to quantify issue. Additional IS capacity secured to increase activity from July 2021, implementation plan under development. Welsh government funding secured for 2021. 			<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>An overall Regional Sustainability Plan to be delivered</td> <td>Service Group Manager Surgical Specialties</td> <td>31st March 2021 (Bi-weekly ongoing)</td> </tr> </tbody> </table>			Action	Lead	Deadline	An overall Regional Sustainability Plan to be delivered	Service Group Manager Surgical Specialties	31 st March 2021 (Bi-weekly ongoing)																																		
Action	Lead	Deadline																																											
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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"> Deputy COO in regular liaison with IS on contract progress. 			Gaps in assurance (What additional assurances should we seek?) Regular liaison with patients on extended waiting list/times and validation.																																										
Additional Comments																																													
Routine appointments were suspended since the advent of the Covid-19 outbreak the following essential Eye services have been maintained during Covid 19. <ul style="list-style-type: none"> AMD treatments Retina services Rapid Access Eye clinic (RACE - Eye Casualty) Some clinically urgent Cataract operations have also been undertaken. 14.04.21 - Additional glaucoma clinic capacity now available in Wellbeing Centre, Swansea University. Work ongoing with Hywel Dda HB on regional solutions commence in July 2021.																																													

Datix ID Number: 1587 Health & Care Standard: 3.1 Safe and Clinically Effective Care		HBR Ref Number: 61 Target Date: 31st March 2022		Current Risk Rating 4 X 4 = 16																																								
Objective: Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morryston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies.		Director Lead: Janet Williams, Interim Director of Operations 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: September 2021																																										
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 4 x 4 = 16 Target: 4 x 2 = 8		<table border="1"> <caption>Risk Score and Target Score Data</caption> <thead> <tr> <th>Month</th> <th>Target Score</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Oct-20</td><td>8</td><td>16</td></tr> <tr><td>Nov-20</td><td>8</td><td>16</td></tr> <tr><td>Dec-20</td><td>8</td><td>16</td></tr> <tr><td>Jan-21</td><td>8</td><td>16</td></tr> <tr><td>Feb-21</td><td>8</td><td>16</td></tr> <tr><td>Mar-21</td><td>8</td><td>16</td></tr> <tr><td>Apr-21</td><td>8</td><td>16</td></tr> <tr><td>May-21</td><td>8</td><td>16</td></tr> <tr><td>Jun-21</td><td>8</td><td>16</td></tr> <tr><td>Jul-21</td><td>8</td><td>16</td></tr> <tr><td>Aug-21</td><td>8</td><td>16</td></tr> <tr><td>Sep-21</td><td>8</td><td>16</td></tr> </tbody> </table>		Month	Target Score	Risk Score	Oct-20	8	16	Nov-20	8	16	Dec-20	8	16	Jan-21	8	16	Feb-21	8	16	Mar-21	8	16	Apr-21	8	16	May-21	8	16	Jun-21	8	16	Jul-21	8	16	Aug-21	8	16	Sep-21	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																																										
Oct-20	8	16																																										
Nov-20	8	16																																										
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Aug-21	8	16																																										
Sep-21	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?)			Mitigating actions (What more should we do?)																																									
<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 Morryston 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 			<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 2022</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Action	Lead	Deadline	Transfer of services from Parkway.	Interim Head of Primary Care	31 st May 2022																																			
Action	Lead	Deadline																																										
Transfer of services from Parkway.	Interim Head of Primary Care	31 st May 2022																																										
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 			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 Morryston. 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 Morryston 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 to 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 Morrision Hospital by 31st May 2021.

The limited theatre capacity available due to Covid restrictions has resulted in an extension of the contract with Parkway until June 2022 being negotiated.

Datix ID Number: 1605 Health & Care Standard: 3.1 Safe and Clinically Effective Care		HBR Ref Number: 63 Target Date: 31st March 2022		Current Risk Rating 4 X 5 = 20																																								
Objective: Screening for Fetal Growth Assessment in line with Gap-Grow (G&G)		Director Lead: Gareth Howells, Director of Nursing & Patient Experience Assuring Committee: Quality and Safety Committee Date last reviewed: September 2021																																										
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>Chart Data</caption> <thead> <tr> <th>Month</th> <th>Target Score</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Oct-20</td><td>12</td><td>20</td></tr> <tr><td>Nov-20</td><td>12</td><td>20</td></tr> <tr><td>Dec-20</td><td>12</td><td>20</td></tr> <tr><td>Jan-21</td><td>12</td><td>20</td></tr> <tr><td>Feb-21</td><td>12</td><td>20</td></tr> <tr><td>Mar-21</td><td>12</td><td>20</td></tr> <tr><td>Apr-21</td><td>12</td><td>20</td></tr> <tr><td>May-21</td><td>12</td><td>20</td></tr> <tr><td>Jun-21</td><td>12</td><td>20</td></tr> <tr><td>Jul-21</td><td>12</td><td>20</td></tr> <tr><td>Aug-21</td><td>12</td><td>20</td></tr> <tr><td>Sep-21</td><td>12</td><td>20</td></tr> </tbody> </table>			Month	Target Score	Risk Score	Oct-20	12	20	Nov-20	12	20	Dec-20	12	20	Jan-21	12	20	Feb-21	12	20	Mar-21	12	20	Apr-21	12	20	May-21	12	20	Jun-21	12	20	Jul-21	12	20	Aug-21	12	20	Sep-21	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																																										
Oct-20	12	20																																										
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Aug-21	12	20																																										
Sep-21	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.			<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Adherence to Gap/Grow Standards</td> <td>Deputy Head of Midwifery</td> <td>31st December 2021</td> </tr> </tbody> </table>			Action	Lead	Deadline	Adherence to Gap/Grow Standards	Deputy Head of Midwifery	31 st December 2021																																	
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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?)																																									
Additional Comments Training currently being provided by appropriately trained obstetrician and the two trainee midwife sonographers are making good progress in their university course and practical skills training. Trainer role currently on Trac (2 year fixed term). 2 current trainee sonographers progressing well through training. Ensure SBAR for recruitment for two further trainee sonographers is completed and presented to NPTSSG group for approval. Update 07.07.21 - Sonography trainer appointed, start date to be confirmed. UWE course to be completed for 2 midwives by September 2021. Business case for 2nd cohort to be completed.																																												

Datix ID Number: 329 Health & Care Standard: 3.1 Safe and Clinically Effective Care		HBR Ref Number: 65 Target Date: 31st March 2022		Current Risk Rating 4 X 5 = 20																																								
Objective: Digitally enabled Care		Director Lead: Gareth Howells, Director of Nursing & Patient Experience Assuring Committee: Quality & Safety Committee		Date last reviewed: September 2021																																								
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.		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.		Rationale for target score: Funding for central monitoring approved for 2021/22 Meeting to be arranged with provider and key stakeholders in SBU to commence the project toward installation and training.																																								
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 31 st December 2011	<table border="1"> <caption>Risk Score and Target Score Data</caption> <thead> <tr> <th>Month</th> <th>Risk Score</th> <th>Target Score</th> </tr> </thead> <tbody> <tr><td>Oct-20</td><td>20</td><td>8</td></tr> <tr><td>Nov-20</td><td>20</td><td>8</td></tr> <tr><td>Dec-20</td><td>20</td><td>8</td></tr> <tr><td>Jan-21</td><td>20</td><td>8</td></tr> <tr><td>Feb-21</td><td>20</td><td>8</td></tr> <tr><td>Mar-21</td><td>20</td><td>8</td></tr> <tr><td>Apr-21</td><td>20</td><td>8</td></tr> <tr><td>May-21</td><td>20</td><td>8</td></tr> <tr><td>Jun-21</td><td>20</td><td>8</td></tr> <tr><td>Jul-21</td><td>20</td><td>8</td></tr> <tr><td>Aug-21</td><td>20</td><td>8</td></tr> <tr><td>Sep-21</td><td>20</td><td>8</td></tr> </tbody> </table>			Month	Risk Score	Target Score	Oct-20	20	8	Nov-20	20	8	Dec-20	20	8	Jan-21	20	8	Feb-21	20	8	Mar-21	20	8	Apr-21	20	8	May-21	20	8	Jun-21	20	8	Jul-21	20	8	Aug-21	20	8	Sep-21	20	8
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Controls (What are we currently doing about the risk?)			Mitigating actions (What more should we do?)																																									
Current controls include all staff undertaking RCOG CTG training and competency assessment. Protocol in place for an hourly "fresh eyes" on 'intrapartum CTG's' and jump call procedures. CTG prompting stickers have been implemented to correctly categorise CTG recordings. Central monitoring is also expected to strengthen the HB's position in defending claims. K2 fetal monitoring system has been identified as the best option for a central monitoring system.			<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 2021</td> </tr> <tr> <td>Procurement meeting to agree costings</td> <td>Deputy Head of Midwifery</td> <td>30th July September 2021</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 2021	Procurement meeting to agree costings	Deputy Head of Midwifery	30 th July September 2021																														
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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?)																																									
Additional Comments 04.05.21 – Update – Awaiting final sign off for purchase of central monitoring. Walk around planned for 12th May 2021 for estates and I.T to cost up the infrastructure aspect of the bid. 07.07.21 – Update – Business case being updated and once finalised will be submitted to BCAG.																																												

Datix ID Number: 1834 Health & Care Standard: 5.1 Timely Care		HBR Ref Number: 66 Target Date: 31st March 2022		Current Risk Rating 5 X 4 = 20																																									
Objective: Best values outcomes from high quality care		Director Lead: Richard Evans, Executive Medical Director Assuring Committee: Quality and Safety Committee		Date last reviewed: September 2021																																									
Risk: The demand & complexity of planned treatment regimes for cancer patients requiring chemotherapy currently exceed the available chair capacity, risking unacceptable delays in access to SACT treatment in Chemotherapy Day Unit with impact on targets and patient outcomes.		Rationale for current score: Reduced risk to 20 as plan agreed for homecare service and plan for increasing chairs going forward.		Rationale for target score: Reduced delays in treatment will reduce risk of harm.																																									
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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. Looking at options around expansion of home care delivery to free up chair capacity in CDU		<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Business case endorsed by CEO for shift of capacity to home care to be considered by the Management Board.</td> <td>Executive Medical Director Service Director Lead for Cancer</td> <td>29th October 2021</td> </tr> <tr> <td>A second business case is being developed to propose relocation of CDU to a vacant ward area, which would increase chair capacity.</td> <td>Executive Medical Director Service Director Lead for Cancer</td> <td>29th October 2021</td> </tr> <tr> <td>Subject to approval of the above relocation will progress with aim of completion by April 2022.</td> <td>Service Director Lead for Cancer</td> <td>1st April 2022</td> </tr> </tbody> </table>		Action	Lead	Deadline	Business case endorsed by CEO for shift of capacity to home care to be considered by the Management Board.	Executive Medical Director Service Director Lead for Cancer	29 th October 2021	A second business case is being developed to propose relocation of CDU to a vacant ward area, which would increase chair capacity.	Executive Medical Director Service Director Lead for Cancer	29 th October 2021	Subject to approval of the above relocation will progress with aim of completion by April 2022.	Service Director Lead for Cancer	1 st April 2022																														
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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. Following completion of the Medical move to Murrison from Singleton following population engagement, assurance reports on activity and improved chair waiting times will be monitored through monthly Cancer Improvement Group		Gaps in assurance (What additional assurances should we seek?) Capital & Revenue assumptions & resources for second business case for increasing chair capacity in 2022/23 to meet increased demand.																																											
Additional Comments																																													

Working with MSD/GE around potential partnership agreement to look at C&D mapping and best practice elsewhere. Covid has impact on demand for chairs due to need to socially distance. Loss of 3 Chairs (due to IPC controls for COVID) has impacted on capacity. Currently running alternate Saturdays in CDU to mitigate loss. Current wait time for SACT >21 days for the majority of patients. Business case for shift of capacity to home care to be considered by the Management Board in July. Second business case to increase chair capacity in development. **Action Completed - Expansion of home care delivery and additional chair capacity - SACT group.**

Update 02.08.21 – Paper on home care expansion with CEO for agreement on next steps.

16.09.2021 - Chairs closed during Covid have been reintroduced so the likelihood has been reduced accordingly. Current score reduced from 25 to 20 accordingly.

04.10.21 SACT expansion paper for home care agreed in BCAG on 08.09.21, this will mitigate loss of 3 chairs due to Covid.

Datix ID Number: 89 Health & Care Standard: 5.1 Timely Care		HBR Ref Number: 67 Target Date: 31st March 2022		Current Risk Rating 5 X 3 = 15																																								
Objective: Best values outcomes from high quality care		Director Lead: Richard Evans, Executive Medical Director Assuring Committee: Quality and Safety Committee Date last reviewed: September 2021																																										
Risk: Clinical risk-target breeches in the provision of radical radiotherapy treatment. Due to capacity and demand issues the department is experiencing target breaches in the provision of radical radiotherapy treatment to patients.		Rationale for current score: Waiting times deteriorating for elective delays patients, particularly prostates discussed in Oncology business meeting. Current Risk reduced to 15. At present 70 patients to be outsourced which increases capacity. New Linac building work underway, which will increase capacity in near future																																										
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 3 = 15 Target: 2 x 2 = 4		<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>Oct-20</td><td>4</td><td>25</td></tr> <tr><td>Nov-20</td><td>4</td><td>25</td></tr> <tr><td>Dec-20</td><td>4</td><td>25</td></tr> <tr><td>Jan-21</td><td>4</td><td>25</td></tr> <tr><td>Feb-21</td><td>4</td><td>25</td></tr> <tr><td>Mar-21</td><td>4</td><td>25</td></tr> <tr><td>Apr-21</td><td>4</td><td>25</td></tr> <tr><td>May-21</td><td>4</td><td>25</td></tr> <tr><td>Jun-21</td><td>4</td><td>25</td></tr> <tr><td>Jul-21</td><td>4</td><td>25</td></tr> <tr><td>Aug-21</td><td>4</td><td>15</td></tr> <tr><td>Sep-21</td><td>4</td><td>15</td></tr> </tbody> </table>		Month	Target Score	Risk Score	Oct-20	4	25	Nov-20	4	25	Dec-20	4	25	Jan-21	4	25	Feb-21	4	25	Mar-21	4	25	Apr-21	4	25	May-21	4	25	Jun-21	4	25	Jul-21	4	25	Aug-21	4	15	Sep-21	4	15	Rationale for target score: Reduced delays in treatment will reduce risk of harm	
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Level of Control =		Controls (What are we currently doing about the risk?)																																										
Date added to the HB risk register 30/11/2019		Mitigating actions (What more should we do?)																																										
Implementation of revised radiotherapy regimes for specific tumour sites, designed to enhance patient experience and increase capacity. Breast hypo fractionation in place. Requests for treatment and treatment dates monitored by senior management team. Protected capacity rate set as part of 2020/21 Operational Plan. Outsourcing of appropriate radiotherapy cases. Additional outsourcing for Prostate RT commenced June 2021.		<table border="1"> <thead> <tr> <th>Action</th> <th>Lead</th> <th>Deadline</th> </tr> </thead> <tbody> <tr> <td>Hypofractionated Prostate - Business plan submitted for additional resources required to implement hypofractionated technique.</td> <td>Service Manager Cancer Services</td> <td>31st December 2021</td> </tr> <tr> <td>Explore the possibility of undertaking SABR treatment for lung cancer patients at SWWCC. Awaiting confirmation from WHSSC on whether they will commission SABR from SBUHB.</td> <td>Executive Medical Director</td> <td>8th September 2021</td> </tr> <tr> <td>New Linac required – Linac case agreed with WG</td> <td>Service Manager Cancer Services</td> <td>31st July 2022</td> </tr> </tbody> </table>		Action	Lead	Deadline	Hypofractionated Prostate - Business plan submitted for additional resources required to implement hypofractionated technique.	Service Manager Cancer Services	31 st December 2021	Explore the possibility of undertaking SABR treatment for lung cancer patients at SWWCC. Awaiting confirmation from WHSSC on whether they will commission SABR from SBUHB.	Executive Medical Director	8 th September 2021	New Linac required – Linac case agreed with WG	Service Manager Cancer Services	31 st July 2022																													
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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?) Performance and activity data monitored, but delays to treatment continue while sustainable solutions found.																																										
Additional Comments 27.04.21 Update - Risk remains 25 due to limited CT and LINAC capacity. Wait time for RT >28 days for the majority of patients. Exploration of further opportunities to (a) increase hyperfractionation for other diseases (b) opportunity to outsource. New CT due to be operational mid-May 2021. If on schedule and additional capacity (hyperfractionation and outsourcing) is confirmed, risk should reduce to 16.																																												

16.06.21 Update – Started sourcing for prostate RT – 70 pts over 6 months. Hypo fractionation case for prostate with CEO for consideration.

02.08.21 Update – Still waiting on hypo fractionation case – outsourcing continues.

31.08.21 Update - Hypofractionated Prostate - Awaiting outcome of business case. Hypofractionated Prostate - Awaiting outcome of business case. No longer in a position to join the PACE C Trial. (high recruitment). Hypofractionated Pancreas - Meeting with clinicians and physics next week, progressing well. Outsourcing - Currently 4 patients attended Rutherford for RT. Current Wait time - artificially low due to drop in demand over summer (as expected) demand already rising for mid-September onwards. Lin B/C replacement - Building work starting September.

06.09.21 Update - Discussed at RTMM. Current Risk reduced to 15. At present 70 patients to be outsourced which increases capacity. Hypofractionated pancreas does not require additional business case. New Linac building work underway, which will increase capacity in near future.

Action complete 27.09.21 – Additional Rx Capacity – Outsourcing to Rutherford - NEW Action being taken forward as part of Covid RT Recovery plan.

04.10.21 Update - 7 Patients have now been sent to the Rutherford for treatment, slow start due to the summer holidays. Lung SABR case discussed in WHSSC management meeting and supported. plan to take to WHSSC management board for approval. With plan to support from Qtr 4 onwards. Prostate RT case issue with getting financial support from Hywel Dda, Director of Strategy written formally to Hywel Dda for clarity on situation. Work continues with Lin C replacement no concerns noted.

Datix ID Number: 2299 Health & Care Standard: 2.4 Infection Prevention and Control (IPC) and Decontamination		HBR Ref Number: 68 Target Date: 31st March 2022		Current Risk Rating 4 X 5 = 20																																								
Objective: Best Value Outcomes from High Quality Care		Director Lead: Keith Reid, Director of Public Health Assuring Committee: Quality and Safety Committee Date last reviewed: September 2021																																										
Risk: Risk of declared pandemic due to Coronavirus Infectious Disease outbreak 2020 leading to disruption to Health Board activities.		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 																																										
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 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>Oct-20</td><td>25</td><td>6</td></tr> <tr><td>Nov-20</td><td>25</td><td>6</td></tr> <tr><td>Dec-20</td><td>25</td><td>6</td></tr> <tr><td>Jan-21</td><td>25</td><td>6</td></tr> <tr><td>Feb-21</td><td>20</td><td>6</td></tr> <tr><td>Mar-21</td><td>20</td><td>6</td></tr> <tr><td>Apr-21</td><td>20</td><td>6</td></tr> <tr><td>May-21</td><td>20</td><td>6</td></tr> <tr><td>Jun-21</td><td>20</td><td>6</td></tr> <tr><td>Jul-21</td><td>20</td><td>6</td></tr> <tr><td>Aug-21</td><td>20</td><td>6</td></tr> <tr><td>Sep-21</td><td>20</td><td>6</td></tr> </tbody> </table>				Month	Risk Score	Target Score	Oct-20	25	6	Nov-20	25	6	Dec-20	25	6	Jan-21	25	6	Feb-21	20	6	Mar-21	20	6	Apr-21	20	6	May-21	20	6	Jun-21	20	6	Jul-21	20	6	Aug-21	20	6	Sep-21	20	6
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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?)																																										
<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.																																										

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:

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

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

08.03.21 – Current score reduced as per e-mail EMD

Datix ID Number: 1418 Health & Care Standard: 5.1 Timely Access		HBR Ref Number: 69 Target Date: 31st March 2022		Current Risk Rating 5 X 4 = 20																																								
Objective: Best values outcomes from high quality care		Director Lead: Janet Williams, Interim Director of Operations / Gareth Howells, Director of Nursing & Patient Experience Assuring Committee: Quality & Safety Committee																																										
Risk: Risk issues related to adolescent patients being admitted to Adult MH inpatient wards- Inappropriate settings resulting in 'Safeguarding Issues' The WG has requested that HBs identify Secondary Care in -patient facilities for the care of adolescents- in Swansea Bay University Health Board Ward F NPT hospital is the dedicated receiving facility with one bed identified.		Date last reviewed: September 2021																																										
Risk Rating (consequence x likelihood): Initial: 2 x 3 = 6 Current: 5 x 4 = 20 Target: 2 x 3 = 6		<table border="1"> <caption>Risk Score and Target Score Data</caption> <thead> <tr> <th>Month</th> <th>Target Score</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Oct-20</td><td>6</td><td>20</td></tr> <tr><td>Nov-20</td><td>6</td><td>20</td></tr> <tr><td>Dec-20</td><td>6</td><td>20</td></tr> <tr><td>Jan-21</td><td>6</td><td>20</td></tr> <tr><td>Feb-21</td><td>6</td><td>16</td></tr> <tr><td>Mar-21</td><td>6</td><td>16</td></tr> <tr><td>Apr-21</td><td>6</td><td>20</td></tr> <tr><td>May-21</td><td>6</td><td>20</td></tr> <tr><td>Jun-21</td><td>6</td><td>20</td></tr> <tr><td>Jul-21</td><td>6</td><td>20</td></tr> <tr><td>Aug-21</td><td>6</td><td>20</td></tr> <tr><td>Sep-21</td><td>6</td><td>20</td></tr> </tbody> </table>		Month	Target Score	Risk Score	Oct-20	6	20	Nov-20	6	20	Dec-20	6	20	Jan-21	6	20	Feb-21	6	16	Mar-21	6	16	Apr-21	6	20	May-21	6	20	Jun-21	6	20	Jul-21	6	20	Aug-21	6	20	Sep-21	6	20	Rationale for current score: Risk score increased to 20.	
Month	Target Score	Risk Score																																										
Oct-20	6	20																																										
Nov-20	6	20																																										
Dec-20	6	20																																										
Jan-21	6	20																																										
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Aug-21	6	20																																										
Sep-21	6	20																																										
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?)			Mitigating actions (What more should we do?)																																									
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.			Action	Lead	Deadline																																							
			Long Length of Stay reduction programme in Mental Health	Service Director	30th September 31st December 2021																																							
Assurances (How do we know if the things we are doing are having an impact?) Individual Rooms with en Suite Facilities, Joint working with CAMHS, Monitoring of staff training, Monitoring of admissions by the MH & LD SG legislative Committee of the HB. The ongoing issues with the risks presented by the use of this has recently been raised at an all Wales level with Welsh Government and a formal review is anticipated. The Service Group continues to flag the risk particularly in light of Ward F being identified as the SPOA for AMH in the HB which has resulted in an increase in acuity and a greater concentration of individuals who are experiencing the early crisis of admission - this has served to increase the already identified risks for young people in the environment.			Gaps in assurance (What additional assurances should we seek?)																																									
Additional Comments																																												
09.06.21 Update - The risk remains at 20 as while the provision is not ideal no other alternative has been identified. Welsh Government Mental Health Improvement monies have been bid for to extend CAMHS crisis and hospital liaison services to be 24/7, which if successful should enhance the support available in such circumstances. As of 05.08.21 there have been 10 admissions to Ward F of a CAMHS patient. Action update 04.10.21 - Due to outbreak status, no reviews of Ward F currently being undertaken. RM to tie in with risk assigner about the need for this to be completed.																																												

Datix ID Number: 2595 Health & Care Standard: 3.1 Safe and Clinically Effective Care		HBR Ref Number: 74 Target Date: 31st March 2022		Current Risk Rating 5 X 4 = 20																																								
Objective: Best Value Outcomes from High Quality Care		Director Lead: Gareth Howells, Director of Nursing & Patient Experience Assuring Committee: Quality and Safety Committee																																										
Risk: Delay in Induction of Labour (IOL) or augmentation of Labour Swansea BAY UHB have developed a local guideline for the management of IOL based on NICE guidance. Women are booked for IOL by a senior obstetrician either for clinical reasons (which may be for fetal or maternal factors) and for prolonged pregnancy at 41+6 when spontaneous labour has not occurred.		Date last reviewed: September 2021																																										
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 4 = 20 Target: 2 x 3 = 6		<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>Oct-20</td><td>6</td><td>20</td></tr> <tr><td>Nov-20</td><td>6</td><td>20</td></tr> <tr><td>Dec-20</td><td>6</td><td>20</td></tr> <tr><td>Jan-21</td><td>6</td><td>20</td></tr> <tr><td>Feb-21</td><td>6</td><td>20</td></tr> <tr><td>Mar-21</td><td>6</td><td>20</td></tr> <tr><td>Apr-21</td><td>6</td><td>20</td></tr> <tr><td>May-21</td><td>6</td><td>20</td></tr> <tr><td>Jun-21</td><td>6</td><td>20</td></tr> <tr><td>Jul-21</td><td>6</td><td>20</td></tr> <tr><td>Aug-21</td><td>6</td><td>20</td></tr> <tr><td>Sep-21</td><td>6</td><td>20</td></tr> </tbody> </table>		Month	Target Score	Risk Score	Oct-20	6	20	Nov-20	6	20	Dec-20	6	20	Jan-21	6	20	Feb-21	6	20	Mar-21	6	20	Apr-21	6	20	May-21	6	20	Jun-21	6	20	Jul-21	6	20	Aug-21	6	20	Sep-21	6	20	Rationale for current score: 15 linked records since January 2021 where IOL was placed on hold. No significant poor outcomes resulted from the cases identified in the linked records. The IOL is booked and it is anticipated this should take place as planned within the standards set. However, for reasons of acuity in either maternity services or neonatal services, admission for IOL, continuation of IOL that has commenced or augmentation of labour is not possible.	
Month	Target Score	Risk Score																																										
Oct-20	6	20																																										
Nov-20	6	20																																										
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Jun-21	6	20																																										
Jul-21	6	20																																										
Aug-21	6	20																																										
Sep-21	6	20																																										
Level of Control = 60%		Rationale for target score:																																										
Date added to the HB risk register 30 th April 2021																																												
Controls (What are we currently doing about the risk?)			Mitigating actions (What more should we do?)																																									
Diary is maintained for booking of IOL with agreed numbers of IOL per day. Daily obstetric consultant ward round to review all women undergoing IOL. Ongoing/regular monitoring by cardiococograph for fetal wellbeing. Labour ward coordinator and labour ward obstetric lead ensure women on ward 19 for IOL are factored into daily planning of workload on labour ward. If IOL's/ Augmentation of labour are put on hold/delayed the women are reviewed by the MDT to assess for any potential risk to mother or baby. The MDT (Obstetric, Neonatal and Midwifery) discuss and consider the impact of delay for each woman. Escalation to the appropriate senior staff takes place and the Escalation Policy is implemented. Daily acuity is gathered and sent to the senior midwifery management team who can anticipate potential problems and support the clinical team. The matron of the unit is contacted in office hours and the senior midwife manager on call is contacted out of hours. The senior midwife will review staffing across all areas and deploy staff if possible including the specialist midwives and the community midwifery on call team. Neighbouring maternity units are contacted to ask if they are able to support by accepting the transfer of women.			Action	Lead	Deadline																																							
			Ongoing review of risk	Head of Midwifery	30 th July September 2021																																							
Assurances (How do we know if the things we are doing are having an impact?) Review of midwifery staffing on ward 19 (antenatal ward), during recent birthrate plus assessment. This will ensure women receive effective midwifery support and reassurance of fetal wellbeing.			Gaps in assurance (What additional assurances should we seek?)																																									
Additional Comments 28.06.21 Update - An electronic diary is being prepared for booking IOL. This will allow all staff easy access to the diary to prevent overbooking and will improve waiting times in antenatal clinic. The updated BR+ assessment has been received into the HB and the review of Ward 19 staffing is incorporated for an additional midwife to support the IOL clinical area to reduce delays. 7.7.21: Impact of BR+ shortfall will impact on the ability of the service prevent delay in IOL. BR+ shortfall compounded by high level of maternity leave and continue to support midwives who are shielding. Newly qualified midwives will join the workforce in September 2021.																																												

Datix ID Number: 2521 Health & Care Standard: 2.4 Infection Prevention and Control (IPC) and Decontamination		HBR Ref Number: 78 Target Date: 31 st March 2022		Current Risk Rating 4 x 4 = 16																																								
Objective: Best Value Outcomes from High Quality Care		Director Lead: Richard Evans, Executive Medical Director Assuring Committee: Quality & Safety Committee																																										
Risk: Nosocomial transmission Nosocomial transmission in hospitals could cause patient harm; increase staff absence and create wider system pressures (and potential for further harm) due to measures that will be required to control outbreaks.		Date last reviewed: September 2021																																										
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 3 x 4 = 12 Chart updated to reflect change		<table border="1"> <caption>Risk Score and Target Score Data</caption> <thead> <tr> <th>Month</th> <th>Target Score</th> <th>Risk Score</th> </tr> </thead> <tbody> <tr><td>Oct-20</td><td>12</td><td>12</td></tr> <tr><td>Nov-20</td><td>12</td><td>12</td></tr> <tr><td>Dec-20</td><td>12</td><td>16</td></tr> <tr><td>Jan-21</td><td>12</td><td>12</td></tr> <tr><td>Feb-21</td><td>12</td><td>16</td></tr> <tr><td>Mar-21</td><td>12</td><td>12</td></tr> <tr><td>Apr-21</td><td>12</td><td>16</td></tr> <tr><td>May-21</td><td>12</td><td>12</td></tr> <tr><td>Jun-21</td><td>12</td><td>16</td></tr> <tr><td>Jul-21</td><td>12</td><td>12</td></tr> <tr><td>Aug-21</td><td>12</td><td>16</td></tr> <tr><td>Sep-21</td><td>12</td><td>16</td></tr> </tbody> </table>				Month	Target Score	Risk Score	Oct-20	12	12	Nov-20	12	12	Dec-20	12	16	Jan-21	12	12	Feb-21	12	16	Mar-21	12	12	Apr-21	12	16	May-21	12	12	Jun-21	12	16	Jul-21	12	12	Aug-21	12	16	Sep-21	12	16
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Jul-21	12	12																																										
Aug-21	12	16																																										
Sep-21	12	16																																										
Level of Control = 40%		Rationale for current score: Outbreak remains in Morriston Service Group and evidence has shown that sustainability of IPC processes are challenging. EMD and Director of Public Health considers this should be increased again to 16 – reflecting less effective track-and-trace measures and indications that testing is not as effective on staff who have been fully vaccinated.																																										
Date added to the HB risk register May 2021		Rationale for target score: Measures in place will require regular review and scrutiny to ensure compliance. Levels of community incidence or transmission may change and the HB will need to respond. Vaccination programme on going but not complete.																																										
Controls (What are we currently doing about the risk?) Nosocomial transmission Silver established to report to Gold. A nosocomial framework has been developed to focus on: (a) prevention and (b) response. Preventative measures are in place including testing on admission, segregating positive, suspected and negative patients, reinforcing PPE requirements, and a focus on behaviours relating to physical distancing. As part of the response, measures have been enacted to oversee the management of outbreaks. Process established to review nosocomial deaths. Audit tools developed to support consistency checking in key areas re: PPE, physical distancing. Testing on admission dashboard in use. Further guidance on patient cohorting produced.		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>Nosocomial transmission Silver established to report to Gold. A nosocomial framework has been developed to focus on: (a) prevention and (b) response.</td> <td>Executive Medical Director & Deputy Director Transformation</td> <td>Monthly ongoing</td> </tr> <tr> <td>Nosocomial Death Reviews using national toolkit. Need to ensure outcomes are reported to the HB Exec and Service Groups with lessons learnt</td> <td>Executive Medical and Nursing Director</td> <td>Monthly ongoing</td> </tr> </tbody> </table>				Action	Lead	Deadline	Nosocomial transmission Silver established to report to Gold. A nosocomial framework has been developed to focus on: (a) prevention and (b) response.	Executive Medical Director & Deputy Director Transformation	Monthly ongoing	Nosocomial Death Reviews using national toolkit. Need to ensure outcomes are reported to the HB Exec and Service Groups with lessons learnt	Executive Medical and Nursing Director	Monthly ongoing																														
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Nosocomial Death Reviews using national toolkit. Need to ensure outcomes are reported to the HB Exec and Service Groups with lessons learnt	Executive Medical and Nursing Director	Monthly ongoing																																										
Assurances (How do we know if the things we are doing are having an impact?) Monitor Outbreaks throughout the HB / Review Nosocomial Deaths and lessons learnt		Gaps in assurance (What additional assurances should we seek?) Audit compliance of sustainable IPC practices and training compliance Implement lessons learnt from outbreaks and death reviews.																																										
Additional Comments July 2021: Review by the EMD and Director of Public Health considers this should be increased to 16 – reflecting less effective track-and-trace measures and indications that testing is not as effective on staff who have been fully vaccinated.																																												

Datix ID Number: 1832 Health & Care Standard: : 3.1 Safe and Clinically Effective Care		HBR Ref Number: 80 Target Date: 31st March 2022		Current Risk Rating 4 x 5 = 20																																								
Objective: Best Value Outcomes from High Quality Care		Director Lead: Janet Williams, Interim Director of Operations Assuring Committee: Quality & Safety Committee																																										
Risk: There are high numbers of clinically optimised patients who are unable to be discharged from a medicine bed due to various issues/delays. The number is now returning to pre-COVID level of +50.		Date last reviewed: September 2021																																										
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 2 = 8		<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>Oct-20</td><td>6</td><td>20</td></tr> <tr><td>Nov-20</td><td>6</td><td>20</td></tr> <tr><td>Dec-20</td><td>6</td><td>20</td></tr> <tr><td>Jan-21</td><td>6</td><td>20</td></tr> <tr><td>Feb-21</td><td>6</td><td>20</td></tr> <tr><td>Mar-21</td><td>6</td><td>20</td></tr> <tr><td>Apr-21</td><td>6</td><td>20</td></tr> <tr><td>May-21</td><td>6</td><td>20</td></tr> <tr><td>Jun-21</td><td>6</td><td>20</td></tr> <tr><td>Jul-21</td><td>6</td><td>20</td></tr> <tr><td>Aug-21</td><td>6</td><td>20</td></tr> <tr><td>Sep-21</td><td>6</td><td>20</td></tr> </tbody> </table>		Month	Target Score	Risk Score	Oct-20	6	20	Nov-20	6	20	Dec-20	6	20	Jan-21	6	20	Feb-21	6	20	Mar-21	6	20	Apr-21	6	20	May-21	6	20	Jun-21	6	20	Jul-21	6	20	Aug-21	6	20	Sep-21	6	20	Rationale for current score: <ul style="list-style-type: none"> Sustained levels of clinically optimised patients leading to overcrowding within ED, use of inappropriate or overuse of decant capacity in ED and delays in accessing medical bed capacity, clearly emerged as themes. Constraints in relation to all patient flows out of Morriston to a more appropriate clinical setting, identified and included in an expanded risk. 	
Month	Target Score	Risk Score																																										
Oct-20	6	20																																										
Nov-20	6	20																																										
Dec-20	6	20																																										
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Jun-21	6	20																																										
Jul-21	6	20																																										
Aug-21	6	20																																										
Sep-21	6	20																																										
Level of Control = 25%		Rationale for target score:																																										
Date added to the HB risk register May 2021																																												
Controls (What are we currently doing about the risk?) <ul style="list-style-type: none"> Clinically optimised numbers are monitored and reviewed weekly by the MDU. Delays are reported and escalated to try to ensure timely progress along a patient's pathway. Review on a patient by patient basis – with explicit action agreed in order to progress transfer to appropriate clinical setting. Critical constricts in relation to access/time delays for social workers and assessment for package of care and social placement – lead times in excess of 5 weeks. Patient COVID-19 status has added an additional level of complexity to decision making. 			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>To be agreed</td> <td></td> <td></td> </tr> </tbody> </table>			Action	Lead	Deadline	To be agreed																																			
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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"> 			Gaps in assurance (What additional assurances should we seek?) <ul style="list-style-type: none"> 																																									
Additional Comments																																												
None.																																												

Datix ID Number: 2788 NEW Health Care Standards: 7.1 Workforce		HBR Ref Number: 81		Current Risk Rating 5 x 5 = 25																																								
Objective: Best value outcomes		Director Lead: Gareth Howells, Director of Nursing & Patient Experience Assuring Committee: Quality & Safety Committee																																										
Risk: Critical staffing levels – Midwifery: Unplanned absence resulting from Covid-19 related sickness, shielding and isolation, alongside other current absences, has resulted in critical staffing levels, further reductions in which could result in unsafe service provision, poor patient outcomes and/or experience. In turn, poor service quality or reduction in services could impact on organisational reputation.		Date last reviewed: September 2021																																										
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 5 x 5 = 25 Target: 4 x 3 = 12	<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>Sep-20</td><td>25</td><td>12</td></tr> <tr><td>Oct-20</td><td>12</td><td>12</td></tr> <tr><td>Nov-20</td><td>12</td><td>12</td></tr> <tr><td>Dec-20</td><td>12</td><td>12</td></tr> <tr><td>Jan-21</td><td>12</td><td>12</td></tr> <tr><td>Feb-21</td><td>12</td><td>12</td></tr> <tr><td>Mar-21</td><td>12</td><td>12</td></tr> <tr><td>Apr-21</td><td>12</td><td>12</td></tr> <tr><td>May-21</td><td>12</td><td>12</td></tr> <tr><td>Jun-21</td><td>12</td><td>12</td></tr> <tr><td>Jul-21</td><td>12</td><td>12</td></tr> <tr><td>Aug-21</td><td>12</td><td>12</td></tr> </tbody> </table>			Month	Risk Score	Target Score	Sep-20	25	12	Oct-20	12	12	Nov-20	12	12	Dec-20	12	12	Jan-21	12	12	Feb-21	12	12	Mar-21	12	12	Apr-21	12	12	May-21	12	12	Jun-21	12	12	Jul-21	12	12	Aug-21	12	12	Rationale for current score: Centralisation of community services has broken down continuity of carer which means women will see many midwives through pregnancy. There is evidence that shows the outcome for women is better with lower interventions when continuity of carer is maintained. This is particularly relevant for women with perinatal mental health issues and for safeguarding. Singleton Hospital working with on average 10 /11 midwives w/c 22/08/2021. The lowest staffing number being 8 instead of 13 midwives.	
Month	Risk Score	Target Score																																										
Sep-20	25	12																																										
Oct-20	12	12																																										
Nov-20	12	12																																										
Dec-20	12	12																																										
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Aug-21	12	12																																										
Level of Control = %	Rationale for target score:																																											
Date added to the risk register 12/10/2021	Controls (What are we currently doing about the risk?)																																											
<ul style="list-style-type: none"> • Home births are suspended. Reduced the on call requirement for community midwives. • All midwives are working at the hours they require up to full time. • A small midwifery bank has been created. • All midwives are offered additional hours. Enhanced overtime promoted, provided and accepted. • Band 6 recruitment in training. • Student midwives on pre-qualifying placement are supporting in the clinical areas within their student capacity. • 11 new midwives have been employed from September- October 2021. 6 started. • Risk assessments are currently taking place with OH and H&S leads support for matrons to return staff to clinical front facing roles where possible • Centralisation of community services to improve staff availability • NPT Birth Centre temporarily suspended - services relocated to The Bay Birth Centre in Singleton Hospital • Updated early warning to WG • Service Group Nurse Director keeping RCM updated 		Mitigating actions (What more should we do?)																																										
		Action	Lead	Deadline																																								
		On-boarding new Band 5 recruits (expected all complete by mid November)	Deputy Head of Midwifery	Mid November 2021																																								
		14 Band 5 graduates from 2020 – preceptorship completion plan (2 have completed, 9 due by end of December)	Deputy Head of Midwifery	End December 2021 (for majority)																																								
		Due to review suspension of the Birth Centre and Home Births	Deputy Head of Midwifery	End October 2021																																								
Midwifery bank & agency SOP has been developed and will be approved this month (already in use).	Deputy Head of Midwifery	20 th October 2021																																										

<ul style="list-style-type: none"> • Daily escalation call with the SG Service Director and Nurse Director to do 24 hour lookback on potential harm events, patient and staff experience, and 3 day look forward of staffing • Briefings for families via corporate comms & online 			
<p>Assurances (How do we know if the things we are doing are having an impact?) Daily briefings with the senior team are taking place for updated position. Weekly meeting held with staff to update on the situation. No surprise submission to Welsh Government 9/7/2021. CHC informed. Engagement with Clinical Supervisors for midwives for staff support. Engagement with workplace representatives. On call manager for Women and Child Health available 24/7. Datix reports are submitted when appropriate.</p>	<p>Gaps in assurance (What additional assurances should we seek?)</p>		
<p style="text-align: center;">Additional Comments</p> <p>In addition to controls listed above, additional measures taken include:</p> <ul style="list-style-type: none"> • Staff support and well-being information circulated, and presented to the staff • Where able, block booking agency midwives to improve the baseline numbers in the obstetric unit. • Enhanced overtime promoted, provided and accepted • Liaison and working closely with the Local Authorities to utilise Jigso and Flying start midwives where possible • Cancelled PROMPT training (being reviewed weekly) • Linking in with Karen re getting an all Wales approach to financing/increasing our part time to full time conversion rates • Utilising our medical teams to support where possible • Ensuring the all Wales Midwifery and Neonatal network are aware and linking ensuring SBUHB are represented in with the weekly risk huddle • Hywel Dda UHB are buddying up to provide support • Ensuring RCM and RCOG COVID guidance is implemented – esp re vaccinations • Maintaining a Maternity Helpline to answer any queries, emails received and messages from women who may be worried. We plan to continue with this (utilising staff who may be pregnant themselves) 			

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 (PROBABILITY) 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 (*)				
	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