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

# HEALTH BOARD RISK REGISTER
# June 2019

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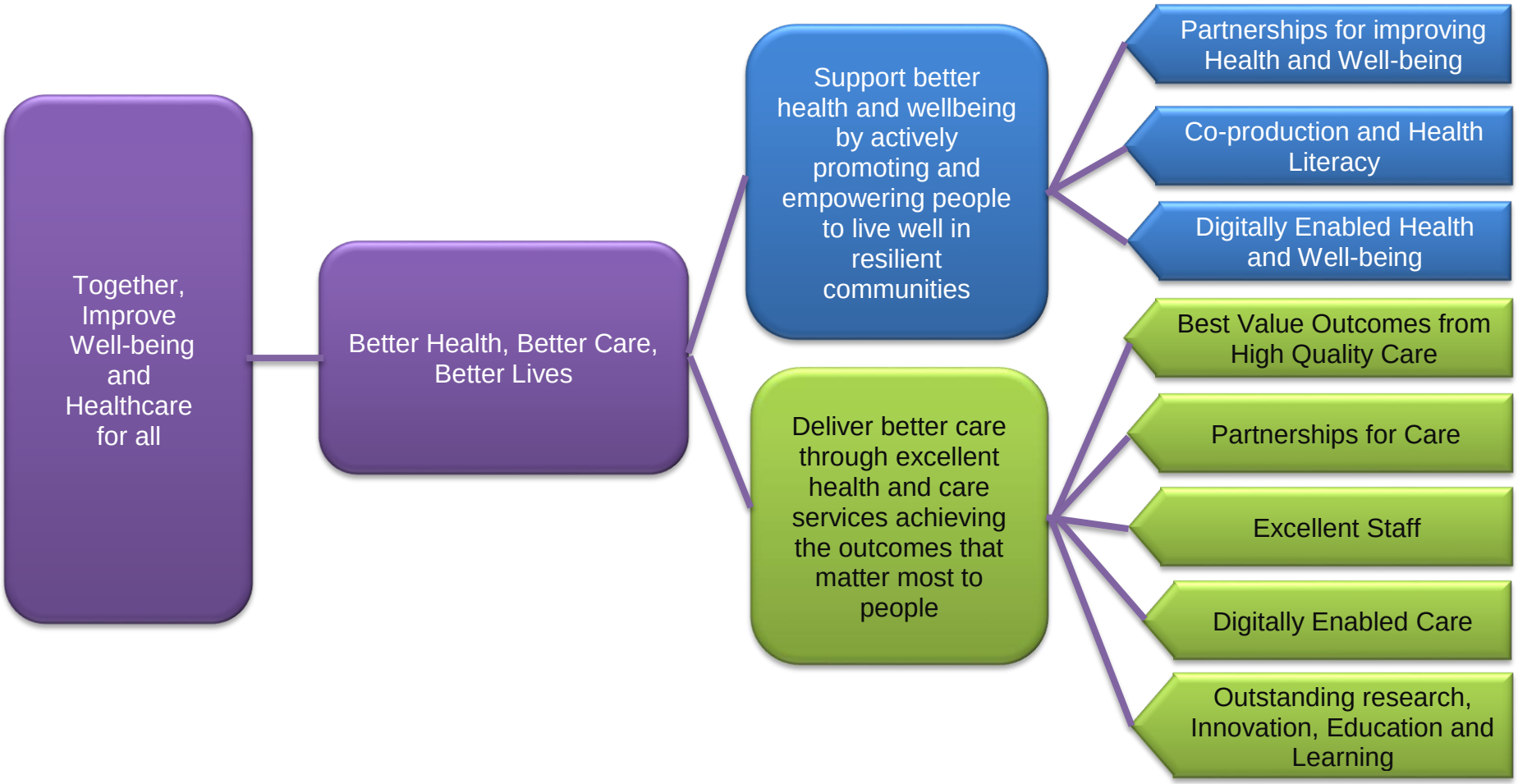
**Aligning Risk with Swansea Bay University Health Board (SBUHB) Strategy**

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



## HEALTH BOARD RISK REGISTER
## DASHBOARD OF ASSESSED RISKS – JUNE 2019

| Impact/Consequences | | | | | | |
|---|---|---|---|---|---|---|
| 5 | | | **15:** Population Health Improvement<br><br>59. Loss of Experienced Finance staff | **56**: Capacity of Workforce function | • **1**: Tier 1 Unscheduled Care Targets |
| 4 | | | | • **3:** Recruitment of Medical and Dental Staff<br>• **11:** Healthcare model for aging population<br>• **16:** Referral to treatment times<br>• **50**: Cancer Target Compliance<br>• **51:** Compliance with Nurse Staffing Levels (Wales) Act 2016<br>• **43:** DOLS Authorisation and Compliance with Legislation<br>• **44**: ED Information Systems<br>• **48:** Child & Adolescence Mental Health Services<br>• **52**: Engagement & Impact Assessment Requirements<br>• **37**:Operational and strategic decisions are not data informed<br>• **58:** Ophthalmology Clinic Capacity<br>• **55:** Boundary Transition<br>• **49:** TAVI Service | • **54:** No Deal Brexit<br>• **45**: Discharge information<br>• **27:** Sustainable Clinical Services for Digital Transformation<br>• **36:** Electronic Patient Record<br>• **57:** Non-compliance with Home Office Controlled Drug Licensing requirements<br>• **42:** Financial Plan |
| 3 | | | | • **13**: Accommodation fit for purpose<br>• **39**: IMTP<br>• **17:** Replacement of medical equipment | • **4:** Infection Control<br>• **41:** Fire Safety Regulation Compliance<br>• **53:** Compliance with Welsh Language Standards |
| 2 | | | | | |
| 1 | | | | | |
| **C X L** | **1** | **2** | **3** | **4** | **5** |
| | Likelihood | | | | |

## Risk Register Dashboard

| Strategic Objective | Risk Reference | Description of risk identified | Initial Score | Current Score | Trend | Controls | Last Reviewed | Scrutiny Committee |
|---|---|---|---|---|---|---|---|---|
| **Best Value Outcomes from High Quality Care** | 1<br>(738) | **Tier 1 Targets**<br>Failure to comply with Tier 1 target for Unscheduled Care which could impact on patient and family experience. | 16 | 25 | ↑ | → | June 2019 | Quality & Safety Committee |
| | 4<br>(739) | **Infection Control Targets**<br>Failure to achieve infection control targets set by Welsh Government | 20 | 12 | ↓ | ↑ | June 2019 | Quality and Safety Committee |
| | 11<br>(837) | **Ageing Population**<br>Failure to provide an appropriate healthcare model for the aging population over the next 20 years. | 16 | 16 | → | → | June 2019 | Quality and Safety Committee |
| | 13<br>(841) | **Health & Safety Standards**<br>Failure to meet the statutory health and safety requirements for our premises. | 16 | 12 | ↓ | ↑ | June 2019 | Health and Safety Committee |
| | 16<br>(840) | **Patient Waiting Times**<br>Failure to achieve compliance with waiting times there is a risk that patients may come to harm. Further, the health board will have financial resource clawed back to Welsh Government is the agreed target is not met. | 16 | 16 | → | → | June 2019 | Performance & Finance Committee |
| | 17<br>(838) | **Replacement of Equipment**<br>An inability to replace key pieces of equipment could adversely affect capacity and patient well being | 16 | 12 | → | → | June 2019 | Health and Safety Committee |
| | 37<br>(1217) | **Information Led Decisions**<br>Operational and strategic decisions are not data informed. | 16 | 12 | → | → | June 2019 | Audit Committee |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 39<br>(1297) | **Approved IMTP**<br>If the Health Board does not have an approved IMTP signed off by Welsh Government, primarily due to the inability to align performance and financial plans it will remain in escalation status, currently "targeted intervention". | 16 | 12 | ↓ | ↑ | June 2019 | Health Board |
| 41<br>(1567) | **Fire Safety of Cladding**<br>Currently an uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations | 15 | 15 | → | → | June 2019 | Health and Safety Committee |
| 42<br>(1398) | **Financial Plan**<br>If the Board is unable to successfully deliver a sustainable service and develop a balanced financial plan to support the Statutory Breakeven Financial Duty. | 12 | 20 | ↑ | ↑ | June 2019 | Performance & Finance Committee |
| 43<br>(1514) | **DoLS**<br>If the Health Board is unable to complete timely completion of DoLS Authorisation then the Health Board will be in breach of legislation and claims may be received in this respect. | 16 | 16 | → | → | June 2019 | Quality and Safety Committee/ |
| 48<br>(1563) | **CAMHS**<br>Failure to sustain Child and Adolescent Mental Health Services (CAHMS). | 16 | 16 | → | → | June 2019 | Performance & Finance Committee |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 49<br>(922) | **Trans-catheter Aortic Valve Implementation (TAVI)**<br>Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI) | 25 | 16 | → | → | June 2019 | Quality and Safety Committee |
| | 50<br>(1761) | **Cancer Targets**<br>Failure to sustain services as currently configured to meet cancer targets | 20 | 16 | ↓ | ↑ | June 2019 | Performance & Finance Committee |
| | 57<br>(1799) | **Controlled Drugs**<br>Non-compliance with Home Office Controlled Drug Licensing requirements. | 20 | 16 | ↓ | ↑ | June 2019 | Quality and Safety Committee |
| **Excellent Staff** | 3<br>(843) | **Recruitment**<br>Failure to recruit medical & dental staff | 20 | 16 | ↓ | ↑ | June 2019 | Workforce & OD Committee |
| | 51<br>(1759) | **Nurse Staffing (Wales) Act**<br>Risk of Non Compliance with the Nurse Staffing (Wales) Act | 16 | 16 | → | → | June 2019 | Quality and Safety Committee, |
| | 56<br>(1796) | **Capacity within WODS**<br>Insufficient capacity of Workforce and OD Function within ABMU to support and deliver the strategic and operational workforce agenda, plans and priorities of the Health Board. | 20 | 20 | → | → | June 2019 | Workforce & OD Committee |
| | 59<br>(1974) | **Loss of Experienced staff within Finance** | 15 | 15 | → | → | June 2019 | Workforce & OD Committee |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Digitally Enabled Care** | 27<br>(1035) | **Sustained Clinical Services**<br>Inability to deliver sustainable clinical services due to lack of digital transformation. | 16 | 12 | ↑ | ↓ | June 2019 | Audit Committee |
| | 36<br>(1043) | **Storage of Paper Records**<br>Failure to provide adequate storage facilities for paper records then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced | 20 | 12 | ↓ | ↑ | June 2019 | Audit Committee |
| | 44<br>(1564) | **Emergency Department (ED) System**<br>Current Emergency department (ED) systems are not fit for purpose. | 20 | 12 | ↓ | ↑ | June 2019 | Audit Committee |
| | 45<br>(1565) | **Discharge Information**<br>If patients are discharged from hospital without the necessary discharge information this may have an impact on their care | 20 | 20 | → | → | June 2019 | Audit Committee |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Partnerships for Improving Health and Wellbeing** | 58<br>(146) | **Excellent Patient Outcomes**<br>There is a failure to provide adequate clinic capacity to support follow-up patients within the Ophthalmology specialty. | 16 | 16 | → | → | June 2019 | Quality and Safety Forum |
| | 15<br>(737) | **Population Health Targets**<br>Failure to achieve population health improvement targets leading to an increase in preventable disease amongst the population resulting in increased morbidity impacting on operational and financial pressures. | 15 | 15 | → | → | June 2019 | Quality and Safety Committee |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Partnerships for Care** | 52<br>(1763) | **Statutory Compliance**<br>The Health Board does not have sufficient resource in place to undertake engagement & impact assess in line with Statutory Duties | 16 | 16 | ➔ | ➔ | June 2019 | Performance & Finance Committee/Health Board |
| | 53<br>(1762) | **Welsh Language Standards**<br>Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board. | 15 | 15 | ➔ | ➔ | June 2019 | Health Board (Welsh Language Group) |
| | 54<br>(1724) | **Brexit**<br>Failure to maintain services as a result of the potential no deal Brexit | 20 | 20 | ➔ | ➔ | June 2019 | Health Board |
| | 55<br>(1764) | **Bridgend Boundary Change**<br>Failure to ensure successful implementation of the Welsh Governments decision to realign the Health Boundary, as it applies to the resident population of the Bridgend County Borough. | 20 | 16 | ↓ | ↑ | June 2019 | Joint Transition Board (JTB) |

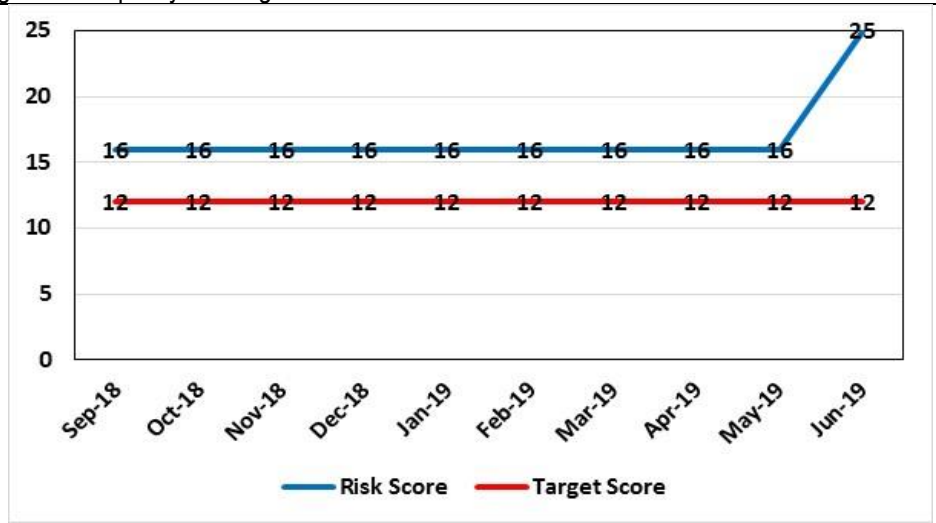
## Risk Schedules

| | |
|---|---|
| **Datix ID Number: 738**<br>**Health & Care Standard: 5.1 Timely Care** | **HBR Ref Number: 1** |
| **Objective**: Best Value Outcomes from High Quality Care | **Director Lead:** Chris White, Chief Operating Officer<br>**Assuring Committee:** Q & S Committee |
| **Risk:** If we fail to comply with Tier 1 target - **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:** June 2019 |

**Risk Rating** (consequence x likelihood):
Initial: 4 x 4 = 16
Current: 5 x 5 = 25
Target: 3 x 4 =12

**Level of Control** = 50%

**Date added to the risk register** 26.01.16




**Rationale for current score:**
At the end of Quarter performance the Health Board did not achieve performance trajectories.
Due to current pressures in MH A&E it was requested by the Q&S Forum that the risk score was upgraded.

**Rationale for target score:**

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

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

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

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Bed utilisation audit being undertaken to support USC system redesign programme in NPT and Swansea. | Assistant Chief Operating Officer | August 2019 |
| Clinical services plan for USC is being finalised. | Assistant Chief Operating Officer | August 2019 |
| Breaking the Cycle implemented Board-wide for first two weeks of July to help address pressures | Chief Operating Officer | July 2019 |
| Implement findings of Kendall Bluck report once supported by Executive Team | Chief Operating Officer | September 2019 |

**Assurances**

**Gaps in assurance**

| | |
|---|---|
| **(How do we know if the things we are doing are having an impact?)**<br>• Executive monitoring/support to achieve improvement plans on a weekly basis. | **(What additional assurances should we seek?)**<br>The need to deliver sustained service. |
| **Current Risk Rating**<br>**5 x 5 = 25** | **Additional Comments** |

| Datix ID Number: 739<br>Health & Care Standard: 2.4 Infection Prevention & Control & Decontamination | HBR Ref Number: 4 |
|---|---|
| **Objective**: Best Value Outcomes from High Quality Care | **Director Lead:** Gareth Howells, Director of Nursing and Patient Experience<br>**Assuring Committee:** Quality and Safety Committee |
| **Risk:** Failure to achieve **infection control** targets set by Welsh Government | **Date last reviewed:** June 2019 |

| **Risk Rating**<br>(consequence x likelihood):<br>Initial: 4 x 5 = 20<br>Current: 3 x 4 = 12<br>Target: 4 x 3 =12 | | **Rationale for current score:**<br>Currently under targeted intervention for rates of infection, achievement of targets are variable with monthly fluctuations |
|---|---|---|
| **Level of Control**<br>= 40% | | **Rationale for target score:** |
| **Date added to the risk register**<br>January 2016 | | Once the infection control team is fully recruited to, ICNet is functioning to its full capability the infection control team will be able to support the clinical areas more and drive service improvements.<br>In addition, a negative pressure isolation facility is being built into the new emergency department at Morriston hospital providing another facility to appropriately manage patients at the front door. Review and implementation of a robust clean of patient rooms following an infection will reduce the risk of cross infection. Plans are in place for initial training for this to commence January 2019. |



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

- Regular monitoring on infection rates
- Policies, procedures and guidelines in place
- Regular reporting through internal processes
- ICNet information management system for infections is in place
- Infection control team support the clinical teams for issues relating to infection control
- A permanent infection control doctor has been recruited
- Recruitment is ongoing and the decontamination lead and assistant director of nursing in infection control have been appointed
- Bug stop quality improvement programme
- Incident reporting

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Recruitment to ensure the team is fully established with the right skills and experience | Assist Dir Nursing Infection Control | July 2019 |
| Ongoing infection control team involvement in site level estates projects to ensure appropriate isolation facilities are factored in from the outset | Senior Infection Control Nurse | December 2019 |
| Review of reporting requirements to enable a focus on driving improvement and service delivery | Assist Dir Nursing Infection Control | August 2019 |
| HPV/UV cleaning post infection to be implemented | Senior Nurse Infection Prevention Control | July 2019 |

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

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

**Gaps in assurance**
**(What additional assurances should we seek?)**
ICNet provides information linked with PAS relating to patients who have been

| | |
|---|---|
| • Infection Control Committee monitors infection rates and identifies key actions to drive improvement<br>• Sub groups to the infection control committee such as the decontamination group provide the assurances and operationally drive key areas of work. | inpatients since the connection was made therefore additional manual records are maintained by the infection control team creating additional work and some duplication. |
| **Current Risk Rating**<br>**4 x 3 = 12** | **Additional Comments**<br>Significant progress to date however trajectory not met overall. Work underway on recruitment to IPC, a work plan to improve practice and improved information available for reporting, oversite and also investigation.<br>13/06/19 Continue to make progress against annual IMTP profiles, however, incidence within the Health Board remains above that for the NHS in Wales. Recruitment to Matron IPC post on 03/06/19. Work in progress to improve incident reporting in relation to infections and pilot to commence on post infection review process. |

| Datix ID Number: 837<br>Health & Care Standard: Staying Healthy 1.1 Health Promotion & Protection & Improvement | HBR Ref Number: 11 |
|---|---|
| **Objective**: Best Value Outcomes from High Quality Care | **Director Lead:** Gareth Howells, Director of Nursing and Patient Experience<br>**Assuring Committee:** Quality and Safety Committee |
| **Risk:** If we fail to provide an appropriate **healthcare model for aging population** over next 20 years care resident population will see a 24% increase in people of a pensionable age and 15% increase in people of non-working age. Providing services to enable citizens to live independently at home is a major challenge. | **Date last reviewed:** June 2019 |

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

**Level of Control**
= 70%

**Date added to the risk register**
January 2013

**Rationale for current score:**
New Service Module being developed

**Rationale for target score:**
New models of care will reduce the risk to be at an acceptable level

| Controls (What are we currently doing about the risk?) | Mitigating actions (What more should we do?) | | |
|---|---|---|---|
| | **Action** | **Lead** | **Deadline** |
| • Twelve standards of care for older people in hospital have been developed jointly by clinical staff, patient groups and voluntary sector organisations.<br>• The 'See It Say It' campaign was established to make it easier for staff, patients and visitors to raise concerns – anonymously if they wish – by phone, text or email<br>• Introduction of the '15 Step Challenge' to improve the first impression patients and visitors get when they enter a ward | Move to a balanced service model with bed provision reducing over time, development of community OPMH Hubs, community development and essential infrastructure services such as support & stay, care home support, memory clinics and Day Services. | Chief Operating Officer | August 2019 |

| Assurances<br>(How do we know if the things we are doing are having an impact?) | Gaps in assurance<br>(What additional assurances should we seek?) |
|---|---|
| **Current Risk Rating**<br>**4 x 4 = 16** | **Additional Comments** |

| **Datix ID Number: 841**<br>**Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety** | **HBR Ref Number: 13** |
|---|---|
| **Objective**: Best Value Outcomes | **Director Lead:** Gareth Howells, Director of Nursing and Patient Experience<br>**Assuring Committee**: Health and Safety Committee |
| **Risk:** Accommodation that does not meet statutory/health and safety requirements could have an adverse impact citizens, staff, financial and operational performance. This is a problem in the acute setting as well as across primary care in community clinics and surgeries. | **Date last reviewed:** June 2019 |

| **Risk Rating**<br>(consequence x likelihood):<br>Initial: 4 x 4 = 16<br>Current: 4 x 3 =12<br>Target: 4 x 3 = 12 | | **Rationale for current score:**<br>Lack of accommodation to meet statutory/health and safety requirements could have an adverse impact citizens, staff, financial and operational performance. |
|---|---|---|
| **Level of Control**<br>= 90% | | **Rationale for target score:** |
| **Date added to the risk register**<br>April 2012 | | |

| **Controls (What are we currently doing about the risk?)** | **Mitigating actions (What more should we do?)** | | |
|---|---|---|---|
| | **Action** | **Lead** | **Deadline** |
| • Key areas where performance linked to health & safety/fire issues flagged through Health & Safety and Quality & Safety Committees and actions agreed to mitigate impacts.<br>• Issues raised through site meetings held regarding service changes for all 4 acute hospital sites | Develop a strategy to improve primary and community services estate. | Asst Director Operations | August 2019 |
| | Develop BJC's to improve the infrastructure of the 3 acute hospital sites (not including NPTH). | Asst Director Operations | August 2019 |

| **Assurances (How do we know if the things we are doing are having an impact?)** | **Gaps in assurance**<br>**(What additional assurances should we seek?)** |
|---|---|
| • The Cabinet Secretary for Health & Social Services has now set the initial pipeline of health and care centres to be delivered by 2020-21.<br>• The following projects have been identified for your Health Board including:<br>Penclawdd Health Centre - refurbishment/redevelopment proposal (£0.800m at 16-17 prices)<br>Murton Community Clinic – refurbishment/redevelopment proposal (£0.400m at 16-17 prices)<br>Bridgend Town Centre Primary Care Centre – new build development (£5.000m at 16-17 prices); and<br>Swansea Wellness Centre – new build development (£10.000m at 16-17 prices).<br>The figures above represent the funding ceiling identified for the schemes.<br>All of the above projects have been identified within the capital pipeline, and we are in the stage of awaiting approval from the Welsh Government for each business cases applicable as soon as possible | |

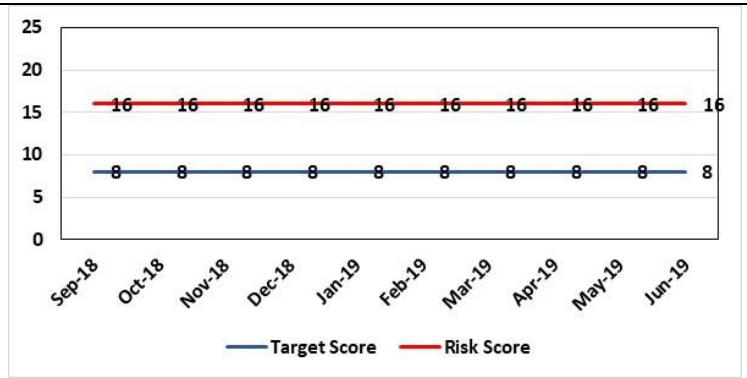
| Current Risk Rating<br>4 x 3 = 12 | Additional Comments |
| --- | --- |

| Datix ID Number: 840<br>Health & Care Standard: 5.1 Timely Care | HBR Ref Number: 16 |
|---|---|
| **Objective**: Best Value Outcomes from High Quality Care | **Director Lead:** Chris White, Chief Operating Officer<br>**Assuring Committee:** Performance & Finance Committee |
| **Risk:** If we fail to achieve compliance with waiting times there is a risk that patients may come to harm. Further, the health board will have financial resource clawed back to Welsh Government is the agreed target is not met. | **Date last reviewed:** June 2019 |

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

**Level of Control**
= 90%

**Date added to the risk register**
January 2013




**Rationale for current score:**
Consequence is high given nature of the risk. Likelihood is being managed through the controls and actions set out.

**Rationale for target score:**

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

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

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

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Escalation and scrutiny to Performance and finance Committee for off profile specialties | Associate Director Performance | Monthly |
| Develop sustainability plans for specialties through the emerging Clinical Services Plan | Associate Director Performance | August 2019 |
| Protect elective capacity during winter period to ensure elective capacity is maintained | Chief Operating Officer | August 2019 |

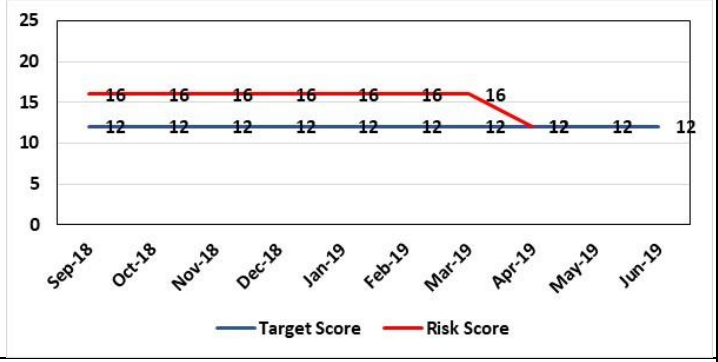
**Assurances**
**(How do we know if the things we are doing are having an impact?)**

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

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

**Current Risk Rating**
**4 x 4 = 16**

**Additional Comments**

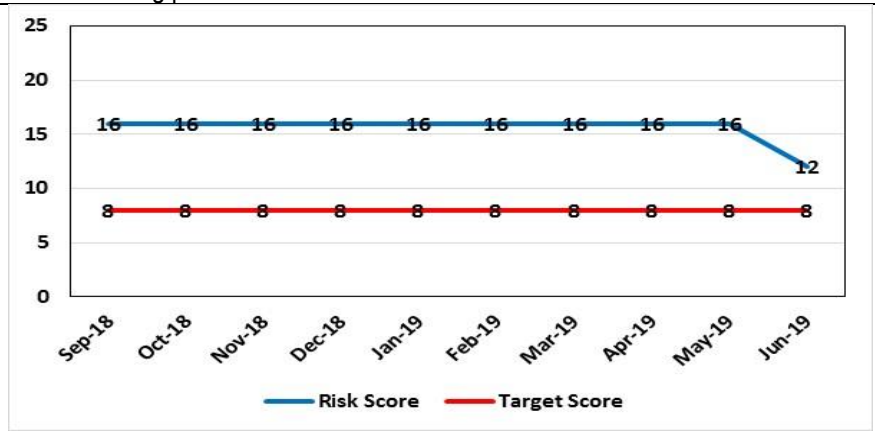
| Datix ID Number: 838<br>Health & Care Standard: Safe Care 2.9 Medical Devices, Equipment & Diagnostic Systems | | HBR Ref Number: 17 |
|---|---|---|
| **Objective**: Best Value Outcomes from High Quality Care | | **Director Lead:** Sian Harrop Griffiths, Director of Strategy<br>**Assuring Committee:** Health and Safety Committee |
| **Risk:** If we are unable to replace key pieces of equipment could adversely affect capacity and patient well being | | **Date last reviewed:** June 2019 |
| **Risk Rating**<br>(consequence x likelihood):<br>Initial: 4 x 4 = 16<br>Current: 4 x 3 =12<br>Target: 4 x 3 = 12 |  | **Rationale for current score:**<br>Database being developed to support an ongoing equipment replacement programme. |
| **Level of Control**<br>= 90% | | **Rationale for target score:** |
| **Date added to the risk register**<br>January 2013 | | |

| Controls (What are we currently doing about the risk?) | Mitigating actions (What more should we do?) | | |
|---|---|---|---|
| | **Action** | **Lead** | **Deadline** |
| Equipment bids regularly reviewed and risk rating of the equipment bids considered.<br>Proposal submitted to WG on use of discretionary capital slippage for medical equipment replacement in December 17. | Ensure that asset life information will be produced in the new single EBME system from 2011/12, is consistent with the Fixed Asset Register and will allow equipment replacement programmes to be planned for future years. | Director of Strategy | December 2019 |
| | Ensure equipment replacement requirements are identified within all future capital new build/ refurbishment schemes | Director of Strategy | December 2019 |
| | Database being developed to support an ongoing equipment replacement programme. | Director of Strategy | March 2020 |

| Assurances<br>(How do we know if the things we are doing are having an impact?) | Gaps in assurance<br>(What additional assurances should we seek?) |
|---|---|
| • Capital Prioritisation Group has been established to allocate discretionary capital in accordance with risk rating. All bids received for funding are risk assessed and verified by the Head of the Medical Equipment Management Service before being considered. When a business case is developed an allocation is included for equipment | |
| **Current Risk Rating**<br>**4 x 3 = 12** | **Additional Comments** |

| Datix ID Number: 1217<br>Health & Care Standard: Effective Care 3.1 Safer & Clinically Effective Care | HBR Ref Number: 37 |
|---|---|
| **Objective**: Best Value Outcomes from Quality Care | **Director Lead:** Chris White, Chief Operating Officer<br>**Assuring Committee:** Audit Committee |
| **Risk: Operational and strategic decisions are not data informed:-**<br>• Business intelligence and information already available is not utilized<br>• Users are unable to access the information they require to make decisions at the right time<br>• Gaps in information collection including patient outcome measures | **Date last reviewed:** June 2019 |

**Risk Rating** (consequence x likelihood):
Initial: 4 x 3 = 12
Current: 4 x 4 = 16
Target: 2 x 4 = 8




**Rationale for current score:**
C – Opportunity cost of not acting on data could mean opportunities for improvement are missed, failures are not identified in a timely manner resulting in adverse national publicity and/or delays in care/increased length of stay.
L - dashboard utilisation is lower than would be anticipated

**Level of Control** = 70%

**Rationale for target score:**

**Date added to the risk register**
June 2016

C- will remain the same or increase due to increased reliance in information
L- Investment in BI will lead to more information be available and used. The higher the use of information at operational level will lead to better quality data.

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

- The Health Board has continued to invest in the provision of Dashboards and we have doubled our licensing stock for both QlikSense and QlikView Business Intelligence Platforms in 2018/19.
- 17 dashboards in place including Mortality, Clinical Variation and Primary & Community Care Delivery Unit Dashboard and Ward Dashboard
- Safety Huddle implemented in Morriston is improving data quality and improving operational working
- Business Intelligent Information Manager appointed, who will take the lead for creating a Business Intelligence Strategy and Implementation Plan
- Investment and revised ways of working introduced within the coding department have achieved coding targets and data quality
- Flexible operational management of Coding Teams on a daily basis to cope with demand. Training programme in place for new coders.
- Short term funding secured at year end to support meeting tier 1 targets but does not resolve ongoing issues
- Information Dept. working with service leads in Planning and Finance to develop meaningful indicators also utilising dashboards to present information in a user friendly way

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Investment and implementation of system to record patient outcome measures | Assist Information Business Manager | March 2020 |
| Produce Business Intelligence Strategy and get signed off by the Board | Assist Information Business Manager | November 2019 |
| Produce BI strategy implementation plan outlining investment requirements in capacity and capability | Assist Information Business Manager | March 2020 |

**Assurances (How do we know if the things we are doing are having an impact?)**
More evidence based and proactive decisions being made.

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

| | |
|---|---|
| Dashboard technology; assist in developing indicators / triangulating information to identify issues | Culture of the organisation needs to change to focus on information and Business intelligence for operational rather than reporting purposes. Capability of operational staff to utilise the tools and capacity to act on the intelligence provided. |
| **Current Risk Rating**<br>**4 x3 = 12** | **Additional Comments**<br>A PROMS Project Manager has been appointed. PROMS pilot has been running in Breast and Lung Cancers. |

| Datix ID Number: 1297<br>Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety | HBR Ref Number: 39 |
|---|---|
| **Objective**: Demonstrating Value and Sustainability<br>Risk in Brief: If the Health Board fails to have an approvable IMTP for 2018/19 then we will lose public confidence | **Director Lead:** Sian Harrop-Griffiths, Director of Strategy<br>**Assuring Committee**: P&F Committee / Strategy, Planning and Commissioning Group Health Board |
| **Risk: Operational and strategic decisions are not data informed:-**<br>Health Board does not have an IMTP signed off by WG, primarily due to the inability to align performance and financial plans. WG also advised that the Health Board needed to have a clear strategic direction by developing an Organisational Strategy and refreshing our Clinical Services Plan. In September 2016, the Health Board was escalated to 'targeted intervention' and having an approved IMTP is a key factor in improving our WG monitoring status. | **Date last reviewed:** June 2019 |

**Risk Rating**
(consequence x likelihood):
Initial: 4 x 4 = 16
Current: 4 x 3 = 12
Target: 4 x 2 = 8

**Level of Control**
= 70%

**Date added to the risk register**
Q4 2016/17

**Rationale for current score:**
Our Organizational Strategy was approved by the Board in November 2018
This Annual Plan includes a balanced financial plan.
We have agreed with Welsh Government that we will continue our detailed planning and submit an approvable IMTP in the Summer of 2019.
We will continue our work from January onwards on our detailed plans to submit an approvable IMTP in the Summer 2019.

**Rationale for target score:**
If the IMTP is approved in Summer 2019 it is likely our targeted intervention status will be improved when next reviewed and the risk can be closed.

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

- Medium term plan with one-year deliverables will be submitted to Board for approval in January – including a balanced financial plan
- Transformation Programme including programme approach has been established.
- Continuous planning through our Transformation Programme will work up detailed plans to submit an approvable IMTP in Summer 2019
- Executive Steering Group in place for development of medium term plan
- Plans will be assured by the P&F Committee before presentation to Board

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Complete implementation of RFID within Health Records | Interim Chief Information Officer | July 2019 |
| Continue with roll out of digitisation of health record with a focus on Outpatients and Nursing documentation | Interim Chief Information Officer | August 2019 |
| Continue with the roll out of WCP | Interim Chief Information Officer | August 2019 |

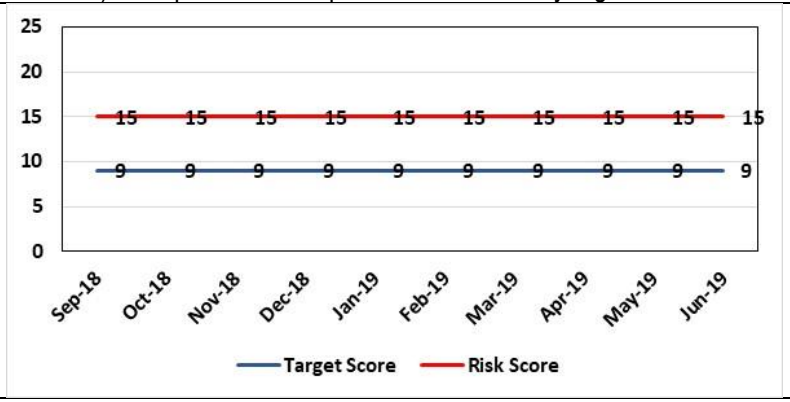
**Assurances (How do we know if the things we are doing are having an impact?)**
Through monthly IMTP briefings, TI meetings and bi-annual JET meeting with WG – planning approach and emerging plans discussed and WG fully supportive of the direction of travel.

**Gaps in assurance (What additional assurances should we seek?)**
EIA in development for PFC assurance
QIAs in development for joint PFC/Q&S assurance

**Current Risk Rating**
**4 x 3 = 12**

**Additional Comments**
Development of all 3 Plans considered by Executive Team and assured by PFC before submission to Board •Through monthly IMTP briefings, TI meetings and bi-annual JET meeting with WG – planning approach and emerging plans discussed and WG fully supportive of the direction of travel.

| Datix ID Number: 1567<br>Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety | HBR Ref Number: 41 |
|---|---|
| **Objective**: Best Value Outcomes from High Quality Care | **Director Lead:** Gareth Howells, Director of Nursing and Patient Experience<br>**Assuring Committee:** Health & Safety Committee |
| **Risk:** Currently an uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations. | **Date last reviewed:** June 2019 |

| **Risk Rating**<br>(consequence x likelihood):<br>Initial: 5 x 3 = 15<br>Current: 5 x 3 = 15<br>Target: 3 x 3 = 9 |  | **Rationale for current score:**<br>Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations |
|---|---|---|
| **Level of Control**<br>= 50% | | **Rationale for target score:** |
| **Date added to the risk register**<br>31/05/2018 | | Target Score should be lower |



| Controls (What are we currently doing about the risk?) | Mitigating actions (What more should we do?) | | |
|---|---|---|---|
| • Fire risk assessments.<br>• Evacuation plans (vertical and horizontal).<br>• Fire safety training.<br>• Professional advice sought on compliance of panels.<br>. | **Action** | **Lead** | **Deadline** |
| | Change in fire evacuation plans and alarm and detection cause and effect | Head of Health & Safety | August 2019 |
| | Finalise Business Case for permanent remediation of the external wall cladding to comply with HTM 05-02 and Building Control Regulations Approved Document B | Assistant Director of Strategy & Workforce | August 2019 |
| | Replacing the existing cladding and insulation with alternative specifications and inserting 30 minute fire cavity barriers where appropriate | Assistant Director of Strategy & Workforce | August 2019 |

| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)** | **Gaps in assurance**<br>**(What additional assurances should we seek?)**<br>Unclear if additional resources will be available |
|---|---|
| **Current Risk Rating**<br>**5 x 3 = 15** | **Additional Comments**<br>Professional assessment of panel compliance being taken forward with NWSSP-SES, building control and WG colleagues. |

| Datix ID Number: 1398<br>Health & Care Standard: Staff Resources 7.1 Workforce | HBR Ref Number: 42 |
|---|---|
| **Objective**: Best Value Outcomes from High Quality Care | **Director Lead:** Lynne Hamilton. Director of Finance<br>**Assuring Committee:** Performance and Finance Committee |
| **Risk:** If the Board is unable successfully to deliver a sustainable service and develop a balanced financial plan to support the Statutory Breakeven Financial Duty. | **Date last reviewed:** June 2019 |

**Risk Rating**
(consequence x likelihood):
Initial: 3 x 4= 12
Current: 4 x 5 =20
Target: 2 x 3 = 6

**Rationale for current score:**
In 19/20 the Health Board has developed a balanced financial plan to support the Statutory Breakeven Financial Duty. However a number of risks have been identified which may result in the breakeven duty not being met in this financial year.

- Ability to deliver required level of savings;
- Cost pressures in excess of plan emerge and are unable to be managed;
- Impact of diseconomies of scale following the Bridgend Boundary Change are unable to be mitigated in full during 2019/20;
- Delivery risks considered too high by Welsh Government and the additional funding support provided in recognition of operational and financial performance improvement is withdrawn;
- Potential for a further adjustment to Health Board core funding allocation in relation to Bridgend Boundary Change.

Target set by WG. Improving likelihood due to enhanced controls and mitigating actions and opportunities.

**Level of Control**
= 50%

**Rationale for target score:**
Aim to increase confidence levels to deliver set target.

**Date added to the risk register**
July 2017

| Controls (What are we currently doing about the risk?) | Mitigating actions (What more should we do?) | | |
|---|---|---|---|
| | **Action** | **Lead** | **Deadline** |
| The Health Board has a number of established financial control measures including authorisation hierarchies, QVC panels and vacancy control panel.<br><br>These controls are being enhanced through the High Value Opportunity workstreams.<br><br>In addition, the Health Board is creating a Delivery team which will support and challenge on all aspects of financial performance including savings. The Delivery team will also support and ensure the development of a strong pipeline of schemes and opportunities. This team are likely to be supported by some External intervention support. | Monitor risk through Performance and Finance Committee | Director of Finance | Monthly Review |

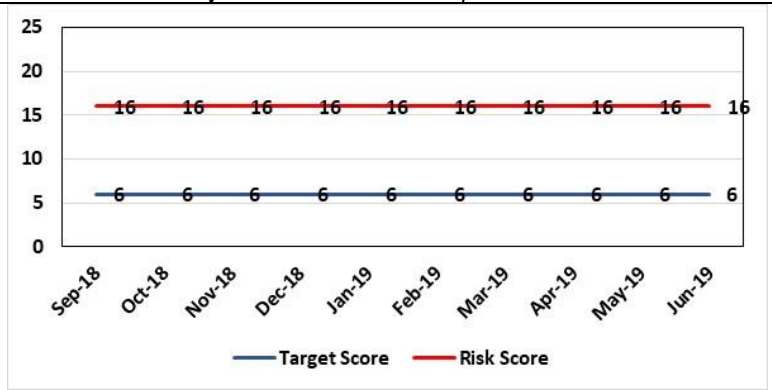
| Assurances<br>(How do we know if the things we are doing are having an impact?) | Gaps in assurance<br>(What additional assurances should we seek?) |
|---|---|
| The Health Board financial performance is reviewed and monitored through :<br>• Unit financial recovery meetings<br>• Financial Management Group (chaired by CEO)<br>• Performance and Finance Committee | |
| **Current Risk Rating**<br>**4 x 5 = 20** | **Additional Comments** |

| Datix ID Number: 1514<br>Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety | HBR Ref Number: 43 |
|---|---|
| **Objective**: Best Value Outcomes from High Quality Care | **Director Lead:** Gareth Howells, Director of Nursing & Patient Experience<br>**Assuring Committee:** Quality & 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:** June 2019 |

**Risk Rating**
(consequence x likelihood):
Initial: 4 x 4 =16
Current: 4 x 4= 16
Target: 3 x 2 = 6

**Level of Control**
= 40%

**Date added to the risk register**
July 2017




**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.

**Rationale for target score:**
Consequences of DoLS breaches for the Health Board will not change. With controls in place, over time likelihood should decrease.

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

- Supervisory body signatories increased from 3 to 7
- BIA rota now implemented
- 2 x substantive BIA posts and additional admin post advertised
- DoLS database updated and DoLS dashboard devised to enable more accurate monitoring and reporting

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Delivery of DOLS Action plan reviewed monthly | Head of Safeguarding | Monthly Review |

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

- Regular scrutiny at Safeguarding Committee and by DoLS Internal Audit; monitoring via DoLS Dashboard which is due to be rolled out imminently and will provide real-time accurate data.

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

**Current Risk Rating**
**4 x 4 = 16**

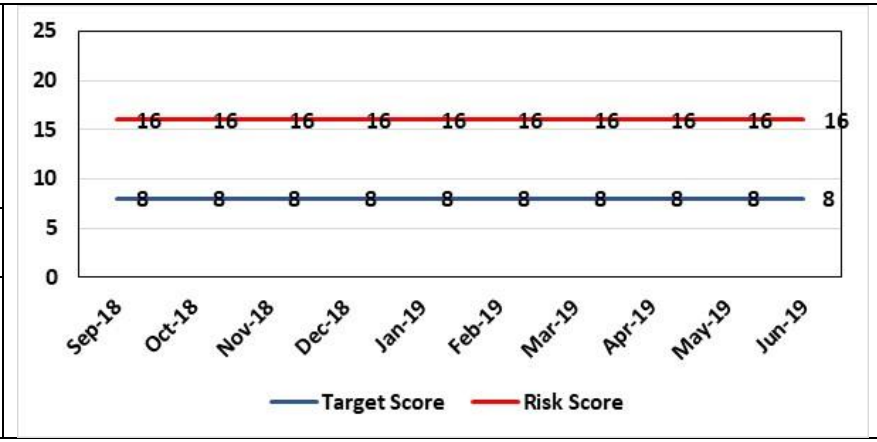
**Additional Comments**

| Datix ID Number: 1563<br>Health & Care Standard: Safe Care 5.1 Access | HBR Ref Number: 48 |
|---|---|
| **Objective**: Best Value Outcomes from High Quality Care | **Director Lead:** Sian Harrop Griffiths, Director of Strategy<br>**Assuring Committee:** Performance & Finance Committee, Health Board |
| **Risk:** Failure to sustain Child and Adolescent Mental Health Services | **Date last reviewed:** June 2019 |

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

**Level of Control**
= 50%

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




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

**Rationale for target score:**
If the IMTP is approved in Summer 2019 it is likely our targeted intervention status will be improved when next reviewed and the risk can be closed.

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

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

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Implementation of the Choice and Partnership Approach (CAPA) started on 1st November 2017 and being closely monitored | CAMHS network | August 2019 |
| Additional investment expected - from Welsh Government is supporting the delivery of Waiting List Initiative clinics to support the position. | CAMHS network | August 2019 |
| The Network is seeking to recruit agency staff to fill existing and upcoming vacancies to ensure that core capacity is maximised. | CAMHS network | August 2019 |

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

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

**Current Risk Rating**
**4 x 4 = 16**

**Additional Comments**
The service is now in the 2nd cycle of CAPA with new job plans agreed from January, with updated demand & capacity mapping. WLI Clinics initiated at POW

| | |
|---|---|
| | Hospital, Bridgend which enabled the 80% target to be achieved by end of end March. This was also achieved for NPT area. However Swansea had a significant backlog, which is starting to be addressed with waiting list initiatives from March 2018.<br>Primary & specialist CAMHS services are delivered by Cwm Taf University Health Board on behalf of ABMU (although this will only be for Swansea & NPT from 1/4/19). Cwm Taf achieved the non-urgent 28 day target for specialist CAMHS by the end of March 2019. Their ability to sustain this performance is dependent on consistency and availability of staff which due to the small numbers in the various CAMHS teams can affect achievement of waiting times significantly. |

| Datix ID Number: 922<br>Health & Care Standard: Effective Care 3.1 Clinically Effective Care | HBR Ref Number: 49 |
|---|---|
| **Objective**: Best Value Outcomes from High Quality Care | **Director Lead:** Richard Evans, Medical Director<br>**Assuring Committee:** Quality & Safety Committee |
| **Risk:** Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI) | **Date last reviewed:** June 2019 |

**Risk Rating**
(consequence x likelihood):
Initial: 5 x 5 = 25
Current: 3 x 4 =16
Target: 3 x 4 = 12

**Level of Control**
= 50%

**Date added to the risk register**
July 2016

**Rationale for current score:**

- Patients waiting in excess of 36 weeks for TAVI procedure as a result of lack of service infrastructure as well as increasing demand.
- Mortality review undertaken which has indicated that patients have come to serious harm as a result of excessive waits.
- Recovery plan commenced on 5th November and has begun to reduce number of patients waiting over 36 weeks however without sustainable service in place from early 2019, backlog will increase again.
- Given reduction in number of patients waiting over 36 weeks since 5th November, risk score has reduced from 25 to 16.

**Rationale for target score:**
Recovery plan provides funded temporary capacity to reduce backlog of patients awaiting procedure. The service projects 0 patients waiting over 36 weeks by the end of December 2018. This will reduce risk of harm however risk of reoccurrence will remain until recurrent service infrastructure is established.

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

- TAVI Recovery Plan implemented with aim of reducing backlog of patients by end of financial year. Operational service meets weekly to oversee this plan.
- Plan is supported with Executive oversight at weekly TAVI OG meeting.
- TAVI has been prioritised for consideration in next year's WHSSC ICP however any funding allocation unlikely to be until spring 2020. TAVI Executive OG Group therefore considering options to mitigate a further increase in TAVI backlog following completion of the recovery plan.

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Clear backlog of patients awaiting TAVI | Directorate Manager | August 2019 |
| Progress case to WHSSC for sustainable TAVI service resource to be included in 2019/20 ICP | Directorate Manager | October 2019 |
| Establish HB support to 'bridge the gap' for sustainable TAVI service between completion of recovery plan in February 2019 and possible receipt of WHSSC funding in April 2020. | Directorate Manager | August 2019 |

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

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

**Current Risk Rating**

**Additional Comments**

| | |
|---|---|
| **3 x 4 = 12** | No patients now waiting > 36 weeks. Agreement to go out to advert to establish one list per week from April therefore closing down TAVI risk. Awaiting response from RCP report.<br>Service awaiting outcome of RCP invited service review<br>Business case for WHSSC funding has been deferred from June Management group.<br>UHB await confirmation of discussion.<br>Whilst WHSSC decision is ongoing Health Board has committed to service improvement - This presents a financial pressure whilst we await WHSSC decision. |

| Datix ID Number: 1761<br>Health & Care Standard: Timely Care 5.1 Access | HBR Ref Number: 50 |
|---|---|
| **Objective**: Best Value Outcomes from High Quality Care | **Director Lead**: Chris White, Chief Operating Officer<br>**Assuring Committee:** Performance & Finance Committee |
| **Risk:** Failure to sustain services as currently configured to meet cancer targets | **Date last reviewed:** June 2019 |

**Risk Rating**
(consequence x likelihood):
Initial: 4 x 5 = 20
Current: 4 x 4 = 16
Target: 4 x 3 = 12

**Level of Control**
= 70%

**Date added to the risk register**
April 2014

**Rationale for current score:**
An overall reducing trend in current risk assessed score. Whilst target not consistently being met, general improvement trajectory which needs to be sustained.

**Rationale for target score:**

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

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

- Tight management processes to manage each individual case on the unscheduled care (USC) Pathway.
- Initiatives to protect surgical capacity to support USC pathways have been put in place in RGH and PCH to protect core activity.
- Prioritised pathway in place to fast track USC patients.
- Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies.
- Overall Cancer target performance plateau at around 90% with ongoing monitoring of related actions in place at F,P&W Committee.
- Small numbers of patients breaching which is impacting on sustained delivery of the 31 and 62 day target.

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Introduction of revised models for rapid diagnostic review / assessment in cancer pathways being introduced. | COO / DPC&MH Med Director | August 2019 |
| Continue close monitoring of each patient on the USC pathways to ensure rapid flow of patients through the pathway. | COO / DPC&MH Med Director | August 2019 |
| Some speciality challenges remain in Lung and Urology - Action plans in place, along with monitoring. | COO / DPC&MH Med Director | August 2019 |

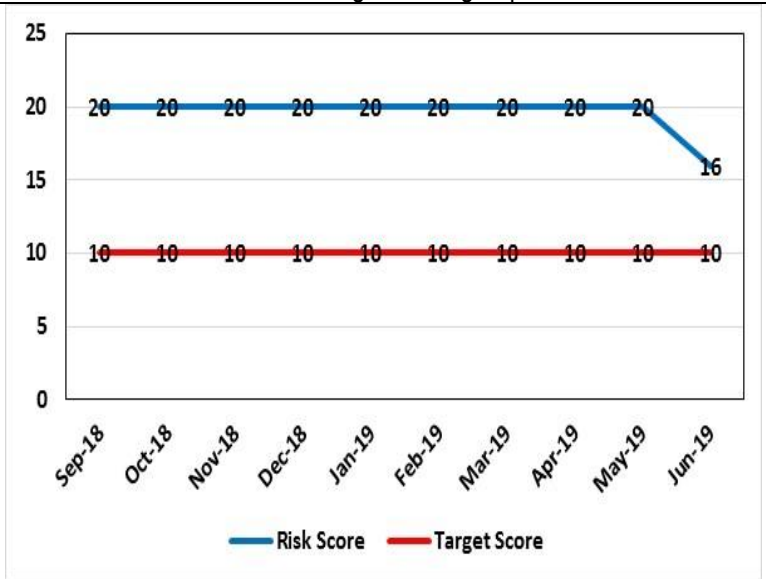
**Assurances**
**(How do we know if the things we are doing are having an impact?)**
General improvement (sustained) trajectory. Need to continue improvement actions and close monitoring.
Early diagnosis pathway launched and impact being closely monitored.

**Gaps in assurance**
**(What additional assurances should we seek?)**
Clear current funding gap.

**Current Risk Rating**
**4 x 4 = 16**

**Additional Comments**
The need to deliver sustained performance.

| **Datix ID Number: 1799**<br>**Health & Care Standard: Controlled Drug 2.6 Medicines Management** | **CRR Ref Number: 57** |
|---|---|
| **Objective**: Best Value Outcomes of High Quality Care | **Director Lead**: Richard Evans, Executive Medical Director<br>**Assuring Committee**: |
| **Risk:** Non-compliance with Home Office Controlled Drug Licensing requirements | **Date last reviewed:** June 2019 |
| **Risk Rating** (consequence x likelihood):<br>Initial: 5 x 4 = 20<br>Current: 4 x 4 = 16<br>Target: 5 x 2 = 10 | **Rationale for current score:**<br>The Health Board has no assurance regarding whether or not it is compliant with Home Office Controlled Drug Licensing requirements at the present time, nor does it have processes in place to ensure any future service change complies.<br>Risk: That the Health Board is operating in breach of the law by managing controlled drugs without an appropriate Home Office Controlled Drug License. Recent legal advice provided to the Health Board has indicated that failure to comply with the Home Office Controlled Drug licensing requirements could result in criminal and civil action, both against responsible individuals and the Health Board as a public body.<br>Risk: That the Health Board is maintaining unnecessary Home Office Controlled Drug Licenses. Each Home Office Controlled Drug license costs around £3k plus additional administrative set-up and maintenance costs. Health Board wide scrutiny is required to ensure no unnecessary licenses are held (one such example has recently been discovered). |
| **Level of Control** = 40% | **Rationale for target score:** |
| **Date added to the risk register** January 2019 | |




| **Controls (What are we currently doing about the risk?)** | **Mitigating actions (What more should we do?)** | | |
|---|---|---|---|
| | **Action** | **Lead** | **Deadline** |
| Legal advice received and principles upon which to decide whether a Home Office Controlled Drug License would be required have been drafted. | The Health Board to develop and implement a corporate Health Board wide policy and control system to ensure compliance with Home Office Controlled Drug licensing requirements both now and in the future including: A baseline audit and assessment of current Controlled Drug management across the Health Board (including the degree of 'management and control' exercised) against the recently received legal advice. | Clinical Director of Medicines Management | August 2019 |

| Assurances<br>(How do we know if the things we are doing are having an impact?) | Gaps in assurance<br>(What additional assurances should we seek?) |
|---|---|
| • To date the HB has received legal advice. Pending policy development, the principles contained within the legal advice are referred to when issues are raised in order to provide consistency in arrangements. | The Health Board could develop and implement a corporate Health Board wide policy and control system to ensure compliance with Home Office Controlled Drug licensing requirements both now and in the future. |
| **Current Risk Rating**<br>**4 x 4= 16** | **Additional Comments**<br>The Home Office are aware that the Health Board have sought independent legal advice regarding the situations where a Home Office Controlled Drug license is required. Advice received to date from the Home Office regarding particular scenarios of Controlled Drug management by the Health Board has differed from the independent legal advice received.<br>The Home Office are currently awaiting the Health Board policy on this matter so that they can review our position. |

| Datix ID Number: 843<br>Health & Care Standard: Staff & Resources 7.1 Workforce | HBR Ref Number: 3 |
|---|---|
| **Objective**: Excellent Staff | **Director Lead:** Hazel Robinson, Director of Workforce and Operational Development<br>**Assuring Committee:** Workforce & OD Committee |
| **Risk:** Failure to recruit medical & dental staff | **Date last reviewed:** June 2019 |
| **Risk Rating**<br>(consequence x likelihood):<br>Initial: 5 x 4 = 20<br>Current: 4 x 4 =16<br>Target: 4 x 3 = 12 | **Rationale for current score:**<br>• National shortages of numbers in some areas can lead to:<br>• Unable to recruit sufficient numbers of trainees to fulfil rotas on all sites<br>• Unable to attract non training grades to complete rotas<br>• Unable to fill Consultant grade posts in some specialties with adverse effects on patient safety and industrial relations. Unable to recruit sufficient registered nursing staff. |
| **Level of Control**<br>= 70% | **Rationale for target score:** |
| **Date added to the risk register**<br>April 2012 | This remains a challenge and is also a national problem. |

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

- Regular monitoring of recruitment position with reports to Executive Team and Board via Medical Director and Medical Workforce Board.
- Specialty based local workforce boards established to monitor and control specific issues. The new HB Workforce & OD Committee will seek assurance of medical workforce plans to maintain services.
- Engagement of the Deanery about recruitment position.

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Medical training initiatives pursued in a number of specialties to ease junior doctor recruitment | Director W&OD. | August 2019 |
| The Medical Workforce Board continues to monitor recruitment and junior doctor's rotas. | Director W&OD. | May 2020 |
| Continue to recruit internationally. | Director W&OD. | May 2020 |

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

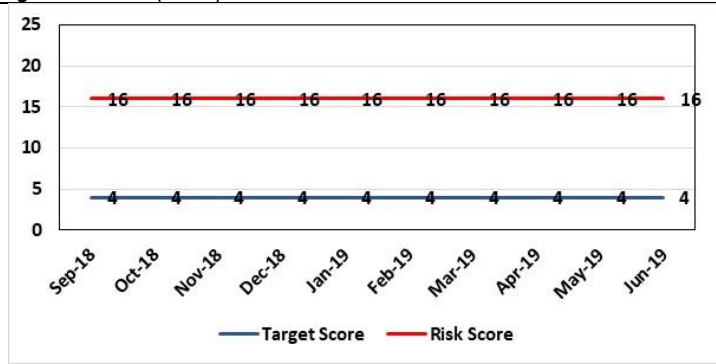
- General situation monitored through W&OD Committee
- Communication with Deanery
- Recruitment campaigns
- Integrated Medicine and Paediatrics short term workforce plans
- Monitoring by Executive Teams and specialty based local workforce boards

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

**Current Risk Rating**
**4 x 4 = 16**

**Additional Comments**
In development despite some work going on with Medacs permanent recruitment arm and participation in BAPIO. A rolling programme of recruitment underway. Participating in the November 2019 BAPIO recruitment round.

| Datix ID Number: 1759<br>Health & Care Standard: Staff & Resources 7.1 Workforce | HBR Ref Number: 51 |
|---|---|
| **Objective**: Excellent Staff | **Director Lead:** Gareth Howells, Director of Nursing<br>**Assuring Committee:** Quality and Safety Committee, NMB |
| **Risk:** Non Compliance with Staffing Levels Act (2016) | **Date last reviewed:** June 2019 |
| **Risk Rating**<br>(consequence x likelihood):<br>Initial: 4 x 4 = 16<br>Current: 4 x 4 = 16<br>Target: 4 x 1 = 4 | **Rationale for current score:**<br>• Section 25B places a duty on LHBs and NHS Trusts to calculate and take steps to maintain nurse staffing levels in specified settings, which are currently adult acute medical and surgical inpatient wards.timescale. |
| **Level of Control**<br>= 80% | **Rationale for target score:**<br>• The Health Board is ensuring we have the structures and processes in place to provide reassurance under the Act and are allocating resources accordingly.<br>• Health Boards are duty bound to take all reasonable steps to maintain nurse staffing levels. |
| **Date added to the risk register**<br>November 2018 | |




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

The Health board has put the following controls in place:-

- Confirmed the designated person
- Represented the All-Wales Nurse Staffing Group and its sub groups
- Contributed with the work undertaken at an all-Wales level on Acuity levels of care.
- Undertaken a formal review across all acute Service Delivery Units for calculating and reporting nurse staffing requirements to ensure a Health Board wide consistent approach is adopted.
- Presented a Health Board position status paper to both Board & Executive team outlining the preparedness for the Nurse Staffing Act (Wales).
- Conducted a review of workforce planning procedures, for 2018 to 2021, which includes; Health Board recruitment events, retention, workforce Planning & redesign, training and development.
- Developed a monthly Health Board Multidisciplinary Nurse Staffing Act Task & Finish Group, chaired by the Interim Deputy Director of Nursing & Patient Experience, which reports to Nursing and Midwifery Board and Workforce & Organisational Development Committee.
- Provided acuity feedback sessions to all Service Delivery Units included in the June audit.
- Formally launched the Nurse Staffing (Wales) Act Guidance.
- Raised the issue regarding Information Technology barriers around the capture of data required for the Act on an All- Wales and Health Board basis.
- Circulated the Welsh Levels of Care and Operational Handbook to Service Delivery Unit Leads.

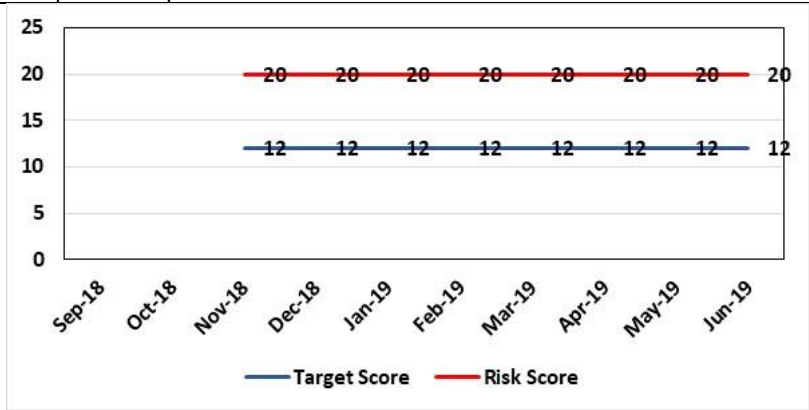
**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| The Ward Sister / Charge Nurse and Senior Nurse should continuously assess the situation and keep the designated person formally appraised. | Director of Nursing & Patient Experience | August 2019 |
| The Board should ensure a system is in place that allows the recording, review and reporting of every occasion when the number of nurses deployed varies from the planned roster. | Director of Nursing & Patient Experience | August 2019 |
| The responsibility for decisions relating to the maintenance of the nurse staffing level rests with the Health Board should be based on evidence provided by and the professional opinions of the Executive Directors with the portfolios of Nursing, Finance, Workforce, and Operations. | Director of Nursing & Patient Experience | August 2019 |
| Health Board should agree the operating framework for these decisions to include actions to be taken, and by whom. | Director of Nursing & Patient Experience | August 2019 |

| | | | |
|---|---|---|---|
| • Confirmed the 32 acute medical & surgical clinical areas that fall within the Act. These areas have been agreed using the criteria set out in the Operational Handbook.<br>• A Rigorous data approval process has been put in place to ensure accuracy of the 6 monthly acuity data prior to sign off. There has also been a number of workshops organised across the organisation to ensure a consistent approach to data collection and there is national work on solutions for electronic capture of acuity data. | | | |
| **Assurances (How do we know if the things we are doing are having an impact?)**<br>• Ongoing robust recruitment and retention plans in place to reduce vacancies in key clinical areas, which is in line with the Health Board recruitment plan.<br>• Accurate reporting of Acuity data and governance around sign off.<br>• Agreed establishments to funded.<br>• Implementation of E-Rostering to enable accurate reporting of Compliance<br>• Implement all Wales Templates, which are visible and signed within the agreed 32 ward areas, informing patients of planned roster.<br>• At least Yearly Board reports outlining compliance and any key risks. | **Gaps in assurance**<br>**(What additional assurances should we seek?)** | | |
| **Current Risk Rating**<br>**4 x 4 = 16** | **Additional Comments** | | |

| Datix ID Number: 1796<br>Health & Care Standard: Staff Resources 7.1 Workforce | HBR Ref Number: 56 |
|---|---|
| **Objective**: Excellent Staff | **Director Lead:** Hazel Robinson, Director of Workforce and Operational Development<br>**Assuring Committee:** Finance, Performance & Workforce |
| **Risk:** Insufficient capacity of Workforce and OD Function within ABMU to support and deliver the strategic and operational workforce agenda, plans and priorities of the Health Board | **Date last reviewed:** June 2019 |

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




**Level of Control**
= 30%

**Date added to the risk register**
November 2018

**Rationale for current score:**

- Since the establishment of the Health Board in 2009 there has been a significant reduction in the workforce and OD staffing levels. The current capacity of the team and the team's ability to provide appropriate, high quality and timely advice on both operational and strategic issues is a significant area of professional concern. Current resourcing levels have been benchmarked with other Health Boards.

**Rationale for target score:**

- Target score reflects requirement to resource the workforce and OD function to be able to meet the operational and Strategic priorities of the Health Board. Failure to do this will negatively impact of financial, service, performance and quality outcomes.

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

Director of Workforce and OD reported risk stocktake to W&OD Committee. A Workforce and OD risk register has been generated as a consequence. Reported at Corporate Performance review with CEO. Reported to Audit Committee.
Further update on risk and progress against these reports to W&ODC in November 2018.
Resource has been secured on a temporary/interim basis to assist with capacity issues. Risks are being monitored through the workforce and od committee on a monthly basis.

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Review of resourcing to take into account Boundary Change | Director of W&OD | August 2019 |

General situation monitored through W&OD Committee.

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

**Current Risk Rating**
**4 x 5 = 20**

**Additional Comments**

Utilise temporary funded capacity to meet immediate areas of risk. Continue to raise resourcing issue at corporate level and through committee governance arrangements. Run at risk.

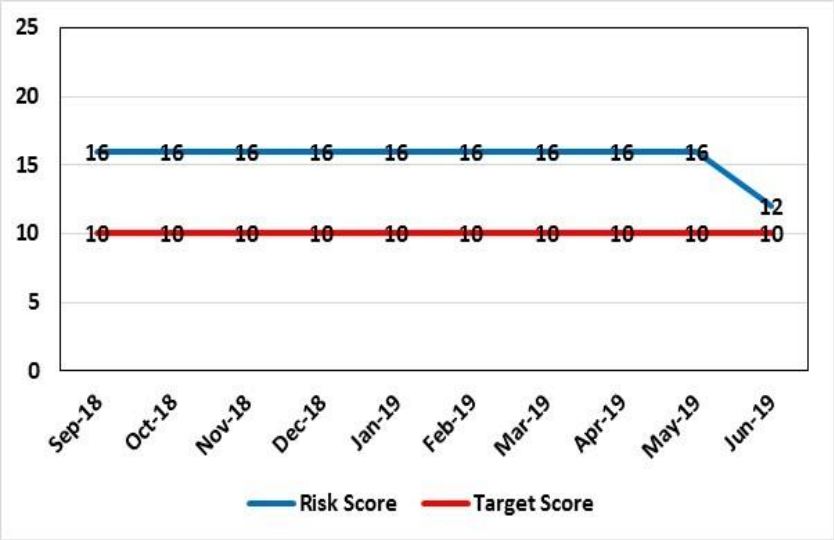
- Actions Complete: Risk Stock Take reported to W&OD Committee, Audit Committee and Corporate Performance Review.
- Update on progress and improvement against key risk areas provided to W&ODC.
- Development of W&OD Risk Register.

| Datix ID Number: 1035<br>Health & Care Standard: Effective Care 3.1 Clinically Effective Care | HBR Ref Number: 27 |
|---|---|
| **Objective**: Digitally enabled care | **Director Lead:** Chris White, Chief Operating Officer<br>**Assuring Committee:** Audit Committee |
| **Risk: Digital Transformation** Inability to deliver sustainable clinical services due to lack of Digital Transformation.<br>There are insufficient resources to:<br>• invest in the delivery of the ABMU Digital strategy,<br>• support the growth in utilisation of existing and new digital solutions<br>• replace existing technology infrastructure and the end of its useful life. | **Date last reviewed:** June 2019 |

**Risk Rating** (consequence x likelihood):
Initial: 4 x 4 = 16
Current: 4 x 3 = 12
Target: 5 x 2 =10

**Level of Control** = 50%

**Date added to the risk register** 2012




**Rationale for current score:**
C – reliance on digital ways of working has increased. Loss of IT service has a greater impact on ability to provide clinical care. Lack of investment in new digital solutions to make services more effective will mean clinical service provision will become unsustainable.
L- There has been an increase in the number of devices in circulation by 3000 (39%) over the last 4 years (2015-2018) without an increase in IT support capacity. HB are currently only able to replace devices that are over 7 years old. Call volumes and wait times have increased over the last 4 years. Key IT maintenance work is not being completed in a timely fashion. Investment required in Informatics to deliver the Digital strategy is greater than the funding currently available. Informatics budget is estimated to be 0.73% of the HB budget - well below the recommended 4%. Resources available to provide digital services could be reduced because of the boundary change.

**Rationale for target score:**
C – of failure will increase as the reliance and proliferation of the use of digital solutions increases.
L – investment will mean the support mechanisms, rate of failure and ability to deliver solutions that meet the needs of users will improve sustainable digital services. There will however always be an inherent risk of failure of IT solutions.

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

- Digital strategy has been approved by the Health Board
- Capital priority group for the HB considers digital risks for replacement technology which is fed into the annual discretionary capital plan
- IBG process allows for investment requests in projects to be submitted to the HB for

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Develop a new Strategic Outline Plan setting out the requirement to deliver the first phase of the Digital strategy. **Three year plan to be developed in line with the Health Boards IMTP Planning process.** | Assistant Informatics Business Manager | September 2019 |

| | | | |
|---|---|---|---|
| consideration and provides scrutiny to ensure Digital resources required are considered for all projects<br>• Informatics prioritisation process has been introduced to ensure requests for digital solutions are considered in terms of alignment to the strategy objective, technical solutions and financial implications<br>• HB has invested £900k recurrently in the project staffing resources to facilitate the delivery of the Informatics Strategic Outline Plan<br>• Working closely with WG to identify funding streams to support investment in digital including the approval of the Informatics Strategic Outline Plan | Work with finance and the Health Board leadership team to identify additional revenue streams.<br>**2019/ 2020 Capital plan approved. 200K revenue increase agreed to reflect growth in IT service provision** | Assistant Informatics Business Manager | March 2020 |
| | Ensure informatics prioritisation process is embedded into the ways of working so that resource implications of digital solutions are transparent and agreed at outset of projects. **Internal processes have been established to ensure that all informatics costs are included in Business cases developed by Informatics. Representation from Informatics at IBG and the Scrutiny Panel.** | Assistant Informatics Business Manager | March 2020 |
| | Ensure business cases requiring digital services include appropriate implementation and support costs. **Internal processes have been established to ensure that all informatics costs are included in Business cases developed by Informatics. Representation from Informatics at IBG and the Scrutiny Panel.** | Assistant Informatics Business Manager | March 2020 |
| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>• Progress has been made in securing capital investment both internally and externally for new developments<br>• IBG and CPG processes are in place and ensuring highest technology replacement risks are being addressed<br>• There are 22 active projects in place and being delivered<br>• Digital enablement is a cornerstone of the organization strategy. Two of the strategies, 8 areas, of focus are digital enablement. | **Gaps in assurance**<br>**(What additional assurances should we seek?)**<br>Lack of certainty over future funding streams makes planning and implementation difficult/less effective<br>Revenue model for support unclear given the financial pressures of the organisation. | | |
| **Current Risk Rating**<br>**4 x 3 = 12** | **Additional Comments**<br>This is further impacted by the boundary change which could have significant impact on resources and capability to deliver digital services going forward. | | |

| Datix ID Number: 1043<br>Health & Care Standard: Effective Care 3.1 Clinically Effective Care | HBR Ref Number: 36 |
|---|---|
| **Objective**: Digitally enabled care | **Director Lead:** Chris White, Chief Operating Officer<br>**Assuring Committee:** Audit Committee |
| **Risk: Paper Record Storage:** Lack of a single electronic record means there is greater reliance on the provision of the paper record. If we fail to provide adequate storage facilities for paper records then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if there is poor records management in some wards. | **Date last reviewed:** June 2019 |

**Risk Rating** (consequence x likelihood):
Initial: 4 x 5 = 20
Current: 4 x 3= 12
Target: 3 x 3 =9

**Level of Control** = 70%

**Date added to the risk register**
June 2016

**Rationale for current score:**
C - Inability to find records for patients could delay care/increase length of stay over 15 days. Could also mean patients receive incorrect treatment
L - we know this happens from incidents raised

**Rationale for target score:**

C - Inability to find records for patients could delay care/increase length of stay over 15 days. Could also mean patients receive incorrect treatment
L – RFID and digitalisation of the health record will reduce the constraints of the current filing methodology and reduce the volume of paper being added to the record. Further digitalisation of the paper record will reduce the reliance of clinicians on the paper record.

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

Temporary retention and destruction plans are in place.
Alternative storage arrangements are being identified and utilised where appropriate.
Ward protocols and audits have been rolled out across sites.
RFID project now approved. Implementation process has started and will change the way records are filed and release storage capacity.
Roll out plan for WCP is in place and being enacted as outlined in the SOP
All records must be documented and risk assessed in the Information Asset Register (IAR)
Develop a case for improved storage solution both for paper and digitally.

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Complete implementation of RFID within Health Records | Interim Chief Information Officer | October 2019 |
| Continue with the roll out of WCP | Interim Chief Information Officer | August 2019 |
| Continue with roll out of digitisation of health record with a focus on Outpatients and Nursing documentation | Interim Chief Information Officer | August 2019 |

| | | | |
|---|---|---|---|
| | Co-ordinate IAR assets | Head of Health Records & Clinical Coding | August 2019 |
| | Develop case for improved storage solution for acute paper record. | Head of Health Records & Clinical Coding | August 2019 |
| **Assurances**<br>**(How do we know if the things we are doing are having an impact?)**<br>• Preparation work for RFID has started to release space and increased destruction levels | **Gaps in assurance**<br>**(What additional assurances should we seek?)**<br>Investment required supporting the delivery and operational costs of the Digital strategy.<br>Reliance on NWIS for delivery of the solution for a fully electronic patient record<br>Impact of the Infected Blood Enquiry on the Health Boards ability to destroy notes. | | |
| **Current Risk Rating**<br>**4 x 3 = 12** | **Additional Comments**<br>All records must be documented and risk assessed in the Information Asset Register (IAR). This will mean that the risk can be quantified and understood. **Action - All SDU and corporate leads**<br>Health Records Department will work with HB colleagues to develop a case for improved storage solution both for paper and digitally.<br>In regard to the plans for the HB wide storage work, given the delay with the implementation of RFID, the timescales have been moved back slightly.<br>Timescales for this work is as followed (based on current allocation of resources / no additional support. A dedicated project resource would get this done quicker)<br>o Scoping and requirements gathering exercise by October 19<br>o Options developed – Q4 2019-20<br>o Business case - Q1 2020-21<br>o Implementation Q3/4 2020-21 | | |

| Datix ID Number: 1564<br>Health & Care Standard: Effective Care 3.1 Clinically Effective Care | HBR Ref Number: 44 |
|---|---|
| **Objective**: Digitally enabled care | **Director Lead:** Chris White, Chief Operating Officer<br>**Assuring Committee:** Audit Committee |
| **Risk: Current ED systems are not fit for purpose:**<br>• There is an increased risk of system (Accent) failure (NPT)<br>• Do not support effective and efficient working processes (Morriston) | **Date last reviewed:** June 2019 |

**Risk Rating**
(consequence x likelihood):
Initial: 5 x 4 =20
Current: 3 x 4 =12
Target: 3 x 2 = 6

**Level of Control**
= 60%

**Date added to the risk register**
May 2018

**Rationale for current score:**

- C – Reduced due to mitigating actions/controls taken to reduce impact of system failure in PoW. Inability to meet A&E targets and ambulances queuing at entrance could have adverse national publicity. Part of targeted intervention monitoring – loss of confidence in Health Board
- L - WEDS has been delayed and the current systems do not meet the requirements of users to aid the improvement of operational services. System in Pow and NPT is still unstable and unsupported

**Rationale for target score:**

- C – moving to a stable supported solution will reduce the impact of failure but the impact of the system not meeting all operational requirements will remain.
- L – of system failure will reduce once a stable supported solution is in place. The National system has been evaluated as meeting operational requirements as part of procurement process, however requirements will change over time.

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

- WPAS has been implemented in Morriston as an interim solution but does not provide all the additional functionality required.
- Archive solution developed for Accent to allow access to historic data in case of failure
- WEDs programme is still being progressed by NWIS
- Rollout of ED WPAS at NPT (June 2019)

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Implement alternative ED system across the Health Board. | Chief Operating Officer | March 2020 |

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

- Replacement of Accent will increase stability of system. Archive solution has been tested.

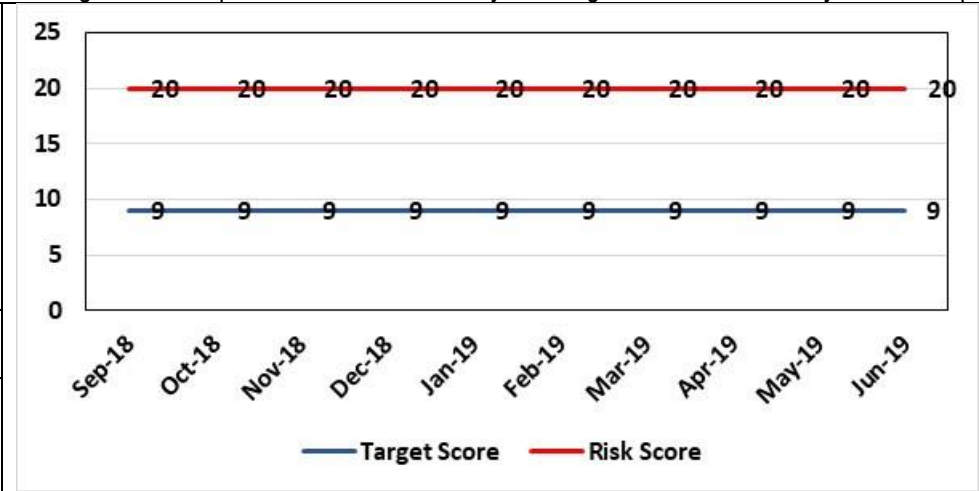
**Gaps in assurance**
**(What additional assurances should we seek?)**
National solution currently being tested so no assurances at this stage the solution will be suitable or on implementation timescales

**Current Risk Rating**
**4 x 3 = 12**

**Additional Comments**
Discussions are ongoing in regard to the National WEDS systems.

| Datix ID Number: 1565<br>Health & Care Standard: Effective Care 3.1 Clinically Effective Care | HBR Ref Number: 45 |
|---|---|
| **Objective**: Digitally enabled care | **Director Lead**: Richard Evans, Medical Director<br>**Assuring Committee**: Audit Committee |
| **Risk:** If patients are discharged from hospital without the necessary discharge information this may have an impact on their care | **Date last reviewed:** June 2019 |

**Risk Rating** (consequence x likelihood):
Initial: 5 x 4 = 20
Current: 5 x 4 = 20
Target: 3 x 3 = 9




**Level of Control** = 50%

**Date added to the risk register** May 2018

**Rationale for current score:**

- Despite the provision of an electronic discharge summary available across the Health Board to support the processing of discharge summaries within agreed targets, compliance with the targets, on average, remains low. GPs are therefore not always provided with the information required to provide continued care on discharge of the patient.

**Rationale for target score:**

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

- Executive directive issued to all SDUs to improve compliance.
- Medical Director in Morriston SDU leading "no discharge summary, no discharge" initiative with training support being provided by Informatics to improve performance.
- E-learning package now available to support training requirements.
- Performance Dashboard available to provide "live" view of EToC status

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| All SDUs to focus on improved performance - actions plans required from each SDU to demonstrate how compliance will be achieved | Medical Director | August 2019 |
| Implementation of WCP will include the MTED module which will allow extra project support to facilitate improved compliance | Medical Director | October 2019 |

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

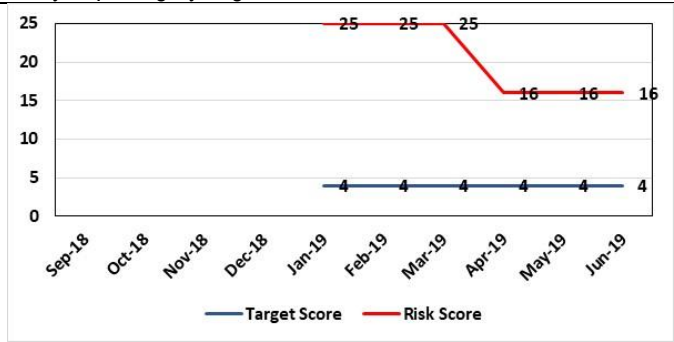
**Gaps in assurance**
**(What additional assurances should we seek?)**

**Current Risk Rating**
**5 x 4 = 20**

**Additional Comments**
The most recent HB "completed & sent" performance was 60% (August 2017) compared with 48% a year ago.• In

| | |
|---|---|
| | August 2017 the best performing hospital is NPTH (83%), this is reduced by the poor performance on wards not directly managed by NPT. Medical Wards regularly achieve 99%• August 2016 v August 2017 Delivery Unit comparisons demonstrate substantial improvement in Morriston, POW & Singleton• Morriston is coming to the end of a 6-month improvement programme which is bearing fruit, performance was 46% in March when it started.<br>MTeD went live on 10 wards (medicine) at Morriston Hospital on 20 May 2019. The delivery unit have also mandated that alongside MTeD, they are implementing a no discharge summary, no discharge policy with an escalation procedure for when patients are discharged without one.<br>Implementation across remaining wards is scheduled for later in the year when we are able to send surgical data with the discharge summary/operation note directly to GPs. |

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




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

- All patients are categorised by condition in order to quantify issue. Second glaucoma consultant appointed November 2018.
- Additional accommodation secured to increase capacity; implementation plan under development. Welsh government funding secured for 2019/20 to employ additional activity and deliver some services in a community setting. Virtual clinics established.
- Service Manager for Ophthalmology providing regular updates via Planned Care Programme

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Strawberry Place ODTC clinics planned to commence in April 2019 | Service Group Manager Surgical Specialties | 30/08/2019 |
| Further additional Glaucoma practitioner and Visual Field Technician posts are to be advertised and recruited to in increase Glaucoma capacity further as part of an OPDTC Outreach Community Clinic in Strawberry Place GP Surgery | Service Group Manager Surgical Specialties | 30/08/2019 |
| Vacant Orthoptist post within AMD filled, start date TBC. | Service Group Manager Surgical Specialties | 30/08/2019 |
| Several posts out for recruitment | Service Group Manager Surgical Specialties | 05/07/2019 |
| An overall Sustainability Plan is to be presented to the Executive Team April 2019 | Service Group Manager Surgical Specialties | 30/08/2019 |

| Assurances<br>(How do we know if the things we are doing are having an impact?) | Gaps in assurance<br>(What additional assurances should we seek?) |
|---|---|
| • A Welsh Government pilot programme was implemented in June 2014. The purpose of the HES project is to use clinic capacity to assess, review and treat patients within clinical priority rather than prioritising new patients based on their waiting time. A Project Management Lead was in post to deliver on the HES objectives. | Extended waiting times for patients requiring routine clinical intervention, but these are still listed as per RTT guidance. |
| **Current Risk Rating**<br>**4 x 4 = 16** | **Additional Comments**<br>Additional Glaucoma practitioner (temporary for 12 months) commenced in post 11/06/2018.<br>2nd Glaucoma Consultant started 05/11/2018.<br>Accommodation in Corridor 3 reconfigured 08/02/2019. Further work needed on accommodation and additional rooms required. Ongoing discussions continue with Singleton Unit so that space can be created to house a co-located Ophthalmology Department Middle grade doctor to commence in post April 2019.<br>Monthly tracker of glaucoma backlog patients indicates reduction of over 800 patients to end of January 2019.<br>Diabetic Retinopathy Virtual Review clinics are to be increased via a WG funded successful bid. |

| Datix ID Number: 737<br>Health & Care Standard: Staying Healthy 1.1 Health Promotion | HBR Ref Number: 15 |
|---|---|
| **Objective**: Partnerships for Improving Health and Wellbeing | **Director Lead:** Sandra Husbands, Director of Public Health<br>**Assuring Committee:** Quality and Safety Committee |
| **Risk:** If we fail to achieve population health improvement targets leading to an increase in preventable disease amongst the population resulting in increased morbidity impacting on operational and financial pressures. | **Date last reviewed:** June 2019 |

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

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

**Level of Control** = 60%

**Rationale for target score:**

**Date added to the risk register** 26.01.16

Manage preventable disease

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

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

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Deliver immunisation awareness training for pre-school settings to promote key vaccination messages | Consultant Public Health Medicine | September 2019 |
| Contribute to the implementation of recommendations made in the "MMR Immunisation: process mapping of the child's journey" report. | Consultant Public Health Medicine | September 2019 |
| Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins | Consultant Public Health Medicine | September 2019 |

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

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

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

**Current Risk Rating**
**5 x 5 = 15**

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

| Datix ID Number: 1763<br>Health & Care Standard: Staff & Resources 7.1 Workforce | HBR Ref Number: 52 |
|---|---|
| **Objective**: Partnerships for Care – Effective Governance | **Director Lead:** Director of Strategy<br>**Assuring Committee:** P&F Committee |
| **Risk:** The Health Board does not have sufficient resource in place to undertake engagement & impact assessment in line with Stat Duties | **Date last reviewed:** June 2019 |

**Risk Rating**
(consequence x likelihood):
Initial: 4 x 4 = 16
Current: 4 x 3 = 12
Target: 4 x 2 = 8

**Rationale for current score:**

- Engagement – a temporary post has been released for a Head of Engagement & an appointment made.
- Postholder started on 7.1.19 but there is no agreement yet for permanent resourcing.
- Impact Assessment – there is no dedicated resource and policies / processes are out of date. A paper has been drafted that recommends processes based on best practice for Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) and preparation for Health Impact Assessment (HIA), as well as preferred option for appointing a full time temporary Impact Assessment Manager.
- The paper was received by the Executive Team in January 2019 and the recruitment paperwork is being prepared.

**Level of Control**
= 50%

**Date added to the risk register**
November 2018

**Rationale for target score:**

- Both of these areas need to have adequate resourcing and robust processes / policies in place for the organisation to make robust plans, engage public confidence and meet our statutory and public duties.

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

- Engagement – a temporary post has been created for a Head of Engagement for 6 months & an appointment made from 7.1.19. The impact of this post will be evaluated in April and a substantive proposal developed to ensure this activity can be delivered in a robust manner going forward on a sustainable basis. Robust processes are, however, in place as agreed with the CHC and based on best practice guidance but there is a lack of capacity to deliver these, leading to significant additional pressures on the lead in Strategy.
- Impact Assessment – a proposal to appoint a temporary Integrated Impact Assessment Manager was received by the Executive Team in January 2019 and the recruitment paperwork is being prepared.

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| Agreement of dedicated resource to support Engagement activity | DoS / DoHR | August 2019 |
| Recruit to agreed temporary Integrated IA Manager | DoTransformation / DoS (TBC) | August 2019 |

**Assurances (How do we know if the things we are doing are having an impact?)**
Temporary additional resource for engagement. Evaluation underway of this resource and its effectiveness - will lead to a proposed way forward for Director of Strategy to consider in April 2019.

**Gaps in assurance**
**(What additional assurances should we seek?)**
Permanent additional resources not yet available

**Current Risk Rating**

**Additional Comments**

| | |
|---|---|
| **4 x 3 = 12** | Agreement for permanent resource at a lower grade for a dedicated engagement post. |

| Datix ID Number: 1762<br>Health & Care Standard: Staff & Resources 7.1 Workforce | HBR Ref Number: 53 |
|---|---|
| **Objective**: Partnerships for Care | **Director Lead**: Pam Wenger, Director of Corporate Governance<br>**Assuring Committee:** Health Board (Welsh Language Group) |
| **Risk:** Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board. | **Date last reviewed:** June 2019 |

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

**Level of Control**
= 60%

**Date added to the risk register**
November 2018

**Rationale for current score:**
As a consequence of an internal assessment of the Standards and their impact on the UHB, it is recognised that the Health Board will not be fully compliant with all applicable Standards.

**Rationale for target score:**
Working through its related improvement plan the likelihood of noncompliance will reduce as awareness and staff training in response to the Standards, is raised.

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

- The Welsh Language Officer has undertaken a self-assessment of the requirements of the new Welsh Language Standards and how they apply to Swansea Bay University Health Board. A Welsh Language Standards Implementation plan has been devised to focus on strengthening and developing compliance in key areas.
- Close constructive working relationships are in place with the Welsh Language Commissioner's Office
- Strong networks are in place with the NHS Wales Welsh Language Officers network to share good practice, inform learning and to develop Business intelligence.
- A Welsh Language Delivery group has been set to integrate Welsh language into the business and share responsibility for compliance and learning – first meeting 14 May 2019.
- Proactive communication and marketing activity is being undertaken across the Health Board to raise awareness of Welsh language compliance, customer service standards and training opportunities.

Working with NHS Wales Shared Services (NWSSP) to achieve compliance for workforce and recruitment standards.

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| To Welsh Language Delivery Group will review the terms of reference for the Group 14 May 2019 and ensure the group comprises of appropriate representation from across all sectors of the organisation. | Director of Corporate Governance | August 2019 |
| Ensure the Board is fully sighted on the UHB's position through regular reporting to the Health Board. Report issued in March 2019 further reports to be issued quarterly. | Director of Corporate Governance | December 2019 |

**Assurances (How do we know if the things we are doing are having an impact?)**
Compliance with Statutory requirements outlined in Welsh Language Act and related Standards.

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

**Current Risk Rating**
**5 x 3 = 15**

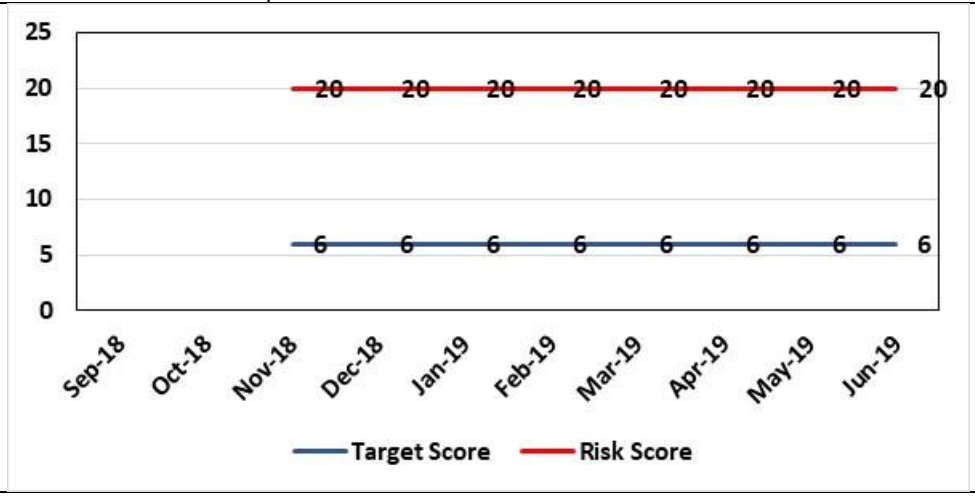
**Additional Comments**
The self-assessment has confirmed that the Health Board is not able to fully comply with all the Standards by May 2019 and that the Health Board will need to take a risk management approach to the delivery of the standards.

| Datix ID Number: 1724<br>Health & Care Standard: Safe Care 2.1 Managing Risk & Health & Safety | HBR Ref Number: 54 |
|---|---|
| **Objective**: Partnerships for Care | **Director Lead:** Sian Harrop Griffiths, Director of Strategy<br>**Assuring Committee:** Health Board |
| **Risk:** Failure to maintain services as a result of the potential no deal Brexit | **Date last reviewed:** June 2019 |

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

**Level of Control**
= 70%

**Date added to the risk register**
November 2018




**Rationale for current score:**
The initial risk assessment is based on the fact that significant work needs to take place to understand the risks in terms of the Health Board's ability to maintain services as business as usual

**Rationale for target score:**
By undertaking the actions highlighted it is anticipated that the arrangements put in place will ensure business as usual in light of a no deal Brexit.

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

- All services to identify high risks related to Brexit on risk register Engagement in health national groups
- Welsh Government is working with NWSSP procurement to commission a review of devices and consumables supply chain in Wales to complement the work already completed at UK level.
- Welsh Government has put in place national communication and co-ordination arrangements, including:
  - A Brexit Ministerial Stakeholder Advisory Forum made up of senior leaders from across the sector, and led by the Cabinet Secretary for Health and Social Services and the Minister for Children, Older People and Social Care;
  - An EU Transition Leadership Group, chaired by WG focusing on ensuring operational readiness arrangements for both health and social services in Wales (terms of reference attached);
  - Regular meetings of NHS emergency planners, chaired by Welsh Government, as part of established resilience arrangements;
  - A 4 Nations public health group addressing public health associated risks and health security concerns, and a joint Welsh Government – Public Health Wales working group considering specific Welsh issues;
  - Working in partnership with the Welsh NHS Confederation to ensure ongoing flexible and effective communication and engagement between us and other stakeholders in the health and care system; and Regular updates on Brexit to the monthly NHS Wales Executive Board meetings.
  - Assessing command and control requirements
  - Work programme monitored via EPRR Strategy Group

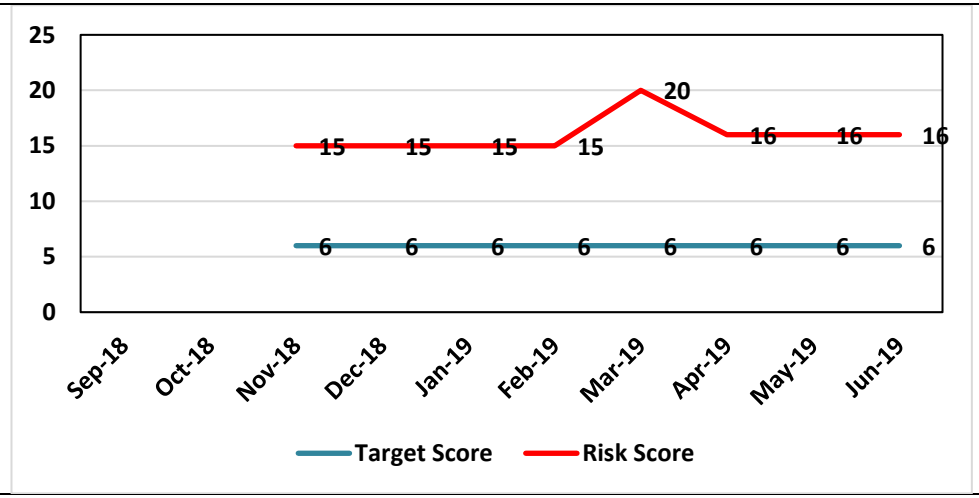
**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| To review and rehearse promptly the existing business continuity and resilience/contingency arrangements, and to do so working with your local and regional partners, including through your local resilience forums. | Director of Strategy | August 2019 |
| To carry out risk assessments | Director of Strategy | August 2019 |

| | | | |
|---|---|---|---|
| ○ All services to complete business continuity plans<br>○ all services to identify high risks related to Brexit on risk register<br>○ Engagement in health national groups | | | |
| **Assurances (How do we know if the things we are doing are having an impact?)**<br>• Work programme in place and monitored via EPRR Strategy Group<br>• All services to complete business continuity plans | **Gaps in assurance (What additional assurances should we seek?)**<br>To understand from the review what arrangements need to be in place to minimise the risks in relation to a potential no deal Brexit. | | |
| **Current Risk Rating**<br>**4 x 5 = 20** | **Additional Comments**<br>There is an obligation to maintain critical services and business as usual in an emergency and this includes Brexit and consequently there is the potential for disruption in commercial and public services and therefore supplies, services, transport, fuel, border issues, EU national issues, immigration, critical infrastructure, energy and command resilience etc. | | |

| Datix ID Number: 1764<br>Health & Care Standard: Safe Care 2.1 Managing Risk & Health & Safety | HBR Ref Number: 55 |
|---|---|
| **Objective**: Partnerships for Care | **Director Lead:** Director of Transformation<br>**Assuring Committee:** Health Board |
| **Risk:** Failure to manage the residual risks arising from the Welsh Governments decision to realign the Health Boundary, as it applies to the resident population of the Bridgend County Borough. | **Date last reviewed:** June 2019 |

**Risk Rating** (consequence x likelihood):
Initial: 5 x 3 = 15
Current: 4 x 4 = 16
Target: 3 x 3 = 9




**Rationale for current score:**

- The risk score has reduced from red 20 to red 16 which reflects that the Bridgend Boundary change took effect 1 April 2019 and that there are ongoing arrangements being put in place to manage the residual risks arising from the transfer.
- The score has reduced to red 16, however it is important to recognise that financial discussions are ongoing with Welsh Government.

**Level of Control** = 70%

**Date added to the risk register** November 2018

**Rationale for target score:**

- The Bridgend Boundary change took effect 1 April 2019 and there are ongoing arrangements being put in place to manage Service Level Agreement's (SLA's) and Long Term Agreements (LTA's) for service delivery.

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

- Responsibility for the provision of health and care services for the Bridgend County Borough Council (BCBC) area transferred to Cwm Taf Morgannwg UHB on the 1 April 2019, this included the transfer of assets, services and resources.
- A Joint Handover statement was approved by the Joint Transition Board on the 23 April 2019 and captures the business of the University Health Boards (UHBs), identifying key achievements, developments and investments, as well as highlighting any outstanding areas of work, risks and considerations which will need to be taken into account by Cwm Taf Morgannwg UHB and Swansea Bay UHB going forward.
- A Memorandum of Understanding (MOU) has been devised which outlines joint agreements and stipulates what Service Level Agreements (SLAs) and Long Term Agreements (LTAs) are in place for cross border working.
- A Quality and Patient Safety legacy document has been devised outlining the outstanding risks and the residual work required post April 2019. (can be accessed from the Joint Handover statement)
- The cost pressures of the transfer are being discussed with Welsh Government

**Mitigating actions (What more should we do?)**

| Action | Lead | Deadline |
|---|---|---|
| **Phase 2 – Service Transformation Plan**<br>**Clinical Services -** Meetings being held to discuss joint arrangements for the provision of services at POW, including an anaesthetic and surgery and Older peoples services<br>**ICT**<br>• ICT SLA and long term plan to Welsh Government<br>• A high level option appraisal to be developed and agreed in principle to take forward for discussion with Welsh Government. | Director of Transformation | September 2019 |

| | | | |
|---|---|---|---|
| | **Finance**<br>• Further discussion to take place with Welsh Government around to cost neutrality and financial stability.<br>• **Health & Safety** – action plan in place to Fire enforcement notice concerning POW site, NWSSP fire assessment report – all issues were due to be completed by March 2019.<br><br>**Commissioning –** discussion ongoing concerning Memorandum of Understanding and SLA/LTA's. | | |
| **Assurances (How do we know if the things we are doing are having an impact?)**<br>• Performance is reviewed at monthly meetings with Cwm Taf Morgnnwg UHB and progress is monitored by the Director of Transformation. | **Gaps in assurance**<br>**(What additional assurances should we seek?)** | | |
| **Current Risk Rating**<br>**4 x 4 = 20** | **Additional Comments**<br>The last Joint Transition Programme group meeting was held in April 2019, all supporting work streams will disband thereafter. The ongoing work to manage the residual issues will need to be included on top of routine duties and responsibilities | | |

| Datix ID Number: 1974<br>Health & Care Standard: Staff Resources | HBR Ref Number: 59 |
|---|---|
| **Objective**: Excellent staff | **Director Lead:** Director of Finance<br>**Assuring Committee:** Workforce & OD |
| **Risk:** Loss of experienced staff within Finance | **Date last reviewed:** June 2019 |

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

**Rationale for current score:**
The Finance department has been under considerable pressure due to the work required to support the Health Board's Targeted Intervention status and the Bridgend boundary change. A number of members of staff had or were in the process of leaving to take up opportunities elsewhere in NHS Wales. This is due to an unprecedented number of opportunities in Finance throughout NHS Wales and a neighbouring Health Board's recruitment drive. Combined with this the Finance Function had to release a number of vacancies to Cwm Taf HB as part of the boundary change arrangements and when these were advertised, it is possible that more staff could leave SBU for those opportunities while it underwent the organisational change process to restructure for the new organisation. These factors could result in the Finance Function being unable to deliver in 2019/20.

**Level of Control**
= 70%

**Date added to the risk register**
November 2018

**Rationale for target score:**
Target score reflects requirement to resource the workforce and OD function to be able to meet the operational and Strategic priorities of the Health Board. Failure to do this will negatively impact of financial, service, performance and quality outcomes.

| Controls (What are we currently doing about the risk?) | Mitigating actions (What more should we do?) | | |
|---|---|---|---|
| The Health Board has a number of control measures including making adjustments within the function to ensure we are in a strong position to deliver, taking this opportunity to reconstruct the Finance Function rather than recruit on a "like for like" basis and actively recruiting to any vacancies we have. | **Action** | **Lead** | **Deadline** |
| | | | |

| Assurances (How do we know if the things we are doing are having an impact?) | Gaps in assurance<br>(What additional assurances should we seek?) |
|---|---|
| • | |
| **Current Risk Rating**<br>**3 x 5 =15** | **Additional Comments** |

**Risk Score Calculation**

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

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