Meeting Date	**28 July 2022**	**Agenda Item**	**2.3**
Report Title	**Risk Management Report**		
Report Author	Neil Thomas, Assistant Head of Risk & Assurance		
Report Sponsor	Hazel Lloyd, Interim Director of Corporate Governance Gareth Howells, Executive Director of Nursing		
Presented by	Hazel Lloyd, Interim Director of Corporate Governance Gareth Howells, Executive Director of Nursing		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to present the Health Board Risk Register (HBRR) to the Board for review and assurance.		
Key Issues	• The Health Board Risk Register for May 2022 was received and endorsed by the Management Board in June 2022. • During April, an additional meeting of the Risk Scrutiny Panel attended by the Executive Medical Director reviewed risks scored 20 and above. Advisory notes were shared with Executive leads following the meeting for consideration during the update process in April 2022. • The May HBRR 2022 currently contains 40 risks, of which 20 have risk scores at, or above, the Health Board's current appetite of 20. Three of these have risk scores of 25 – the report indicates some of the actions being taken to address them. • The delivery of risk management training workshops for managers in service groups is continuing. They have completed in two service groups (NPTS and PCT); commenced in the remaining two (MH&LD and Morriston). • At the final meeting of the Covid-19 Gold Command arrangements for the ongoing oversight of the remaining risks on the Covid-19 Gold risk log were agreed. Proposals for the ownership and management of risk information in the Datix risk register have been agreed. • A revised approach to the expression of the Board's risk appetite has been developed for members' consideration. • There is a national programme to migrate concerns management from the legacy DatixWeb system to a new Once4Wales system – Datix Cymru. Modules for managing incidents, complaints, patient experience feedback and claims are now live. However, there is a need to close down records remaining open within the legacy system by the end of August 2022 (when the legacy system becomes read-only) or transfer them into the new system. A risk-based approach to this task was agreed at Management Board in June. Details have been received by the Quality & Safety Committee for review & assurance.		

Specific Action Required *(please choose one only)*	Information	Discussion	Assurance	Approval
	☐	☐	☐	☒
Recommendations	Members are asked to: • **NOTE** the updated Health Board Risk Register and changes to the risks outlined in this report; • **CONSIDER** whether further assurance is required in respect of risk register entries or the action taken to address risks identified – particularly risks with 25 and 20 ratings; • **NOTE** the development of a draft risk appetite and **AGREE** to receive the document at the next Board meeting for endorsement.			

HEALTH BOARD RISK REPORT

1. INTRODUCTION

The purpose of this report is to present the Health Board Risk Register (HBRR) to the Health Board for review and assurance.

2. BACKGROUND

2.1 Risk Management Framework

The Audit Committee is responsible for reviewing the establishment and maintenance of an effective system of risk management and providing assurance to the Board in that respect. While this is the case, individual risks have been assigned to other Board committees for more detailed scrutiny and assurance. The intention is that committee work programmes are aligned so that progress made to address key risks is reviewed in depth. Regular HBRR update reports are submitted to the Board and the committees of the Board to support this.

Executive Directors are responsible for managing risk within their area of responsibility. The Management Board, chaired by the Chief Executive, oversees the overall operation of the risk management framework and the management of risks within the health board risk register.

Risk Register management is supported by a Risk Management Group (RMG) which meets quarterly and is responsible for overseeing the operational management of risk, ensuring local systems and processes are in place and are operating effectively to ensure appropriate reporting and escalation. The Group last met in June 2022.

Additionally, a Risk Scrutiny Panel is responsible for ensuring there is an appropriate and robust risk management system in place and working throughout the organisation. It is responsible for moderating new risks and risks escalated to the Health Board Risk Register (HBRR) and Board Assurance Framework (BAF) and recommending and advising the Management Board on the escalation and de-escalation of risks. The Panel last met in May 2022.

2.2 Risk Appetite

Risk appetite and tolerance provide clarification on the level of risk the Board is prepared to accept.

Following the onset of the Covid-19 pandemic, members of the Board agreed that the risk appetite threshold would be raised. This was agreed for an initial period of 3 months, but has remained raised throughout the pandemic to date, though additional narrative explanation has been provided to supplement the numeric threshold. The current risk appetite, as endorsed by the Board in March 2022 indicates that risks assessed at a threshold score of 20 or above should be addressed as a priority, and there is a low tolerance to risks with a high impact on the quality and safety of staff and patient care.

These arrangements are reviewed regularly by the Executive Team, Audit Committee and the Board.

2.3 Health Board Risk Register (HBRR)

The Health Board Risk Register (HBRR) is intended to summarise the greatest organisational risks facing the Health Board and the actions being taken to mitigate them. A copy of the most up to date HBRR is attached at **Appendix 1**.

Each Health Board risk has a lead Executive Director who is responsible for ensuring there are mechanisms in place for identifying, managing and alerting the Board to significant risks within their areas of responsibility through regular, timely and accurate reports to the Management Board/Executive Team, relevant Board Committees and the Board.

2.4 Covid-19 Risk Register

In recognition that Covid-19 is an issue which the Health Board is managing, a separate risk register was established to capture the key risks associated with managing the response to the pandemic. The final meeting of the Covid-19 Gold Command took place in April 2022. At that meeting, arrangements for the ongoing oversight of the remaining risks on the Covid-19 Gold risk log were agreed. Within the Datix risk register each risk has been assigned an executive lead, a senior manager accountable to the executive lead for the management of the risk, and a risk owner responsible for the management of the risk and update of risk information within the risk register.

3. MANAGEMENT OF HEALTH BOARD RISK REGISTER (HBRR)

3.1 Action to Update the HBRR

Since the last meeting, the Risk Scrutiny Panel (RSP) met in March and early May (deferred April meeting) to consider risks escalated by service groups and corporate directorates. Risks were received from:

- Morriston Service Group
- Neath Port Talbot & Singleton Service Group (Maternity)
- Primary Community & Therapies Service Group

In addition to the above, following discussion at Management Board, at a Risk Scrutiny Panel meeting in April the Executive Medical Director reviewed Health Board Risk Register risks scored 20 and above. Advisory notes were shared with Executive leads following the meeting for consideration during the update process in April. Notes were circulated again in May so that changes not actioned during the April cycle due to annual leave could be considered. This was the first Panel to review and feed back to risk owners on Health Board register entries relating to high scoring risks. Amendments have been made to a number of risk entries – the process will be repeated to drive further improvements over coming meetings.

This report indicates the changes made during the above period. The most recent changes made in the May cycle of revisions are highlighted within the register itself in red.

3.2 Risk Register Summary

The Health Board Risk Register presents:

- A summary 'heat map' of risks;
- A dashboard of risks impacting upon particular Health Board objectives, together with trend arrows indicating changes in risk score following the last edition of the HBRR, and an indication of those committees allocated to oversee individual risks in depth;
- Individual risk register scorecards.

Table 1 below stratifies the risks recorded within the HBRR as it has been received at the most recent meetings (inclusive of this meeting):

Table 1: Summary of Risk Assessment Scores

Risk Analysis	Number of Risks					
	Jun 2021	Sep 2021	Jan 2022	Feb 2022	Apr 2022	May 2022
High Risk (>= appetite): Risk Score of 20-25 (Red)	20	21	25	24	21	20
High Risk (< appetite): Risk Score of 16-19 (Red)	9	8	7	8	8	10
Moderate Risk: Risk Score 9-15 (Amber)	8	9	8	7	10	8
Manageable Risk: Risk Score of 5-8 (Yellow)	1	1	1	0	0	2
Acceptable Risk: Risk Score of 1-4 (Green)	0	0	0	0	0	0
Total	**38**	**39**	**41**	**39**	**39**	**40**

Three risks are assessed to have scores of 25 currently.

Further detail on the above risks can be found within the Risk Register at **Appendix 1.** The following movements are noted in March – May:

- Two new risks were added to the register:
  - *HBR 84 Cardiac Surgery*
  - *HBR 85 ALNET (Additional Learning Needs & Education Tribunal) Act*
- One risk has increased in score:
  - HBR 27 *Digital Transformation*

  Another increased during the period but has since been reduced:
  - HBR 60 *Cyber Security*
- Six risk scores have been reduced:
  - HBR 43 *Deprivation of Liberty Safeguards*
  - HBR 63 *Screening for Fetal Growth Assessment (Gap-Grow)*
  - HBR 75 *Whole Service Closure*
  - HBR 76 *Partnership Working*
  - HBR *77 Workforce Resilience*
  - HBR *82 Closure of Burns Service*

- One risk has been closed in the register:
    - HBR 70 *Data Centre Outages*

Section 3.3 below expands on these and other changes.

3.3 New Risks, Increasing & Decreasing Risks

The new risk(s) added to the HBRR is/are:

Table 2: New Risks

Risk Ref	Risk	Lead Exec Director	Current Risk Score
84	**Cardiac Surgery** A Getting It Right First Time review identified concerns in respect of cardiac surgery (including patient pathway/process issues) that present risks to ensuring optimal outcomes for all patients. Potential consequences include the outlier status of the health board in respect of quality metrics, including mortality following mitral valve surgery and aortovascular surgery. This has resulted in escalation of the service by WHSSC. *(This risk has been added to the HBRR, recognising the escalated status of the service at WHSSC.)*	Executive Medical Director	16
85	**Non-Compliance with ALNET Act** There are risks to the Health Board's ability to meet its statutory duties and establish the effective collaborative arrangements required by the ALN Act, which is being implemented through a phased approach. This risk is caused by: • Lack of staff resource needed to carry out the additional work needed to comply with the ALN Act for operational services, especially those in the PCST Service Group, though the size of the gap in terms of staff resource is currently unclear. • Gaps in the structure and processes needed to meet the requirements of the ALN Act leading to slippage against a previous ALN work plan. There is a need to identify and progress the work needed for 2022/23, and without adequate planning capacity, existing staff will not be able to make the progress what is needed. • Issues around multi-agency working which may impact on levels of demand on operational services, and on existing SLAs through which the Health Board delivers some services to partner LAs. • Aspects of the requirements on Health Board's which are currently ambiguous and uncertainty regarding the implementation timetable. *(Potential consequences are detailed in HBRR)*	Director of Therapies & Health Sciences	20

The risk(s) with increased scores is/are:

Table 3: Risks with Increased Scores

Risk Ref	Risk	Lead Exec Director	Previous Risk Score	Current Risk Score
27	**Digital Transformation** Inability to deliver sustainable clinical services due to lack of Digital Transformation. There are insufficient resources to: • invest in the delivery of the ABMU Digital strategy, • support the growth in utilisation of existing and new digital solutions • replace existing technology infrastructure and the end of its useful life. Risk increased as reduction in capital funding in 22/23 has increased the likelihood of the health board not being able to replace aging infrastructure such as the Storage Area Network (SAN). Acceleration of the Cwm Taf Morgannwg UHB SLA disaggregation has been proposed and there are further pressures on revenue funding.	Director of Digital	12	16

The risk(s) with reduced scores is/are:

Table 4: Risks with Reduced Scores

Risk Ref	Risk	Lead Exec Director	Previous Risk Score	Current Risk Score
43	**Deprivation of Liberty Safeguards** Due to a lack of Best Interest Assessor resource, there is a risk of failure to complete and authorise the assessments associated with Deprivation of Liberty/Liberty Protection Safeguards within the legally required timescales, exposing the health board to potential legal challenge and reputational damage.	Executive Director of Nursing	16	12
63	**Screening for Fetal Growth Assessment in line with Gap-Grow** There is not enough Ultrasound capacity within Swansea Bay UHB to offer all women serial ultrasound	Executive Director of Nursing	20	16

Risk Ref	Risk	Lead Exec Director	Previous Risk Score	Current Risk Score
	scan screening in the third trimester in line with the UK perinatal Institute Growth Assessment Programme (GAP). Welsh Government mandate fetal growth screening in line with the GAP programme. There is significant evidence of the increased risk for stillbirth or neonatal mortality/morbidity (hypoxic ischaemic encephalopathy (HIE)), where a fetus is growth restricted (IUGR) and/or small for gestational age fetus (SGA). Identification and appropriate management for IUGR/SGA in pregnancy will lead to improved outcomes for babies.			
75	**Whole Service Closure** Risk that services or facilities may not be able to function if there is a major incident or a rising tide that renders current service models unable to operate.	Chief Operating Officer	15	10
76	**Partnership Working** There are some remaining tensions between the Health Board and some trade union partners within SBUHB particularly in response to the supply of PPE which has the potential to create unrest in the workforce and hamper an effective response to COVID-19.	Director of Workforce & OD	15	10
77	**Workforce Resilience** Culmination of the pressure and impact on staff wellbeing - both physical and mental relating to Covid Pandemic. Local prevalence of Covid infections increasing positive testing and the debilitating effect of the second wave impacting staff. Impact direct in terms of Covid / related sickness (symptomatic Absence) and self-isolation (Asymptomatic). Increased staff absence impact on the pressures for those still in work.	Director of Workforce & OD	20	12

Risk Ref	Risk	Lead Exec Director	Previous Risk Score	Current Risk Score
82	**Risk of closure of Burns service if Burns Anaesthetic Consultant cover not sustained** There is a risk that adequate Burns Consultant Anaesthetist cover will not be sustained, potentially resulting in closure to this regional service, harm to those patients would require access to it when closed and the associated reputational damage. This is caused by: • Significant reduction in Burns anaesthetic consultant numbers due to retirement and long-term sickness • Inability to recruit to substantive burns anaesthetic posts • The reliance on temporary cover by General intensive care consultants to cover while building work is completed in order to co-locate the burns service on General ITU • Reliance on capital funding from Welsh Government to support the co-location of the service.	Executive Medical Director	20	16

The risk(s) closed within the HBRR is/are:

Table 5: Closed Risks

Risk Ref	Risk	Lead Exec Director	Commentary
70	**Data Centre Outages** There is a risk of national data centre outages which disrupt health board services. The failure of national systems causes severe disruption across NHS Wales, affecting Primary and secondary care services. The delivery of national services are the responsibility of Digital Health & Care Services Wales (DHCW).	Director of Digital	The likelihood associated with this risk has been re-assessed as lower on basis of higher levels of availability with WLIMS following the hardware and software upgrades and the migration of services from Blaenavon to CloudCentres Data Centre. Consequently, the risk score was adjusted to 12 in the March HBRR and the Director of Digital subsequently approved its de-escalation from the HBRR for ongoing local management on the service risk register.

Further detail on open risks above is provided in the Health Board Risk Register.

3.4 Action on the Highest Risks (Score=25)

There are three risks with a score of 25 currently. The below table provides information on action being taken to address these risks:

Table 5: Action on Risks with Score=25

Risk Ref	Risk & Mitigating Actions	Lead Executive Director
1	**Access to Unscheduled Care** ***If we fail to provide timely access to Unscheduled Care then this will have an impact on quality & safety of patient care as well as patient and family experience and achievement of targets. There are challenges with capacity/staffing across the Health and Social care sectors.*** Actions completed and/or new controls introduced include: • Joint WAST Stack review by GP and APP (Advanced Paramedic Practitioner). • OPAS (Older People's Assessment Service) have undertaken training with nursing homes (on management of patient falls) & set up direct contact details with nursing homes. • The frailty short-stay unit has been re-established. • The third phase of procurement to commission additional care home beds is complete. Targets for actions have been refreshed where required and the following actions have been added or amended: • Review roles & service models in order to increase SDEC working hours and throughput of patients. sustainably. [Target 30/09/2022] • OPAS developing a proposal to assess elderly patients at home. [Target 30/07/2022] • Introduce Band 6 navigator role in ED for better streaming of patients. [Target 30/07/2022] In addition to detail currently recorded in the Risk Register, at the District Nursing summit held in June 2022 the following areas of ongoing work were considered: • Flow into and out of the Virtual Wards – understanding pathway confusion • Digital enhancements • Developing and supporting specialist pathways • Develop a robust single point of access • Increasing "same day" discharge, turn around and alternatives to admission A plan to progress work, including resources required, is being developed by the Primary Community & Therapies Service Group. This work will be considered for reflection in subsequent iterations of the risk register. Additionally, the Chief Operating Officer & Executive Medical Director have engaged with WG in the social care	Chief Operating Officer

Risk Ref	Risk & Mitigating Actions	Lead Executive Director
	taskforce to look for alternative ways to provide out of hospital care, towards addressing risk #80 in relation to the Discharge of Clinically Optimised Patients. This may have a further impact on this Unscheduled Care risk also, though the level of impact and timescale are to be determined. A further key development to note with most potential to address this risk is the Acute Medical Services Redesign, which is aimed at unblocking bottlenecks and streamlining the delivery of care. The business case has been approved and the initiative is now entering formal consultation under the Organisational Change Policy.	
50	**Access to Cancer Services** ***A backlog of patients now presenting with suspected cancer has accumulated during the pandemic, creating an increase in referrals into the health board which is greater than the current capacity for prompt diagnosis and treatment. Because of this there is a risk of delay in diagnosing patients with cancer, and consequent delay in commencement of treatment, which could lead to poor patient outcomes and failure to achieve targets.*** The following actions have been completed since last meeting: • Process for clinical harm review implemented • Cancer Programme Board established in order to oversee and monitor delivery progress of the Health Board Cancer Recovery & Sustainability Plan. Additional notes: Overall there has been marked reduction in the 62+ day backlog, but in certain specialties long waits remain. The top 6 tumour sites of concern in this respect have improvement plans in place. Ongoing & new actions include: • The NPTS Service Group is implementing a phased and sustainable solution for the required uplift in endoscopy capacity that will be key to supporting both the Urgent Suspected Cancer backlog and future cancer diagnostic demand on Endoscopy Services. [Target: 01/09/2022] • The Deputy Chief Operating Officer is overseeing the working through of Demand & capacity plans for the top 6 tumour sites. [Target: 30/06/2022]	Chief Operating Officer
64	**Health & Safety Infrastructure** ***Insufficient resource and capacity of the Health, safety and fire function within SBUHB to maintain legislative and regulatory compliance for the workforce and for the sites across SBUHB.*** Summary progress notes on addressing this risk: Two fire advisors were successfully appointed in December 2021 and commenced in February 2022. The additional fire	Director of Finance & Performance

Risk Ref	Risk & Mitigating Actions	Lead Executive Director
	resource has enabled the development of a rolling 12 month FRA programme to maintain 100% compliance of completion and during Q1 regular fire safety tours will be introduced, providing presence and support at each of the service groups. Audits will be developed to review actions identified in the FRA and maintain fire compliance. The team will also be reviewing fire evacuation plans and drawings. Additionally, it has been agreed by the health board to recruit one H&S Advisor and one Manual Handling Trainer/Advisor. The post will be advertised in Q1 2022/23, with the end of Q1 or beginning of Q2 for successful candidates to commence. Given that the posts will take time to have any impact on training and audit, it is possible that the risk score can be reduced slightly in 6 months' time after successful recruitment with a targeted reduction in Q4.	

Further detail on the above risks can be found at **Appendix 1**, in addition to actions to address other risks above the Health Board's risk appetite. The Health Board has produced a **Simple Guide to Risk Assessment & Management** to support staff scoring risks. This is available on the Health Board's intranet site, and sets out the criteria to support the scoring of the different types of risks.

3.5 Covid-19 Risk Register Closure

The final meeting of the Covid-19 Gold Command took place in April 2022. At that meeting, arrangements for transfer and ongoing oversight of the remaining risks on the Covid-19 Gold risk log were agreed:

Table 6: Transfer of risks in the Covid-19 Gold Command risk register

Gold Ref	Risk Title & Description	Risk Score	Executive Owner (in Gold log)	Oversight to Transfer to:
COV 004	**Covid related sick absence** Number of staff who are absent from work through self-isolation or family illness will impact on ability to deliver safe care for patients; and will impact on ability to keep capacity open and to staff surge and super surge capacity. Note: This risk only captures the total of staff absence as reported weekly to Welsh Government. Risk score reflects the position in comparison with wave one position which peaked at 1700 staff absent.	15	Director of Workforce	Workforce & OD Committee Monitored via Workforce Directorate and reported to W&OD Committee as appropriate.
COV 005	**Care Homes** Potential failure in local care home sector to manage staff absences could result in emergency closure of care home which will place undue pressure and therefore on	16	Director of Nursing	Transformation Board The Chief Operating Officer will oversee this following transfer.

Gold Ref	Risk Title & Description	Risk Score	Executive Owner (in Gold log)	Oversight to Transfer to:
	community health and social services to support and/or lead to an increase in patient admission to hospital. Risk of patient harm if care homes are not adequately covered.			
COV 009a	**Workforce Shortages** Measures the risk to service provision, deployment plans and health board strategic workforce related developments ie surge capacity, field hospital / immunisation programme in the context of the number of available staff. Factors impacting cover Covid and general sick absence, deployment restrictions relating to staff Covid risk assessment, general turnover, and outbreaks. Key risk areas where specific workforce shortages impact is the greatest (eg ITU, A&E, Covid wards) are reflected in the overall score.	15	Director of Workforce	Workforce & OD Committee Monitored via Workforce Directorate and reported to W&OD Committee as appropriate.
COV 009b	**Workforce Recruitment** Despite efforts to recruit staff into substantive, agency, bank and other roles the health board fails to meet the expanding requirement to replace staff where Covid related, or increase staff resource as a consequence of new staff resource needs. The workforce staff recruitment/supply risk has been assessed not just against the existing health board plans which had already highlighted the difficulties with staffing super surge. The risk score reflects the risks with meeting every and all existing confirmed requirements. The risk includes the internal risk given the pressures on relatively small departments who need to support recruitment. There is significant pressure on the pool of non-registered staff in the south west of Wales with health boards and local authorities all recruiting from the same pool. This impacts not only on the availability but quality of candidates.	12	Director of Workforce	Workforce & OD Committee Monitored via Workforce Directorate and reported to W&OD Committee as appropriate.
COV 015	**Mass Vaccination** The health board has operationalised its Mass Vaccination Programme in line with the strategic plan submitted to Welsh Government in 2020. Risks that are being managed in the programme	12	Director of Public Health	Immunisation Silver Group

Gold Ref	Risk Title & Description	Risk Score	Executive Owner (in Gold log)	Oversight to Transfer to:
	are: - delivery of booster vaccine supply to enable the Board to meet the milestones set out in the National Vaccination Strategy for the first phase of the programme from September 2021 - Delivery of a safe and effective programme that is being rolled out at pace and with significant and ensuring effective and timely communication to the public and key stakeholders - changes to guidance that necessitate frequent adaption of delivery models in line with JCVI and/or Welsh Government policy decisions.			
COV 017	**Nosocomial Transmission** Nosocomial transmission in hospitals due to the unavailability of single rooms and the inadequacy of ventilation systems (natural & mechanical) could cause patient harm, increase staff absence, and create wider system pressures (and potential for further harm) due to measures that will be required to control outbreaks.	20	Executive Medical Director	Infection Prevention & Control Committee Nosocomial deaths review will continue, but the Nosocomial group will stand down and this risk will be transferred for IPCC oversight. Additionally, it was agreed clinical oversight at Executive level will continue and small group meetings may be convened if issues arise. NB This risk scoring 20 has previously been escalated and is already captured within the HBRR.
COV 019a	**Opening of Field Hospital (revised model - December 2020)** Risk of patient harm if the field hospital is opened without adequate assurance that the clinical and workforce models are robust and that appropriate policies and procedures are in place.	16	Director of Finance	Field Hospital Decommissioning Group The management of the Field Hospital will transfer to the Field Hospital Establishment Group, but there will be a name change to the "Decommissioning Group" and it will report to Management Board. All actions/risks related to the Field Hospital will be owned in the new Governance stream. Since the Gold meeting, the Director of Finance has approved closure of this risk following formally

Gold Ref	Risk Title & Description	Risk Score	Executive Owner (in Gold log)	Oversight to Transfer to:
				agreement at Board to close the field hospital.
COV 024	**Fragility of External Domiciliary Care Market** Significant reduced staffing levels in domiciliary care agencies due to staff exiting the care home sector for employment in alternative business such as hospitality and retail has resulted in a number of providers being unable to fulfil contracts with attendant handbacks of packages of care. This high level of additional demand has impacted flow from hospital, from bedded reablement and out of domiciliary reablement services where there is any recourse to long term care resulting in delays across all of the discharge pathways and many of the admission avoidance support routes for those in crisis in the community.	25	Community Silver (now stood down also)	Transformation Board The Chief Operating Officer will oversee this following transfer.

In order to support the ongoing management of risks within Datix now that the Covid-19 Risk Register no longer exists as a separate entity, changes have been circulated separately to lead Executives to align Datix entries to lead Execs/management reporting arrangements. Additionally, leads have been asked to consider if any risks require escalation to the Health Board Risk Register. Final arrangements will be shared with the Risk Scrutiny Panel for review.

4. GOVERNANCE AND RISK

4.1 Risk Appetite & Tolerance Levels

Risk appetite is defined as the amount and type of risk an organisation is prepared to pursue, retain or take in pursuit of its strategic objectives. As noted earlier, the current risk appetite, as endorsed by the Board in November 2021 indicates that risks assessed at a threshold score of 20 or above should be addressed as a priority, and there is a low tolerance to risks with a high impact on the quality and safety of staff and patient care.

Following previous discussions at Board, further work has been carried out to develop a more nuanced approach to risk appetite through the risk management group. A risk appetite statement has been drafted and is being discussed with Directors, senior staff and members of the Risk Management Group.

It is not possible to eliminate all risks which are inherent to achieving our objectives and fulfilling our statutory obligations, so we may need to consider and/or accept a certain degree of risk where it is in the best interest of our patients or staff ie taking managed risk (in keeping with our statements of risk appetite) may result in positive benefits for our patients, service users, staff and visitors. To support effective risk

management and decision making the types of risks the health board may face are listed below together with the draft summary position of the health board's risk appetite for each and also the tolerance levels for each type:

Type of Risk	Risk Appetite	Risk Tolerance Levels*	Assuring Committee
Quality	Cautious	15	Quality & Safety
Workforce	Open	16	Workforce & OD
Financial	Open	16	Performance & Finance
Regulatory Compliance	Cautious	15	Audit
Reputational	Cautious	15	Audit
Health & Safety	Cautious	15	Health & Safety
Estates management	Open	16	Health & Safety
Digital & Informatics	Seek	20	Performance & Finance
Emergency Preparedness & Business Continuity	Open	16	Board

* Risks below these levels will be tolerated, but action would be expected to reduce those risks achieving or exceeding these levels.

As part of the risk and assurance process risks at or above the tolerance levels for the types of risks will be reported to the assuring committee for oversight, scrutiny and as appropriate deep dive reviews.

Responses to the draft risk appetite statement will be considered and it is proposed that the final draft of the document is considered at the next Board meeting for approval.

4.2 Risk Management Workshop Training

Delivery of Risk Management Workshops has been completed within Neath Port Talbot & Singleton and Primary Care & Therapies service groups.

Workshops have started in Morriston and Mental Health & Learning Disabilities.

Corporate directorates will follow.

4.3 Datix Cymru Risk Module

As previously reported, as part of the Once4Wales Concerns Management System Programme, a workstream group, supported by weekly meetings of a task & finish group, is meeting nationally to develop a new risk register module within Datix Cymru for use by organisations within NHS Wales.

The task & finish group has been working through design of the module with the Once4Wales team. An updated 'sandpit' module has been received from the supplier and is currently being evaluated by the group.

4.4 Migration from DatixWeb to Datix Cymru – Concerns Management Modules

The health board uses modules within the Datix Web system for the management of concerns. During 2021/22, the national Once4Wales Concerns Management System Programme has been managing the transition of all NHS Wales Organisations from their legacy concerns management systems within DatixWeb to the cloud-based Datix Cymru system. In Swansea Bay, the incident management module of Datix Cymru went live in April 2022; the modules for managing complaints and other feedback went

live in July 2021. Following these transitions, the licence for continued use of these legacy DatixWeb modules will expire at the end of August 2022, following which access to the module will become 'read-only'. There is a need to close down or transfer all remaining open records within DatixWeb. Any records not closed by the end of August will no longer be able to be actively managed within the legacy system and will require transfer into the new Datix Cymru module. No electronic means of transfer has been provided as part of the programme – the approach required will be manual.

The number of open records remaining in legacy modules requiring management action to close or transfer is significant and discussion with Datix user leads in services indicated concern in respect of the ability to close down all remaining cases fully. The re-entry of large volumes of records would potentially require a significant amount of staff time. Following discussion with services at the former Quality & Safety Governance Group, it was agreed to explore a risk-based approach to the review & closure of records. A paper was prepared and shared with Datix user leads, Service Group Directors and Executive Quality & Safety leads, following which categories of record have been agreed for batch closure, or investigation/transfer at Management Board. The outcome has been reported to Quality & Safety Committee for review and steps are now being taken to implement arrangements.

5. FINANCIAL IMPLICATIONS

There are financial implications to minimising the risks entered on the HBRR in relation to significant revenue implication around strengthening resources in the Health Board, Service Groups and Directorates. Capital monies will also be required in relation to supporting the improvements required to improve and further detail is provided in the individual entry on the HBRR.

6. RECOMMENDATIONS

Members are asked to:

- **NOTE** the updated Health Board Risk Register and changes to the risks outlined in this report;

- **CONSIDER** whether further assurance is required in respect of risk register entries or the action taken to address risks identified – particularly risks with 25 and 20 ratings;

- **NOTE** the development of a draft risk appetite and **AGREE** to receive the document at the next Board meeting for endorsement.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒

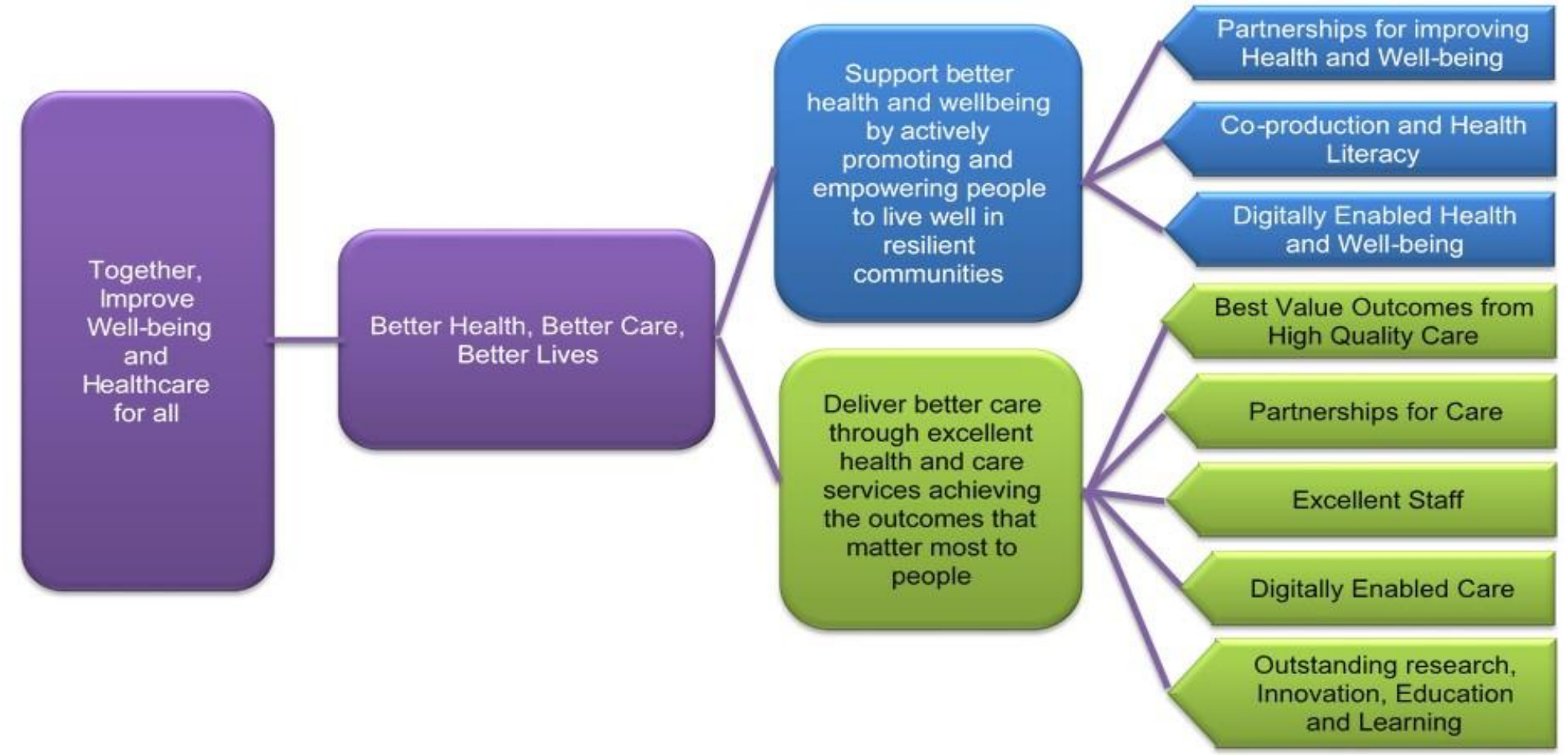
Quality, Safety and Patient Experience
Ensuring the organisation has robust risk management arrangements in place that ensure organisational risks are captured, assessed and mitigating actions are taken, is a key requisite to ensuring the quality, safety & experience of patients receiving care and staff working in the UHB.
Financial Implications
The risks outlined within this report have resource implications which are being addressed by the respective Executive Director leads and taken into consideration as part of the Board's IMTP processes.
Legal Implications (including equality and diversity assessment)
It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks faced by the organisation, as failure to do so could have legal implications for the UHB.
Staffing Implications
All staff have a responsibility for promoting risk management, adhering to SBUHB policies and have a personal responsibility for patients' safety as well as their own and colleague's health and safety. Executive Directors/Unit Directors are requested to review their existing operational risks on Datix Risk Module to ensure SBUHB has an accurate and up to date risk profile.
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)
The HBRR and the Covid 19 risk register sets out the framework for how SBUHB will make an assessment of existing and future emerging risks, and how it will plan to manage and prepare for those risks.

Report History	• Based on report prepared for Management Board 15th June and Audit Committee 14th July.
Appendices	• Appendix 1 – Health Board Risk Register (HBRR)

HEALTH BOARD RISK REGISTER
May 2022

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

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



HEALTH BOARD RISK REGISTER
DASHBOARD OF ASSESSED RISKS – May 2022

Impact/Consequences						
	5		**75:** Whole Service Closure **76:** Partnership Working	**53:** Compliance with Welsh Language Standards **67:** Access to Cancer Services – Radiotherapy **79**: Finance Recovery of Access Times	**16:** Access to Planned Care **51:** Compliance with Nurse Staffing Levels (Wales) Act 2016 **60:** Cyber Security **Reduced from 25** **66:** Access to Cancer Services – SACT **69:** Adolescents being admitted to Adult MH wards **73:** There is potential for a residual cost base increase post COVID-19 as a result of changes to service delivery models and ways of working. **74:** Induction of Labour (IOL) **83:** Release of Bed Capacity Savings	**01:** Access to Unscheduled Care Service **50:** Access to Cancer Services **64:** H&S Infrastructure
	4			**13:** Environment of Health Board Premises **37:** Operational and strategic decisions are not data informed **52**: Engagement & Impact Assessment Requirements	**27:** Digital Transformation to Deliver Sustainable Clinical Services **36:** Electronic Patient Record **39:** IMTP Statutory Responsibility **41:** Fire Safety Regulation Compliance **48:** Child & Adolescence Mental Health Services **57:** Non-compliance with Home Office Controlled Drug Licensing requirements **61:** Paediatric Dental GA Service – Parkway **63:** Screening for Fetal Growth Assessment in line with Gap-Grow (G&G) **Reduced from 20** **82:** Risk of closure of Burns Service **Reduced from 20** **84:** Cardiac Surgery	**03:** Workforce Recruitment of Medical and Dental Staff **04:** Infection Control **58:** Ophthalmology Clinic Capacity **65:** CTG Monitoring in Labour Wards **72:** CRL & Capital Plan **78:** Nosocomial Transmission **80:** Inability to Transfer Patients **81:** Critical Staffing Levels: Midwifery **85:** Non Compliance with ALN Act New Risk
	3				**43:** DOLS/LPS Authorisation and Compliance with Legislation **Reduced from 16** **77:** Workforce Resilience	
	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[1]	Controls	Last Reviewed	Scrutiny Committee
Best Value Outcomes from High Quality Care	1 (738)	**Access to Unscheduled Care Service** If we fail to provide timely access to Unscheduled Care then this will have an impact on quality & safety of patient care as well as patient and family experience and achievement of targets. There are challenges with capacity/staffing across the Health and Social care sectors.	20	25	➔	➔	May 2022	Performance & Finance Committee
	4 (739)	**Infection Control** Risk of patients acquiring infection as a result of contact with the health care system, resulting in avoidable harm, impact on service capacity, and failure to achieve national infection reduction goals.	20	20	➔	➔	May 2022	Quality & Safety Committee
	13 (841)	**H&S Compliance: Environment of Premises** Risk of failure to meet statutory health and safety requirements.	16	12	➔	➔	May 2022	Health & Safety Committee
	16 (840)	**Access to Planned Care** There is a risk of harm to patients if we fail to diagnose and treat them in a timely way.	16	20	➔	➔	May 2022	Performance & Finance Committee
	37 (1217)	**Information Led Decisions** Risk that operational and strategic decisions are not data informed.	16	12	➔	➔	May 2022	Audit Committee
	39 (1297)	**Risk of Failure to Develop an Approvable IMTP - Statutory Compliance** Failure to have an approvable IMTP for 2022/23 then we will lose public confidence and breach legislation.	16	16	➔	➔	May 2022	Performance & Finance Committee

[1] This indicates whether there has been an increase / decrease in risk score since the previous month's HBRR.

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	41 (1567)	**Fire Safety Compliance** 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	16	→	→	May 2022	Health & Safety Committee
	43 (1514)	**DoLS Reduced from 16** Due to a lack of Best Interest Assessor resource, there is a risk of failure to complete and authorise the assessments associated with Deprivation of Liberty/Liberty Protection Safeguards within the legally required timescales, exposing the health board to potential legal challenge and reputational damage.	16	12	↓	→	May 2022	Quality & Safety Committee
	48 (1563)	**CAMHS** Failure to sustain Child and Adolescent Mental Health Services (CAMHS).	16	16	→	→	May 2022	Performance & Finance Committee
	50 (1761)	**Access to Cancer Services** There is a risk of delay in diagnosing patients with cancer, and consequent delay in commencement of treatment, which could lead to poor patient outcomes and failure to achieve targets.	20	25	→	→	May 2022	Performance & Finance Committee
	57 (1799)	**Controlled Drugs** Non-compliance with Home Office Controlled Drug Licensing requirements.	20	16	→	→	May 2022	Audit Committee
	63 (1605)	**Screening for Fetal Growth Assessment in line with Gap-Grow Reduced from 20** There is not enough Ultrasound capacity within Swansea Bay UHB to offer all women serial ultrasound scan screening in the third trimester in line with the UK perinatal Institute Growth Assessment Programme (GAP).	12	16	↓	→	May 2022	Quality & Safety Committee

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	64 (2159)	**Health and Safety Infrastructure** Insufficient resource and capacity of the health, safety and fire function to maintain legislative and regulatory compliance.	20	25	→	→	May 2022	Health & Safety Committee
	66 (1834)	**Access to Cancer Services (SACT)** Delays in access to SACT treatment in Chemotherapy Day Unit	25	20	→	→	May 2022	Quality & Safety Committee
	67 (89)	**Risk target breaches – Radiotherapy** Clinical risk – Target breeches of radical radiotherapy treatment	16	15	→	→	May 2022	Quality & Safety Committee
	69 (1418)	**Safeguarding** Adolescents are being admitted to adult mental health wards	20	20	→	→	May 2022	Quality & Safety Committee
	72 (2449)	**CRL & Capital Plan** Reduced discretionary capital funds and reduced National NHS funds requiring a restricted Capital Plan for 2022-23	20	20	→	→	May 2022	Performance & Finance Committee
	73 (2450)	**Finance** There is a potential for a residual cost base increase post COVID-19 as a result of changes to service delivery models and ways of working.	20	20	→	→	May 2022	Performance & Finance Committee
	74 (2595)	**Delays in Induction of Labour (IOL)** Delays in IOL can introduce avoidable risk and unnecessary intervention which can lead to poor clinical outcome for mother and/or baby. Delays in IOL lead to increased complaints and decreased patient satisfaction.	20	20	→	→	May 2022	Quality & Safety Committee

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	75 (2522)	**Whole Service Closure** Risk that services or facilities may not be able to function if there is a major incident or a rising tide that renders current service models unable to operate.	20	10	→	→	May 2022	Performance & Finance Committee
	78 (2521)	**Nosocomial Transmission** Nosocomial transmission in hospitals could cause patient harm; increase staff absence and create wider system pressures (and potential for further harm) due to measures that will be required to control outbreaks.	20	20	→	→	May 2022	Quality & Safety Committee
	79 (2739)	**Finance - Recovery of Access Times** Potential risk that resource available is below the ambition of the board to provide improved access.	15	15	→	→	May 2022	Performance & Finance Committee
	80 (1832)	**Inability to Transfer Patients** If the health board is unable to discharge clinically optimised patients there is a risk of harm to those patients as they will decompensate, and to those patients waiting for admission.	20	20	→	→	May 2022	Quality & Safety Committee
	81 (2788)	**Critical Staffing Levels: Midwifery** Midwifery absence rates are outside of 26.9% uplift leading to difficulty in maintaining midwifery rotas in the hospital and community setting.	25	20	→	→	May 2022	Quality & Safety Committee
	82 (2554)	**Risk of closure of Burns service if Burns Anaesthetic Consultant cover not sustained** There is a risk that adequate Burns Consultant Anaesthetist cover will not be sustained, resulting in closure to this regional service and the associated reputational damage. This is caused by: • Decreasing consultant numbers due to retirement • Anaesthetists not gaining CCT with appropriate ICM and Burns experience. **Reduced from 20**	12	16	↓	→	May 2022	Performance & Finance Committee

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	83 (2961)	**Release of Bed Capacity Savings** There is a risk that the health board will not be able to release sufficient bed capacity to meet the requirements of savings schemes predicated on bed release.	20	20	→	→	May 2022	Performance & Finance Committee
	84 (3036)	**Cardiac Surgery** A Getting It Right First Time review identified concerns in respect of cardiac surgery (including patient pathway/process issues) that present risks to ensuring optimal outcomes for all patients	25	16	→	→	May 2022	Quality & Safety Committee
	85 (2561)	**Non-Compliance with ALN Act New Risk** There are risks to the Health Board's ability to meet its statutory duties and establish the effective collaborative arrangements required by the ALN Act, which is being implemented through a phased approach.	25	20	New	New	May 2022	Quality & Safety Committee
Excellent Staff	3 (843)	**Workforce Recruitment** Risk of failure to recruit medical & dental staff	20	20	→	→	May 2022	Workforce & OD Committee
	51 (1759)	**Nurse Staffing (Wales) Act** Risk of Non Compliance with the Nurse Staffing (Wales) Act	16	20	→	→	May 2022	Workforce & OD Committee
	76 (2377)	**Partnership Working** There are growing tensions between the Health Board and some trade union partners within SBUHB particularly in response to the supply of PPE which has the potential to create unrest in the workforce and hamper an effective response to COVID-19. (From Covid-19 Register)	25	10	→	→	May 2022	Workforce & OD Committee

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	77 (2569)	**Workforce Resilience** Culmination of the pressure and impact on staff wellbeing - both physical and mental relating to Covid Pandemic. (From Covid-19 Register)	25	12	→	→	May 2022	Workforce & OD Committee
Digitally Enabled Care	27 (1035)	**Digital Transformation to Deliver Sustainable Clinical Services** Inability to deliver sustainable clinical services due to lack of digital transformation.	16	16	→	→	May 2022	Audit Committee
	36 (1043)	**Storage of Paper Records** Failure to provide adequate storage facilities for paper records then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if there is poor records management in some wards.	20	16	→	→	May 2022	Audit Committee
	60 (2003)	**Cyber Security** Reduced from 25 The level of cyber security incidents is at an unprecedented level and health is a known target.	20	20	↓	→	May 2022	Audit Committee
	65 (329)	**CTG Monitoring on Labour Wards** Misinterpretation of cardiotocograph and failure to take appropriate action is a leading cause for poor outcomes in obstetric care leading to high value claims.	16	20	→	→	May 2022	Quality & Safety Committee
Partnerships for Improving Health and Wellbeing	58 (146)	**Ophthalmology - Excellent Patient Outcomes** Risk of failure to provide adequate clinic capacity to support follow-up patients within the Ophthalmology specialty.	12	20	→	→	May 2022	Quality & Safety Committee
	61 (1587)	**Paediatric Dental GA Service – Parkway** Safety risk of general anaesthetic procedures performed on children outside of an acute hospital setting.	15	16	→	→	May 2022	Quality & Safety Committee

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
Partnerships for Care	52 (1763)	**Statutory Compliance: Engagement & Impact Assessment** The Health Board does not have sufficient resource in place to undertake engagement & impact assess in line with Statutory Duties	16	12	➔	➔	May 2022	Performance & Finance Committee
	53 (1762)	**Welsh Language Standards** Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.	15	15	➔	➔	May 2022	Health Board (Welsh Language Group)

Risk Schedules

Datix ID Number: 738 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 1** **Target Date: 31/07/2022**	**Current Risk Rating** **5 x 5 = 25**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Inese Robotham, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee **For information:** Quality & Safety Committee	
Risk: Access to Unscheduled Care If we fail to provide timely access to Unscheduled Care then this will have an impact on quality & safety of patient care as well as patient and family experience and achievement of targets. There are challenges with capacity/staffing across the Health and Social care sectors.		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 5 x 5 = 25 Target: 3 x 4 =12		**Rationale for current score:** Post wave 2 of COVID 19 Morriston and Singleton have experienced a steady increase in emergency demand to pre-covid levels. Capacity is limited due to covid response and therefore remains a high risk. Current score raised due to increasing pressures	
Level of Control = 50%		**Rationale for target score:** Our annual plan is to implement models of care that reflect best practice. This will improve patient flow, length of stay and reduce emergency demand.	
Date added to the HB risk register 26.01.16			

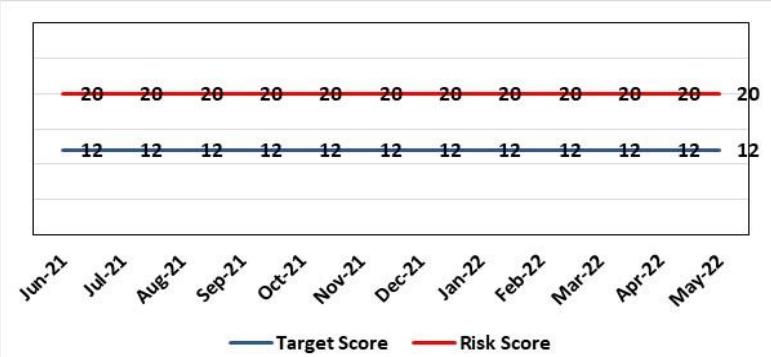
Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Programme management office in place to improve Unscheduled Care. • Daily Health Board wide conference calls/ escalation process in place. • Regular reporting to Executive and Health Board/Quality and Safety Committee. • Increased reporting as a result of escalation to targeted intervention status. • Targeted unscheduled care investment of £8.5m in the annual plan, including a new Acute Medical Model focused on increasing ambulatory care. • Development of a Phone First for ED model in conjunction with 111 to reduce demand. • 24/7 ambulance triage nurse in place • Joint WAST Stack review by GP and APP (Advanced Paramedic Practitioner) • OPAS (Older People's Assessment Service) have undertaken training with nursing homes (on management of patient falls) & set up direct contact details with nursing homes • Re-establish the frailty short-stay unit	Re-establish short stay unit on ward D at Morriston	SGD (Morriston)	31/07/2022
	Review roles & service models in order to increase SDEC working hours and throughput of patients sustainably.	SGD (Morriston)	30/09/2022
	OPAS developing a proposal to assess elderly patients at home	SGD (Morriston)	31/07/2022
	Introduce Band 6 navigator role in ED for better streaming of patients	SGD (Morriston)	31/07/2022

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
• New Urgent & Emergency Care Board to meet monthly	The need to deliver sustained service.

Additional Comments / Progress Notes

Zero tolerance target of 4 hours agreed. SOP in place. Currently not achieving due to Omicron surge and increased pressures at Morriston.

Patient pathways that can bypass ED have been identified, but the EMD is working with WAST and SBU clinicians to maximise the number of patients receiving SDEC (Same Day Emergency Care).
Acute hub relocated to TAWE as planned in December. Estates works have commenced in Enfys ward.
Update 11.02.22 Action closed: Business case to take virtual wards up to 8 have been submitted to Management Board.
03/05/2022 controls & actions updated. Two actions completed - Re-establish the frailty short stay unit on RDU and Third phase of procurement to be undertaken to commission additional care home beds.
08/06/2022: AMSR business case has been approved & the next stage is OCP process.

Datix ID Number: 843 **Health & Care Standard: Staff & Resources 7.1 Workforce**		**HBR Ref Number: 3** **Target Date: 31st March 2023**	**Current Risk Rating** **4 x 5 = 20**
Objective: Excellent Staff		**Director Lead:** Debbie Eyitayo, Director of Workforce and OD **Assuring Committee:** Workforce and OD Committee	
Risk: Workforce recruitment of medical & dental staff		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 5 =20 Target: 4 x 3 = 12		**Rationale for current score:** National shortages of numbers in some areas can lead to: • Inability to recruit sufficient numbers of trainees to fulfil rotas on all sites • Inability to attract non training grades to complete rotas • Inability to fill Consultant grade posts in some specialties with adverse effects on patient safety and employer relations. Inability to recruit sufficient registered nursing staff.	
Level of Control = 70%		**Rationale for target score:** This remains a challenge and is also a national problem.	
Date added to the HB risk register April 2012			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• 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. • Weekly workforce delivery meetings with CEO to review progress against critical medical and clinical posts • Working with specialist agency and head hunters to improve chances to fill hard to recruit posts • Plan to work with a marketing agency to develop a branding and attraction campaign for the health board.	**Action**	**Lead**	**Deadline**
	Medical training initiatives pursued in a number of specialties to ease junior doctor recruitment	Director W&OD	31/03/2023
	The Medical Workforce Board continues to monitor recruitment and junior doctor's rotas.	Director W&OD	31/03/2023
	Continue to recruit internationally.	Director W&OD	31/03/2023
	Continue to work with head hunters	Director W&OD	31/03/2023

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
• General situation monitored through W&OD Committee • Communication with Deanery • Recruitment campaigns • Monitoring by Executive Teams and specialty based local workforce boards • Workforce planning and deployment taskforce meetings with service groups • Weekly workforce delivery meetings with CEO as above	Locum cover Adequate supply of doctors who can work in this country Ability to flexibly deploy doctors in training. Dedicated work between workforce and finance to review and confirm budgeted medical workforce establishment by service group to confirm SIP and vacancy factor.

Additional Comments / Progress Notes

17/01/2022: We have over established locum posts in specialties such as medicine, ITU and Anaesthetics in anticipation of trainee gaps and turnover. We have adopted a more pastoral approach to International medical recruitment as part of onboarding but we need to focus on measures to support retention. We have signed a contract with SBW to improve the HBs branding and attraction SBW will also support individual campaigns.
May 2022: Action Targets and Gaps in Assurance updated

Datix ID Number: 739 **Health & Care Standard: 2.4 Infection Prevention & Control & Decontamination**		**HBR Ref Number: 4** **Target Date: 31st March 2023**	**Current Risk Rating** **4 x 5 = 20**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality and Safety Committee	
Risk: Risk of patients acquiring infection as a result of contact with the health care system, resulting in avoidable harm, impact on service capacity, and failure to achieve national infection reduction goals.		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 =12		**Rationale for current score:** Health Board incidence of key Tier 1 infections per 100,000 population above All Wales rates, indicating Health Board's population at greater risk of infection. High occupancy rates & frequent ward moves associated with increased risk of infection transmission. Lack of decant facilities compromises environment deep cleaning & decontamination, and planned preventative maintenance programmes. Varying levels of IPC and antimicrobial stewardship responsibility embedded across all disciplines and groups. Incomplete systems for recording compliance with IPC training for all staff groups. Need improved systems to allow Delivery Groups to review compliance reports for cleanliness scores, ventilation validation/compliance, water safety, and decontamination.	
Level of Control = 40%		**Rationale for target score:** Improved governance structures for IPC and antimicrobial stewardship will drive improved local ownership and embed responsibility for these priorities for all levels of staff. Adequately maintained & clean environments facilitate good IPC & minimise infection risks. Reduced occupancy & frequency of patient moves mitigate against infection transmission. Compliant ventilation systems and water safety minimise infection risks. Access to timely data on infections, training, antimicrobial stewardship, cleaning at ward/unit/practice level enables Service Groups to identify areas for focused Quality Improvement programmes, drive improvement, & effectively measure outcomes.	
Date added to the HB risk register January 2016			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Policies, procedures, protocols and guidelines supplement the National Infection Control Manual. • Seven-day infection prevention & control service provides advice and support HB staff. • Medical microbiology & infectious diseases team provides expertise and support. • Infection Prevention & Control related training provided programmes. • Surveillance of infections, with early identification of increased incidence, and instigation of controls. • Provision of cleaning service to meet National Standards of Cleanliness. • Engineering controls for water safety, ventilation, and decontamination.	Drive improvements in prudent antimicrobial prescribing	Cons. Antimicrobial Pharmacist	31/07/22
	Develop ward to board Dashboard on key Tier 1 infections	HoN IP&C & Digital Intelligence	31/07/22
	Achieve compliance with IPC mandatory training	Service Group Triumvirates	31/03/23

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
• Clear Corporate and Service Group IPC Assurance Framework in place. • Ongoing monitoring of infection control rates, with weekly feedback corporately & to Service Groups. • Infection Control Committee and Quality Priority Sub-groups receive assurance reports, monitor infection rates, and identify key actions to drive improvement. Quality Priority Sub-groups of ICC review progress of improvement actions. • Training compliance. • IPC, antimicrobial, decontamination and cleaning audit programmes. • Compliance and validation systems for water safety, ventilation systems and decontamination.	Review single room capacity. Poor condition of hospital estate requires investment. High activity limits access for planned preventative maintenance and necessary HTM validation/compliance checks. Seek improved Corporate and Service Group oversight of compliance with ventilation, water safety, decontamination & cleaning checks. Challenge to sustain cleaning workforce to achieve National Minimum Standards of Cleanliness. Review plans to reduce bed occupancy rates and patient multi-ward moves. Investment in ESR Self-service to provide data on IPC-related training compliance. Investment in digital intelligence systems to provide Board to Ward oversight of infection, antimicrobial, cleanliness, and training data.

Additional Comments / Progress Notes

Update February 2022 - Three actions closed – 1. Define governance structures to support the HCAI Quality Priority. 2. Recruitment to support strengthening governance of decontamination processes. 3. Recruitment of key personnel to support improvements in antimicrobial prescribing.

21/03/22 - IPC Improvement Plan approved in principle by Management Board on 9th March 2022, with amendments to be incorporated in next iteration. The aim is to create a guiding coalition of responsible clinical leaders (not just nursing staff) at all levels in the organisation who see the intrinsic benefits and reduction in harm from infection. Management Board IPC Improvement Plan Paper and actions attached in Documents on Datix. This will be presented at the next Infection Control Committee on 30/03/22 and is for adoption by all Service Groups.

20/04/2022 - The Infection Improvement Plan was amended to incorporate discussions from members at the March Management Board. The amended version (v2) was resubmitted to the Management Board in April 2022. Each Service Group will develop their action plans to support the Health Board's infection improvement goals.

Datix ID Number: 841 Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety	HBR Ref Number: 13 Target Date: TBC	Current Risk Rating 4 x 3 = 12
Objective: Best Value Outcomes	**Director Lead:** Inese Robotham, Chief Operating Officer / Sian Harrop-Griffiths, Director of Strategy **Assuring Committee**: Health and Safety Committee	
Risk: Health & Safety Compliance – Environment of Premises. Risk relates to compliance in terms of appropriate accommodation in line with Health and Safety Regulations.	**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 =12 Target: 4 x 3 = 12		**Rationale for current score:** The accommodation is varied in age, tired and in need of upgrading/refurbishment to enable improved condition and compliance to regulations and WHBN/WHTMs.
Level of Control = 90%		**Rationale for target score:** Risk assessments of premises.
Date added to the HB risk register 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. Health & Safety and Quality & Safety Committees and agreed actions to mitigate impacts. • Actions addressed through site meetings trade improvements on the 2 acute hospital sites. • Primary Care premises, audits commissioned and delayed due to covid.	The Health Boards 'Change for the Future' which is about improving access to services, will include a review of the whole estate and its suitability	Assistant Director of Operations (Est) & Assistant Director of Strategy (Capital)	31/05/2022
	There is a 6 facet survey scheduled to be completed by 31/03/22 covering the occupancy and utilisation of the various sites	Assistant Director of Operations (Est)	31/05/2022
	A review is currently taking place of current PCST structures and governance arrangements for estates and H&S to cover key compliances and escalation processes, with a draft report targeted for 31/12/21	Service Group Director (PCT) & Assistant Director of Health & Safety	31/05/2022
	Work is being progressed to understand the detail in each of the leased properties to ensure appropriate levels of responsibility are identified for the landlord and the tenant/occupier	Service Group Director (PCT) supported by ADoOperations (Est), ADoStrategy (Capital) and ADoH&S	31/05/2022

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

Additional Comments / Progress Notes

Update 18.03.22 – Update on 'Change for the Future' and '6 Facet survey' actions – The Health Board has commissioned a six facet review with equality access assessment included within the specification. Work has commenced and is due to be completed by the end of March 2022.

Datix ID Number: 840 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 16** **Target Date: 30/09/2022**	**Current Risk Rating** **5 x 4 = 20**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Inese Robotham, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee **For information:** Quality & Safety Committee	
Risk: Access and Planned Care. There is a risk of harm to patients if we fail to diagnose and treat them in a timely way.		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 4 = 20 Target: 4 x 2 = 8		**Rationale for current score:** All non-urgent activity was cancelled due to response to the Covid-19 pandemic and has increased the backlog of planned care cases across the organisation. Whilst mitigating measures such as virtual clinics have been put in place new referrals are still being accepted which is adding to the outpatient backlog particularly in Ophthalmology and Orthopaedics. The significant reduction in theatre activity during the pandemic increased the number of patients now breaching 36 and 52 week thresholds.	
Level of Control = 90%		**Rationale for target score:** There is scope to reduce the likelihood score to reduce the overall risk to an acceptable level. The Risk target date indicates when we expect to see some reduction in waiting lists – albeit the overall risk level may remain as work continues.	
Date added to the HB risk register January 2013			

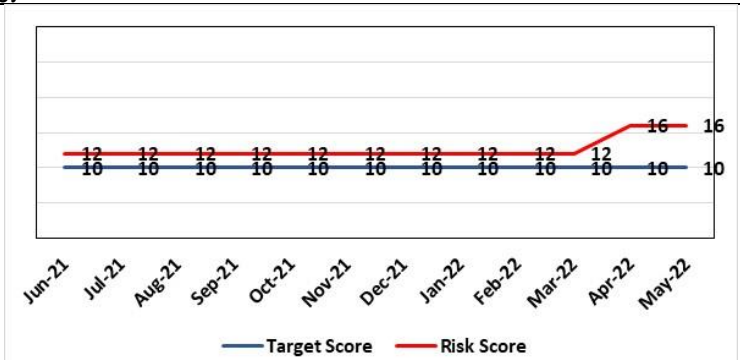
Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Post Covid 19 the focus is on minimising harm by ensuring that the patients with the high clinical priority are treatment first. The Health Board is following the Royal College of Surgeons guidance for all surgical procedures and patients on the waiting list have been categorised accordingly. • There is a bi-weekly recovery meeting for assurance on the recovery of our elective programme. • Specialty level capacity and demand models set out the baseline capacity and identify solutions to bridge the gap. Non-recurring pump – prime funding is available to support initial recovery measures. Fortnightly performance reviews track progress against delivery. • A focused intervention is in train to support to the 10 specialties with the longest waits. • Long waiting patients are being outsourced to the Independent Sector • Additional internal activity is being delivered on weekends (via insourcing)	Implement demand management initiatives between primary and secondary care to reduce the number of new patients awaiting outpatient appointments.	Service Group Directors	30/06/2022
	Implement a full range of interventions to support patients to be kept active and well whilst on a waiting list. The focus will be on cancer patients awaiting surgery and long waiting orthopaedic patients.	Service Group Directors	30/06/2022
	Develop robust demand and capacity plans for delivery in 2022/23	Service Group Directors/ Deputy COO	30/06/2022

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
• Weekly meetings in place to ensure patients with greatest clinical need are treated first.	

Additional Comments / Progress Notes

03/05/2022 – Paper was presented to Management Board 20/04/22 detailing progress and plans for 2022/2023.

08/06/2022: Looking to free up Theatres Admission Unit of outliers to return use to surgical patients.

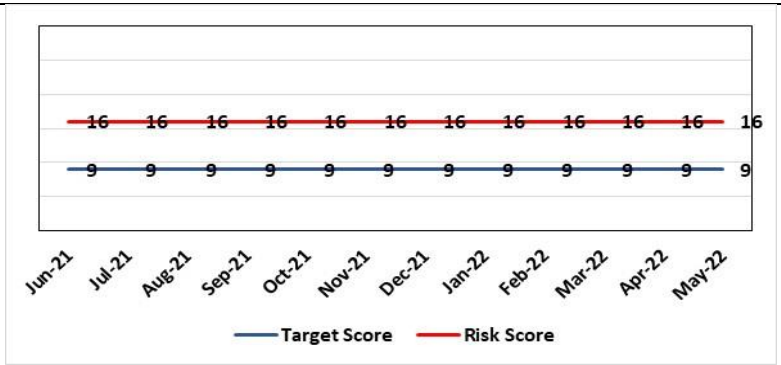
Datix ID Number: 1035 Health & Care Standard: Effective Care 3.1 Clinically Effective Care	HBR Ref Number: 27 Target Date: 31st July 2023	Current Risk Rating 4 x 4 = 16
Objective: Digitally enabled care	**Director Lead:** Matt John, Director of Digital **Assuring Committee:** Audit Committee	
Risk: Digital Transformation Inability to deliver sustainable clinical services due to lack of Digital Transformation. There are insufficient resources to: • invest in the delivery of the ABMU Digital strategy, • support the growth in utilisation of existing and new digital solutions • replace existing technology infrastructure and the end of its useful life.	**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 5 x 2 = 10		**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- Reduction in capital funding in 22/23 has increased the likelihood of HB not being able to replace aging infrastructure such as the SAN. Acceleration of the CTM SLA disaggregation has been proposed and there are further pressures on revenue funding.
Level of Control = 50%		**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.
Date added to the HB risk register 2012		

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• Digital Strategy has been approved by the Health Board and outlines requirements • HB Capital priority group considers digital risks for replacement technology which is fed into the annual discretionary capital plan • Digital Services prioritisation process is in place Digital Leadership Group provides the overarching governance to the delivery of the Digital Strategic Plan including financial considerations. • Digital Services revenue requirements are included in 21/22 annual plan	Assessment of funding gaps and the opportunities to bridge them to be undertaken with Finance	Assistant Director of Digital: Business Management and Information Governance	31/07/22

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
• Progress has been made in securing capital investment both internally and externally. • The Digital Services plan is being delivered. • Financial plan for 21/22 agreed and aligned to Digital Plan	• Lack of certainty over future capital and revenue funding streams makes planning and implementation difficult/less effective.

Additional Comments / Progress Notes

Update 14/3/2022 - Reviewed by the Digital Services Risk Management Group on the 8th March 2022 and no further updates required for the Executive Risk Management for this month.
Update 14.04.2022 - Recommendation approved by the Digital Services Risk Management Group to increase the likelihood of this risk from 3 to 4 to 16.
Action completed – Establish 5year financial plan for Digital including the risks of the termination of the CTM SLA.

Datix ID Number: 1043 Health & Care Standard: Effective Care 3.1 Clinically Effective Care	HBR Ref Number: 36 Target Date: 31st March 2023	Current Risk Rating 4 x 4 = 16
Objective: Digitally enabled care	**Director Lead:** Matt John, Director of Digital **Assuring Committee:** Audit Committee **For information:** Health & Safety 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. There is an increased fire risk where medical records are stored outside of the medical record libraries.	**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 4 = 16 Target: 3 x 3 =9 **Level of Control** = 70% **Date added to the HB 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. Increased risk of fire where records are stored outside of the medical record libraries. L - we know this happens from incidents raised **Rationale for target score:** C - The increased development and adoption of the digital record will reduce the need for the paper health record being available at the point of care. L - The increased development and adoption of the digital record, the introduction of RFID and the approach to management of the paper record identified in the Business case process should reduce the amount of paper required to be stored and managed.

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• There is a plan in place to increase the functionality of the electronic record to document patient care. The delivery of the plan is overseen by the Digital Leadership Group and progress provided to Management Board. (Supported by individual project boards as appropriate) • Records managed by the Medical Records libraries are RFID tagged and location tracked • Medical Record libraries are regularly risk assessed for fire by health and safety • Alternative offsite storage arrangements have been identified. • All records must be documented on the Information Asset Register (IAR)	Develop Business Case for the scanning of patients records.	Head of Health Records & Clinical Coding	30th September 2022
	Once Business Case is approved, relocate Health records to the new site. Business Case being presented to Management Board – 18/05/2022	Head of Health Records & Clinical Coding	TBC

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
• RFID has been implemented for the acute record improving the management and storage of records • Health Records performance reports developed in line with RFID technology • Attainment of the Tier 1 Health Board target for clinical coding completeness which relies on the timely availability and quality of the Paper record and electronic sources • Monitoring complaints and incident reporting. • Electronic record is being implemented in accordance with the plan eg implementation of WNCR, ETR, HEPMA etc.	Investment required supporting the delivery and operational costs of the Digital strategy. Reliance on NWIS for delivery of the solution for a fully electronic patient record. Impact of the Infected Blood Enquiry on the Health Boards ability to destroy notes.

	Process for ensuring clinical adoption of electronic ways of working and cessation of adding information to the paper record that is already available electronically needs to be agreed and enforced by the Health Board. Impact of the infected Blood Inquiry on the health boards ability to destroy notes has considerably increased the pressure on storage capacity and negating some of the mitigating actions that are in place.
Additional Notes 16.02.22 – No further update for February 2022 Update 14.04.2022 – Business Case approved at BCAG for centralised storage Unit for Health Records pending funding. Going to Management Board on the 19th April 2022. Two Actions completed: Reviewing different off site options for a centralised storage facility for all active acute records to include a centralised scanning model and Develop Business Case/paper for improved offsite storage solution for the acute paper records.	

Datix ID Number: 1217 **Health & Care Standard: Effective Care 3.1 Safe & Clinically Effective Care**		**HBR Ref Number: 37** **Target Date: 31st March 2023**	**Current Risk Rating** **4 x 3 = 12**
Objective: Best Value Outcomes from Quality Care		**Director Lead:** Matt John, Director of Digital **Assuring Committee:** Audit Committee	
Risk: Operational and strategic decisions are not data informed: • Business intelligence and information already available is not utilised • Users are unable to access the information they require to make decisions at the right time • Gaps in information collection including patient outcome measures		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 3 = 12 Target: 4 x 2 = 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. Management Board have approved the investment for 4 BI partners to work with the SDGs to become more data driven.	
Level of Control = 70%		**Rationale for target score:** 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.	
Date added to the HB risk register June 2016			

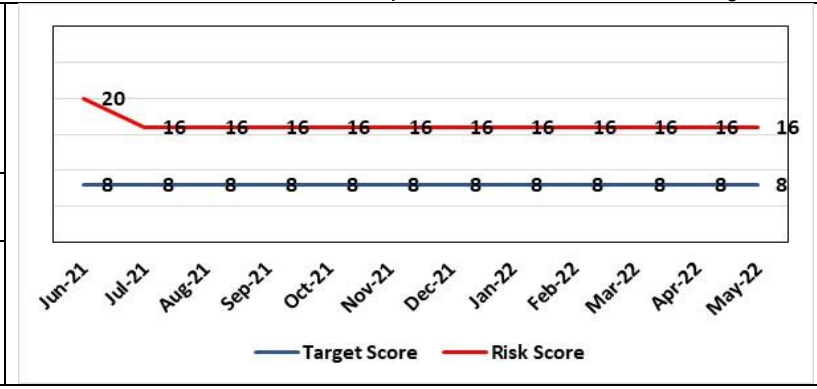
Controls (What are we currently doing about the risk?)

- BI partner roles have been funded and will be introduced to support the SDG's to become more data driven.
- COVID19 Dashboards Developed and utilised to inform the decision making process at Gold
- The Health Board has invested in interactive dashboards with the addition of the Power BI Business Intelligence software and infrastructure to support it.
- 33 dashboards in place including Cancer, Patient Flow, Outpatients, Mortality, Clinical Variation, Primary & Community Care Delivery Unit Dashboard and Ward Dashboard
- Safety Huddle implemented in Morriston has improved data quality and improved operational working
- Investment and revised ways of working across the coding department has achieved coding and data quality targets
- Information Dept. working with Planning and Finance leads to develop meaningful indicators, utilising dashboards to present information in a user friendly way
- New technologies being reviewed for advanced analytics and integration into a new Health Board analytics platform.
- Health Board has representation on national groups such as the Advanced Analytics Group (AAG), all Wales Business Intelligence and Data Warehousing Group and Welsh Modelling Collaborative.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Establishment of data literacy programme educating users on data concepts, skills and tools	Assistant Director of Digital Intelligence	31st August 2022
Natural Language Process capability to allowing users access to clinic letter/documents converted into meaningful analytics	Assistant Director of Digital Intelligence	31st December 2022
Establishment of certified training programme for trained users to create their own dashboards – March 2023	Assistant Director of Digital Intelligence	31st March 2023

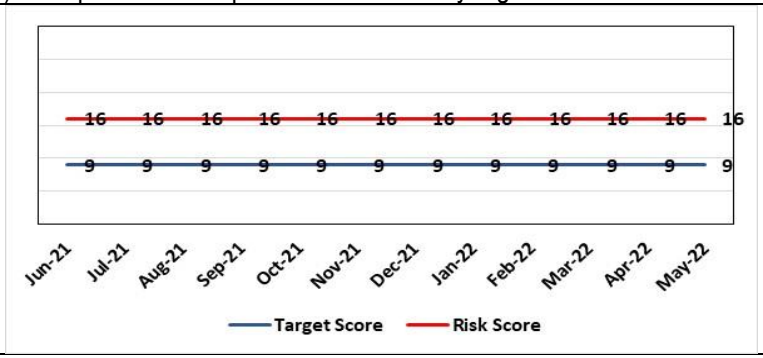
Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
More evidence based and proactive decisions being made. Dashboard technology; assist in developing indicators / triangulating information to identify issues	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.
Additional Comments / Progress Notes	
Update 14.04.2022 – Action completed: In line with the BI Strategy & Implementation Plan a new data warehouse server brought on line and all existing data migrated onto it ready for further work to be undertaken to increase our levels of Business Intelligence maturity and the delivery of the Ambitions set out within the strategy. 18.05.22 - Reviewed by the Risk Management Group on the 10th May and no amendments for this month's submission	

Datix ID Number: 1297 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**		**HBR Ref Number: 39** **Target Date: 30th June 2022**	**Current Risk Rating** **4 x 4 = 16**
Objective: Demonstrating Value and Sustainability .		**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee**: Health Board ,Performance and Finance Committee	
Risk: Failure to Develop an Approvable IMTP (statutory compliance) Failure to have an approvable IMTP for 2022/23 then we will lose public confidence and breach legislation.		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 4 x 2 = 8		**Rationale for current score:** Our Organisational Strategy was approved by the Board in November 2018 Quarterly and half year plans submitted for 2020/21 The 2021/22 Annual Plan was submitted to WG on 30.06.21 and included a balanced financial plan. The Health Board does not have a WG approved IMTP.	
Level of Control = 70%			
Date added to the HB risk register July 2017		**Rationale for target score:** If the IMTP is approved, it is likely our enhanced monitoring status will be improved when next reviewed.	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• An Annual Plan was approved by the Board on 23 June 2021 and submitted to WG on 30 June 2021. Delivery against this Plan was reported Quarterly to Board and Welsh Governemnt • A Recovery and Sustainability Working Group was established in July 2021, chaired by CEO with independent members and Executive leads to steer development of the R&S Plan • The existing IMTP Executive Steering Group will provide oversight of the R&S Plan, Performance and Finance Plans assured by P&F Committee. W&OD Committee reviews the workforce plan, Q&S Committee the Q&S elements. JET meetings with WG • The Health Board has submitted 3 year Recovery and Sustainability Plan to WG on 31.03.22 which will provide the foundation to deliver an agreed IMTP for 2022/23.if approved	**Action**	**Lead**	**Deadline**
	Development of draft Recovery and Sustainability Plan for approval by the Board	Dir of Strategy & Dir of Finance	30/06/2022
Assurances (How do we know if the things we are doing are having an impact?) Robust programme arrangements are in place to execute the R&S Plan and for 22/23 these arrangements have been strengthened with updated reporting and monitoring arrangements agreed by Management Board in May and June 2022.	**Gaps in assurance (What additional assurances should we seek?)**		

Additional Comments / Progress Notes

22.02.2022 – Timescales for completion of IMTPs have been changed by Welsh Government – now changed to 31/03/22. Board has been kept updated at each meeting and at briefing sessions since December. Accountable Officer letter to be submitted to WG on ability to submit a balanced IMTP by 28/02/22 following Board.
31.03.2022 – The Board approved the Recovery and Sustainability Plan for submission to Welsh Government for consideration for approval as an IMTP by the Minister. The Plan is now part of a collective review process and approval will be confirmed by June 2022.
06.06.22 Feedback from WG on the R&s plan is expected by 30.06.22

Datix ID Number: 1567 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**		**HBR Ref Number: 41** **Target Date: February 2024**	**Current Risk Rating** **4 x 4 = 16**
Objective: Best Value Outcomes		**Director Lead:** Darren Griffiths, Director of Finance & Performance **Assuring Committee:** Health and Safety Committee	
Risk: Fire Regulation Compliance 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:** May 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 4 x 4 = 16 Target: 3 x 3 = 9		**Rationale for current score:** Cladding applied to Singleton Hospital front flank is not compliant with fire regulations. General compliance with fire regulations and WHTM/WHBN requirements.	
Level of Control = 50%		**Rationale for target score:** Once sufficient resources and the cladding is replaced the risk score will reduce significantly. This will be reduced in stages as resources are implemented and cladding replaced.	
Date added to the HB risk register 31/05/2018			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Fire risk assessments. • Evacuation plans (vertical and horizontal). • Fire safety training. • Professional advice sought on compliance of panels. • East flank panels removed • Business case being developed for south panel removal and updating.	Change in fire evacuation plans and alarm and detection cause and effect	Head of Health & Safety	31/05/2022
	Replacing the existing cladding and insulation with alternative specifications and inserting 30 minute fire cavity barriers where appropriate	Service Improvement Manager	28/02/2024

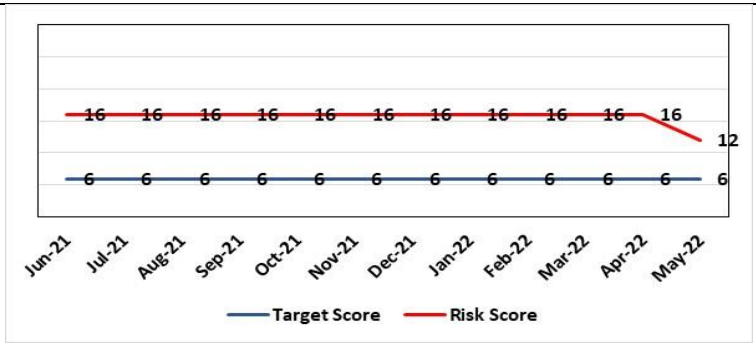
Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance** **(What additional assurances should we seek?)**
• Monitoring through the H&S committee to receive assurance and or identify gaps for key compliance and adherence to applicable legislation. • NWSSP internal audits • Site visits/tours to identify compliance and gaps in compliances. • Completion of FRA's within targeted schedule	Suitable resources to be in place, all fire risk assessments and actions from them completed. Fire safety audits carried out internally. Fire compartmentation surveyed to provide assurance of fire stopping. Fire schematics updated and fire evacuation drawings updated in in place.

Additional Comments / Progress Notes

17.01.22: Cladding project board met on 14.01.22 for an update on the progress of the cladding project, due to a number of reasons (Asbestos removal - Expert witness investigations). The latest expected completion date is March 2024. The cladding replacement works (fire integrity) is not now expected to be completed until March 2024, therefore, this will impact on the ability to reduce the risk rating at present and will be continually reviewed.

15.06.22: Currently there is no change and nothing to add.

Datix ID Number: 1514 Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety	HBR Ref Number: 43 Target Date: 31st September 2022	Current Risk Rating 3 x 4 = 12
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality and Safety Committee	
Risk: Due to a lack of Best Interest Assessor resource, there is a risk of failure to complete and authorise the assessments associated with Deprivation of Liberty/Liberty Protection Safeguards within the legally required timescales, exposing the health board to potential legal challenge and reputational damage.	**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 3 x 4 = 12 Target: 3 x 2 = 6	**Rationale for current score:** Although processes have been planned in order to reduce the breach position they have yet to be fully implemented. The impact is yet to be realised. The position will be reviewed next month.	
Level of Control = 40%	**Rationale for target score:** Consequences of DoLS breaches for the Health Board will not change. With controls in place, over time likelihood should decrease.	
Date added to the HB risk register July 2017		



Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
Additional supervisory body signatories in place – this is being undertaken as overtime using additional WG funds BIA rota now implemented but limited uptake due to inability to release staff. BIA Training undertaken for 9 nursing staff (7 within the Long Term Care Team). Able to undertake assessments utilising additional monies from WG. 1 x substantive BIA in post and additional admin post in place. 1 band 6 BIA currently being advertised. DoLS database updated and DoLS dashboard in place, monitoring applications and breaches via dedicated BIAs and Admin. Delivery of DOLS Action plan reviewed monthly Regular reporting to Mental Health and Legislative Committee (MHLC) Health Board presence at National and regional meetings relating to DoLS / LPS Increased IMCA services to support increased BIA resource Additional funding received from WG to manage the backlog of DoLS assessments and implementation of LPS. Current MCA practice reviewed to support MCA DoLS issues in practice Use of WG funding to support changes to service model. Use of WG funding to commission 250 assessments from private provider to address the backlog of DoLS assessments. Bid sent to WG to request additional funding to address the ongoing DoLS breaches expected to occur during 2022	Business case for revised service model (cannot be finalised prior to WG consultation)	Head of Nursing LPS	31/09/2022
	Agency commissioned to support backlog of assessments	GND Primary and Community	31/09/2022
	Overtime agreed to fund sign off from nurse assessor team to process the backlog assessments	GND Primary and Community	31/09/2022
	Recruitment process underway for substantive BIA	GND Primary and Community	31/05/2022

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
Regular scrutiny at Service Group and Safeguarding Committee and by DoLS Internal Audit; monitoring via DoLS Dashboard this will provide real-time accurate data. Update report to MHLC, impact of backlog of DoLS breaches and new LPS implementation	

Additional Comments / Progress Notes

03.05.2022 update
Agency Best Interest Assessor's (BIA) commissioned utilising welsh government funding.
Four experienced competent BIA's (from Liquid Personnel) began undertaking assessments from March 2022.
Weekly allocation meetings set up to track and monitor action on the backlog.
The backlog at 03/05/2022 stands at 62 referrals. It is anticipated that approximately 12 plus assessments will be completed per week.
The Dols Team Leader has arranged regular weekly coordination and allocation/peers support for each Monday morning at 10am with Liquid Personnel BIA's and will support with overseeing the Quality Assurance process required as the Supervisory Body (SB) function.
There are 6 signatories based within the Long Term Care Team that will be supporting the signatory SB functions, in focusing on clearing the Dols backlog over the subsequent months.
Additional information received from Head LPS
New legislation changes regarding Liberty Protection Safeguards (LPS) were expected in April 2022. Confirmation received from UK government December 2021 that this is to be delayed.
WG Draft code of Practice launched 17th March – 16 week consultation concludes 7th July. Health Board and regional response to be developed with LPS Head of Nursing.
Additional funding received from WG to manage the backlog of DoLS assessments and implementation of LPS have been utilised to support training and IMCA services to address the backlog. Options for a new service model have been presented and terms of reference have been drafted for a senior working group to support this work.
30.05.2022 - Liquid Personnel continue to complete approximately 5-7 per week. Current backlog is 55 to date. No changes to the risk score. No further changes to report.

Datix ID Number: 1563 Health & Care Standard: Safe Care 5.1 Access	HBR Ref Number: 48 Target Date: 31st March 2023	Current Risk Rating 4 x 4 = 16
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee:** Performance and Finance Committee, Health Board **For information:** Quality & Safety Committee	
Risk: Failure to sustain Child and Adolescent Mental Health Services	**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 4 x 2 = 8	**Rationale for current score:** Difficulties with sustainable staffing affecting performance.	
Level of Control = 50%	**Rationale for target score:** New service model and improved performance	
Date added to HB the risk register 31/05/2018		

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• Performance Scrutiny - is undertaken at monthly commissioning meetings between Swansea Bay & Cwm Taf Morgannwg University Health Boards. Improved governance - ensures that issues and concerns are discussed by all interested parties including local authorities to support the network identify local solutions. • New Service Model was established by Summer 2019 which gave further stability to service. • Staffing of service is being strengthened & supplemented by agency staff • External support secured to determine future delivery arrangements and more immediate performance improvements	The Network is seeking to recruit agency staff to fill existing and upcoming vacancies to ensure that core capacity is maximised.	Assistant Director of Strategy	05/12/2022
	Service Specification being developed.	Assistant Director of Strategy	31/07/2022
	Board to consider future delivery arrangements.	Assistant Director of Strategy	30/09/2022

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

Additional Comments / Progress Notes

Update 22.02.2022 - Potential for repatriation of CAMHS service from Cwm Taf Morgannwg HB being considered through commissioning additional external support to review.
Action complete 01.04.22 - Improvement plan has been shared by CTM and is monitored monthly. Action to mitigate the risk to young people waiting is being taken including utilisation of the third sector for support. An update went to the performance & finance committee in March.

Datix ID Number: 1761 **Health & Care Standard: Timely Care 5.1 Access**		**HBR Ref Number: 50** **Target Date: 31/07/2022**	**Current Risk Rating** **5 x 5 = 25**
Objective: Best Value Outcomes from High Quality Care		**Director Lead**: Inese Robotham, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee **For information:** Quality & Safety Committee	
Risk: Access to Cancer Services A backlog of patients now presenting with suspected cancer has accumulated during the pandemic, creating an increase in referrals into the health board which is greater than the current capacity for prompt diagnosis and treatment. Because of this there is a risk of delay in diagnosing patients with cancer, and consequent delay in commencement of treatment, which could lead to poor patient outcomes and failure to achieve targets.		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 5 x 5 = 25 Target: 4 x 3 = 12		**Rationale for current score:** Risk score updated based on being off trajectory for SCP and Backlog increasing.	
Level of Control = 70%		**Rationale for target score:** Target score reflects the challenge this area of work present the Board and where small numbers of patients impact on the potential to breach target.	
Date added to the HB risk register April 2014			

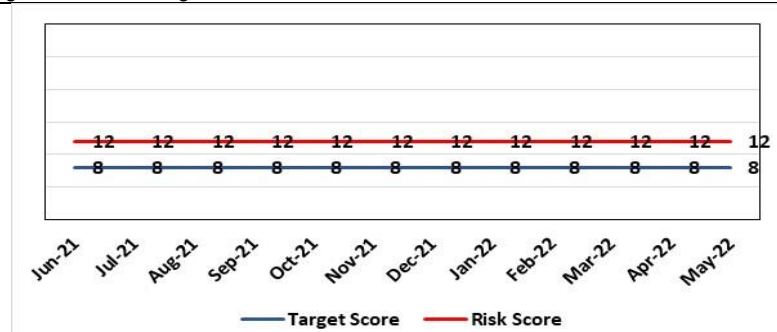
Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Tight management processes to manage each individual case on the Urgent Suspected Cancer Pathway. Enhanced monitoring & weekly monitoring of action plans for top 6 tumour sites. • Initiatives to protect surgical capacity to support USC pathways have been put in place • Additional investment in MDT coordinators, with cancer trackers appointed in April 2021. • Prioritised pathway in place to fast track USC patients. • Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. This will form part of the remit of the Cancer Performance Group. • Weekly cancer performance meetings are held for both NPTS and Morriston Service Groups by specialty. • The top 6 tumour sites of concern have developed cancer improvement plans. • Additional work being undertaken as part of diagnostic recovery and theatre recovery workstreams. • Endoscopy contract has been extended for insourcing.	Phased and sustainable solution for the required uplift in endoscopy capacity that will be key to supporting both the Urgent Suspected Cancer backlog and future cancer diagnostic demand on Endoscopy Services.	Service Group Manager	01/09/2022
	Demand & capacity plans worked through for top 6 tumour sites.	Deputy COO	30/06/2022
Assurances (How do we know if the things we are doing are having an impact?) Backlog trajectory accepted at Management Board on 15th September and trajectory will be monitored in weekly enhanced monitoring meetings. Cancer Performance Group being established to support execution of the services delivery plans for improvements.	**Gaps in assurance (What additional assurances should we seek?)** Performance and activity data monitored, but delays to treatment continue while sustainable solutions found.		

Additional Comments / Progress Notes
07.02.22 - A health board Cancer Performance Group has been established in November 2021. A work programme for the group has been established. 01.03.22 – CEO has requested zero waits over 100days by end of March 2022. Deputy COO meeting with teams with longest waits. 19.04.22 – Two actions completed - Implement a process for clinical harm review and Cancer Programme Board established. 03.05.22 – Overall there has been marked reduction in the 62+ day backlog, but in certain specialties long waits remain – see above controls in relation to improvement plans. 08.06.22 – Action added

Datix ID Number: 1759 Health & Care Standard: Staff & Resources 7.1 Workforce		HBR Ref Number: 51 Target Date: 30th September 2022	Current Risk Rating 5 x 4 = 20
Objective: Excellent Staff		**Director Lead:** Gareth Howells, Executive Director of Nursing **Assuring Committee:** Workforce and OD Committee	
Risk: Non Compliance with Nurse Staffing Levels Act (2016)		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 4 = 20 Target: 4 x 2 = 8		**Rationale for current score:** • Risk is high due to COVID related sickness and high (although improving) level of registered nursing vacancies • Service group scores remain high.	
Level of Control = 80%		**Rationale for target score:** • The Health Board is ensuring we have the structures and processes in place to provide reassurance under the Act and are allocating resources accordingly. • Health Boards are duty bound to take all reasonable steps to maintain nurse staffing levels.	
Date added to the HB risk register November 2018			

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
The Health board has put the following controls in place: • Designated person confirmed as Director of Nursing & Patient Experience. • 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. • The Ward Sister / Charge Nurse and Senior Nurse should continuously assess the situation and keep the designated person formally apprised. • The Health Board NSA Steering group continues to meet on a monthly basis, ensuring risks are presented at each meeting, chaired by the Interim Deputy Director of Nursing and reports to NMB and Workforce & Organisational Development Committee • Health Board has representation at the All-Wales Nurse Staffing Group and its sub groups • Bi-annual calculations undertaken across all acute Service Delivery Units for calculating and reporting nurse staffing requirements • Mandatory Assurance Report submitted to November Board, May Assurance Board Paper currently being prepared, for draft submission to March Nurse Staffing Group • Workforce planning & redesign, training and development. recruitment and retention continues. Weekly Workforce meeting for each Service Group, on a rotation basis, re-instated w/c 15th November 2021, every fifth week all Service groups to attend for Transformation work. • Student Streamlining and Overseas recruitment continues. • Robust roster scrutiny is undertaken to optimise nursing workforce • Implementation of SafeCare underway. Roll out to first 5 wards in MHSG commenced 1st February 2022. All Wales SOP has been supported by All Wales NSA Group and remains a working document as	Student Streamlining and Overseas recruitment	Executive Director of Nursing	15/06/2022 Monthly ongoing
	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. Implementation of Safecare, commenced 1st February, roll out plan is 32 weeks.	Executive Director of Nursing	15/06/2022 Monthly ongoing

implementation of Safecare continues and understanding evolves. • Workforce Plans have been developed by each Service Group to agree staffing in light of escalation to surge & super surge due to COVID-19, with consideration of all reasonable steps. • Service groups continue daily staffing huddles and daily staffing tool and escalate as appropriate • Risk register reviewed monthly.			
Assurances (How do we know if the things we are doing are having an impact?) • 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. • Accurate reporting of Acuity data and governance around sign off. • Agreed establishments to be funded. • E-Rostering implemented and roster scrutiny undertaken, ensuring effective staff allocation • All Wales Templates are visible informing patients/visitors of planned roster. • At least Yearly Board reports outlining compliance and any key risks. • Mandatory Assurance report to Board in May. • Monitoring arrangements • HB NSA and NMB • Patient Information available on all Section 25B wards	**Gaps in assurance (What additional assurances should we seek?)** • Issue raised regarding Information Technology barriers around the capture of data required for the Act on an All- Wales and Health Board basis. • Implementation of SafeCare end of this year potential to cause additional work at ward level, particularly around the bi-annual acuity data collection, planned support from corporate nursing team to reduce impact as much as possible. • Ongoing work across Wales to ensure IT systems are compatible with each other for operational and reporting purposes.		
Additional Comments / Progress Notes 08.04.2022 - Monthly NSA Steering Group discussed Service group risks; Primary and Community Care score = 20 with improving picture within Health visiting; currently MHSG score has increased from 16 to 20, NPTSHSG reports score at 25 further update was requested from Unit Nurse Director - issues discussed included split ward templates for ongoing cladding work, medical wards report 40% unavailability, with 18% related to sickness. Midwifery has improving picture and have re-started home births on a case by case basis. Mental Health and learning Disability risk score reported at 15. Overall Corporate risk remains at 20 and will be updated if necessary following update from NPTSHSG. 11.05.2022 - Corporate risk remained at 20 following discussions with NPTSHSG regarding the cladding work and ability to maintain nurse staffing levels with split ward templates. HB Nurse staffing meeting was held on 10.05.2022, risk scores were discussed. Reported scores are MHSH = 20, NPTSHSG = 20, Maternity services = 20, District nursing = 20, Mental Health = 20. Target score date is 30.09.2022, this date is a guide to when the risk score should improve following actions taken. Particularly around Student streamlining and improvements from a COVID-19 perspective. One action completed - Review Workforce Plan from W&OD meeting held in April 2022			

Datix ID Number: 1763 **Health & Care Standard: Staff & Resources 7.1 Workforce**		**HBR Ref Number: 52** **Target Date: 31st July 2022**	**Current Risk Rating** **4 x 3 = 12**
Objective: Partnerships for Care – Effective Governance		**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee:** Performance and Finance Committee	
Risk: The Health Board does not have sufficient resource in place to undertake engagement & impact assessment in line with strategic service change		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 = 12 Target: 4 x 2 = 8		**Rationale for current score:** • Current lack of sustainable funding source to secure capacity	
Level of Control = 50%		**Rationale for target score:** • All 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.	
Date added to the HB risk register November 2018			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Band 6 recruited to provide engagement support. • Band 8b Head of Engagement & Partnerships appointed to provide additional support for engagement. • Robust policies and processes to be in place for Impact Assessment going forward. • EIA responsibilities incorporated into planning roles going forward. • Consideration being given to temporary support.	Review of the current process for developing Equality Impact Assessments around service change, engagement and consultation.	Interim Assistant Director of Strategy	31/05/2022
	Robust policies and processes to be in place for Impact Assessment going forward.	Interim Director of Communications	31/07/2022
	Conclude work on exec equalities portfolios	Interim Assistant Director of Strategy	30/06/2022

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Equality Impact specialist advice and support to be considered as part of resourcing for engagement.	Permanent additional resources not yet available

Additional Comments / Progress Notes

Update 22.02.2022 – Due to long term absence of Assistant Director of Strategy action not completed. Will now be progressed with Director of Workforce and OD when Assistant Director returns to work.

Interim Director of Communications developing proposals to strengthen Communication and Engagement mechanisms within the Health Board which will provide further support, and reduce risk score. Timescale to be finalised.

Datix ID Number: 1762 **Health & Care Standard: Staff & Resources 7.1 Workforce**		**HBR Ref Number: 53** **Target Date: 31st December 2022**	**Current Risk Rating** **5 x 3 = 15**
Objective: Partnerships for Care		**Director Lead**: Hazel Lloyd, Interim Director of Corporate Governance **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:** May 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 3 = 15 Target: 3 x 3 = 9		**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. This position has been confirmed/verified via an independent baseline assessment.	
Level of Control = 60%		**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.	
Date added to the HB risk register November 2018			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• An independent baseline assessment of the Health Board's position against the Standards has been undertaken. This is in addition to the Health Board's own self-assessment. • Work to implement the recommendations contained within the above baseline assessment has commenced. • An online staff Welsh Language Skills Survey has been launched. • Close constructive working relationships are in place with the Welsh Language Commissioner's Office • Strong networks are in place amongst WLO across NHS Wales to inform learning and development of responses to the Standards. • 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. • Meetings of the Welsh Language Standards Delivery Group have recommenced (March 2022)	**Action**	**Lead**	**Deadline**
	Ensure the Board is fully sighted on the UHB's position through regular reporting to the Health Board.	Head of Compliance	30/06/2022
	Recruit to current vacancy within the Welsh language Translation Team	Welsh Language Officer	30/06/2022
Assurances (How do we know if the things we are doing are having an impact?) 1. Compliance with Statutory requirements outlined in Welsh Language Act and related Standards. 2. Meetings with the Welsh Language Commissioner. 3. Self-Assessment against the requirements of More Than Just Words. 4. Production of an Annual Report.	**Gaps in assurance** **(What additional assurances should we seek?)** Meetings of the Welsh Language Standards Delivery Group, which is charged with 'overseeing compliance with the Welsh Language Standards and reporting on such to the Executive Board and the Board' need to be reinstated once the Welsh Language Officer has taken up her post.		

Additional Comments / Progress Notes

March 2022 – Two actions closed – Review and update Welsh language standards and Reinstate quarterly meetings

March 2022 - Risk reviewed and updated. Meetings of the Welsh Language Standards Delivery Group have recommenced. Risk score remains unchanged.

Datix ID Number: 1799 **Health & Care Standard: Controlled Drug 2.6 Medicines Management**		**HBR Ref Number: 57** **Target Date: 1st September 2022**	**Current Risk Rating** **4 x 4 = 16**
Objective: Best Value Outcomes of High Quality Care		**Director Lead**: Richard Evans, Executive Medical Director (tb reviewed) **Assuring Committee**: Audit Committee	
Risk: Non-compliance with Home Office (HO) CD Licensing requirements. The Health Board (HB) currently has limited assurance regarding compliance with HO CD Licensing requirements, nor does it have processes in place in respect of future service change compliance.		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 2 = 8		**Rationale for current score:** Risk: That the HB is operating in breach of the law by managing CDs without an appropriate HO CD License. Legal advice received has indicated that failure to comply with the HO CD licensing requirements could result in criminal and civil action, both against responsible individuals and the HB as a public body. The HB ratified a policy to determine requirements for HO Licenses in August 2020 however the content of the policy differs from HO advice received to date – the HB are awaiting response from the HO having shared a copy of this policy and have asked for a meeting to discuss differences in opinion. As such then, the risk of non-compliance with HO direction and associated consequences still stand. Risk: That the HB is maintaining unnecessary HO CD Licenses. Each HO CD license costs around £3k plus additional administrative set-up and maintenance costs.	
Level of Control = 40%			
Date added to the HB risk register January 2019		**Rationale for target score:** Following either the HO agreeing with the content of the HB 'Policy to determine the requirement for HO CD Licenses,' or a position of compromise being agreed there will be a training session held with all Service Groups supported at Executive level.	

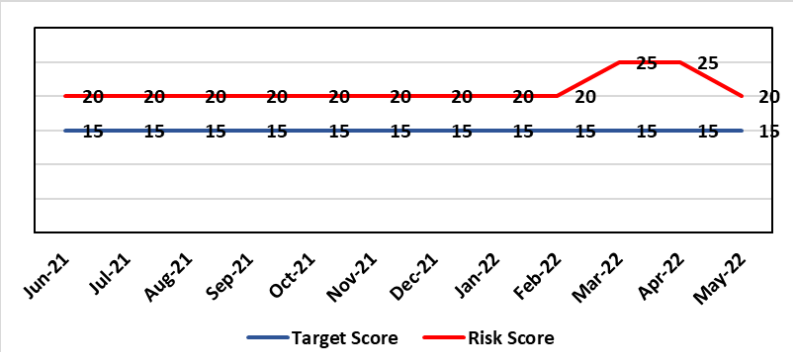
Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
PW, Director of Corporate Governance, has formally written to the HO to share a copy of the HB's, 'Policy to determine the requirement for HO CD Licenses,' and to ask for a meeting at their earliest convenience to discuss difference of opinion regarding number and nature of licenses required. In the meantime, in response to difficulties sourcing CDs from the pharmaceutical wholesale system for HMP Swansea due to uncertainty around whether a HO CD license is required at this site, the HB have decided to apply for such a license. This decision, whilst not in line with above HB policy, does follow HO direction and is anticipated will result in resumption of normal supply of CDs to HMP Swansea. Additionally, the CD Accountable Officer is currently working with Service Group Triumvirates to strengthen CD Governance. This will provide an opportunity to expedite some of the actions outlined in this register entry once position agreed with HO.	HB to discuss and agree a policy position on the requirements for HO CD Licenses with the HO.	CD Pharmacy	01/09/2022
	Upon agreement of policy with the HO: HB to undertake baseline assessment of current CD management (including any HO CD licenses currently held) in line with agreed policy on requirements for HO CD licenses	CD Pharmacy	01/09/2022
	Upon agreement of policy with the HO: HB to develop and implement a control system to ensure compliance with agreed policy on HO license requirements.	CD Pharmacy	01/09/2022

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
The HB policy on HO CD licenses is referred to when issues are raised in order to provide consistency in arrangements.	The HB will develop a license compliance register, this is expected to be maintained by the Corporate Governance Team thus ensuring there is sufficient segregation of duty.

Additional Comments / Progress Notes
We are awaiting advice from the Home Office. The intention is review this risk following receipt of that advice with a view to de-escalating if appropriate. Update 12/04/22 – The Director of Corporate Governance has contacted the Home Office but no official reply to date regarding the Health Board's Home Office CD License policy position. Home Office conducted a visit 15/03/22 at HMP Swansea in relation to the application for a Home Office CD license for HMPS. Action complete - Apply for a HO CD License for HMP Swansea. – Awarded 31/03/2022 subject to invoice payment. Update 18.05.22 - No change since previous update of 12.04.22.

Datix ID Number: 146 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**		**HBR Ref Number: 58** **Target Date: 30/09/2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Excellent Patient Outcomes		**Director Lead**: Inese Robotham, Chief Operating Officer **Assuring Committee**: Quality and Safety Committee	
Risk: Failure to provide adequate clinic capacity for follow-up patients **Ophthalmology** results in a delay in treatment and potential risk of sight loss.		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 5 = 20 Target: 4 x 2 = 8		**Rationale for current score:** Risk rating increased to 20 in July 2020 due to Covid-19 pandemic backlog has continued to grow.	
Level of Control = 40%		**Rationale for target score:** Mitigation plan via outsourcing will reduce the backlog to pre-covid levels.	
Date added to the HB risk register December 2014			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• All patients are categorised by condition in order to quantify issue. • Community optometry scheme successfully implemented to reduce number of diabetic retinopathy patients on follow up list. • Scheme developed for assessment of glaucoma patients by community optometrists for virtual review by consultant ophthalmologists to reduce follow up backlog. • Outsourcing of cataract activity to reduce overall service pressures.	An overall Regional Sustainability Plan to be delivered	Service Group Manager Surgical Specialties	31/03/2023
Assurances **(How do we know if the things we are doing are having an impact?)** • Deputy COO holds Gold Command meetings on a monthly basis to monitor progress.	**Gaps in assurance** **(What additional assurances should we seek?)** Regular liaison with patients on extended waiting list/times and validation.		
Additional Comments / Progress Notes			

Datix ID Number: 2003 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**HBR Ref Number: 60** **Target Date: 31st December 2022**	**Current Risk Rating** **5 x 4 = 20**
Objective: **Digitally Enabled Care**	**Director Lead:** Matt John, Director of Digital **Assuring Committee:** Audit Committee	
Risk: Cyber Security - high level risk The level of cyber security incidents is at an unprecedented level and health is a known target. The health board's digital services (users, devices and systems) increases year on year and therefore the impact of a cyber-security attack is much higher than in previous years. Risks of large fines associated with outages of systems and loss of data with associated UK regulations. The largest risks to the organisation are on user awareness, unsupported software and devices not managed by the ICT department, for example medical devices. The risk of a cyber-attack has increased globally as a result of the Russian invasion of Ukraine, and the use of Russian software in the Health Board	**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x ~~5~~ 4 = ~~25~~ 20 Target: 5 x 3 = 15		**Rationale for current score: C and L** Global tensions have increased the risk of cyber-attack, along with the use of Russian Security Software in the Health Board now posing additional risk. The Ireland Health Service were subjected to a ransomware attack (May 2021) by a Russian gang. The increase in users and devices increases the threat landscape. Mandatory training not adopted to date. New Risk Factors • Cyber Warfare- Increased risk of Cyber Security war directly or indirectly impacting SBU • Kaspersky- Russian Security Software on all SBU Desktops and Servers
Level of Control **Date added to the HB risk register** July 2019		**Rationale for target score:** C- Will remain the same or increase due to increased reliance in information L- The overall likelihood score would decrease to 3 if mandatory Cyber Security training is achieved and implemented across the Health Board

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Cyber Security Manager and Cyber Team in place, proactive approach to cyber security adopted. National and security tools in place which actively protect digital services, highlight vulnerabilities and provide warnings when potential attacks are occurring. A patching regime has been in place for which ensures desktops, laptops and servers are protected against any known security vulnerabilities. Work ongoing to replace out of date systems. • Complete annual Cyber Security Assessment as part of annual NIS compliance work with Cyber Resilience Unit in DHCW	Decommission Kaspersky infrastructure following removal of Kaspersky from all Clients/Servers	Cyber Security Manager	Complete
	Adopt mandatory Cyber training across SBUHB, or identify alternative options- WG Procurement underway for national solution.	Assistant Director of Digital Technology	30th June 2022 Ongoing awaiting national update

• Digital Services Management Group established to ensure systems are compliant with security standards. Cyber Security training and phishing stimulation in place to increase staff awareness. • Digital Tactical Command and Control response to increased risk – Increasing defences and removing Kaspersky Security software from all servers and desktops.	Complete an Improvement Plan based on the Assurance Report from the Cyber Security Resilience Unit	Cyber Security Manager	31st May 2022
Assurances (How do we know if the things we are doing are having an impact?) Submissions of the Cyber Assessment Framework response to the Cyber Resilience Unit (onto Welsh Government) as part of NIS compliance will identify recommendations and actions to undertake as part of an annual assessment and continuous improvement cycle.	**Gaps in assurance (What additional assurances should we seek?)** Cyber Security Training is not mandatory and the biggest risk is our staff's awareness to identify phishing/scam emails and malicious websites. CTM Princess of Wales devices still on SBU network but running Kaspersky – negotiated removal of Kaspersky with CTM with plan to remove and manage with Defender by 20/05/22		
Additional Comments / Progress Notes Update 14.04.2022 – 3 actions completed: • Complete subsequent Cyber Security Assessment as part of annual NIS compliance work with Cyber Resilience Unit in DHCW. • Set up Digital Tactical Command and Control • Develop a mitigating plan to manage the Kaspersky risk Replacement of Kaspersky on all SBU Laptops/Desktops. Update 17.05.2022 - Welsh Government confirmed ongoing procurement of a National Training Package for Cyber Security training – expectation Welsh Government will make its use mandatory. Update Post Management Board 15.06.2022: Risk level reduced following decommissioning of Kaspersky infrastructure.			

Datix ID Number: 1587 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 61** **Target Date: 1st June 2022**	**Current Risk Rating** **4 X 4 = 16**
Objective: Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morriston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies.		**Director Lead:** Inese Robotham, Chief Operating Officer **Assuring Committee:** Quality and Safety Committee/Strategy Planning and Commissioning Committee	
Risk: Paediatric dental GA/Sedation services provided under contract from Parkway Clinic, Swansea. Medical Safety risk GAs performed on children outside of an acute hospital setting.		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 4 x 4 = 16 Target: 4 x 2 = 8		**Rationale for current score:** There is no immediate access to crash team/ICU facilities in in Parkway Clinic – the client group are undergoing G/A/sedation. Paediatric GA/Sedation services provided under contract from Parkway Clinic, Swansea continue due to lack of capacity for these patients to be accommodated in Secondary Care	
Level of Control = 60%		**Rationale for target score:** Relocation of the paediatric GA service [provided by Parkway Clinic] to a hospital site being treated as a priority	
Date added to the HB risk register 4th July 2018			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
Consultant Anaesthetist present for every General Anaesthetic clinic. Assurance Documentation supplied by Parkway Clinic including confirmation of arrangements in place with WAST and Morriston Hospital for transfer and treatment of patients New care pathway implemented - no direct referrals to provider for GA. Multi-drug sedation ceased from Sep 2018 in line with WHC 2018 009 Revised SLA/Service Specification HIW Inspection Visit Documentation provided to HB All extended GA cases require approval from paediatric specialist prior to treatment	**Action**	**Lead**	**Deadline**
	Transfer of services from Parkway.	Interim Head of Primary Care	31/05/2023

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
RMC collate referral and treatment outcome data for review by Paediatric Specialist Regular clinical meeting arranged with Parkway to discuss individual cases/concerns Regular clinical/ management meeting for CDS/primary care management team to discuss service pathway /concerns/issues arising Roll out of new pathway to encompass urgent referrals T&F Group established to lead transfer from community centre to MHSDU.	ToR for the task and finish group should continue to include consideration of the pressures on the POW special care dental GA list and this service is considered alongside any plans for the Parkway contract.

Additional Comments / Progress Notes

25.04.2022 Update - Current position reviewed at Senior Management Board April 2022. Extension agreed until 31st May 2023 due to current theatre challenges. Agree repatriation remains a priority and to be included in theatre planning. Deputy COO to re-establish TFG.

Datix ID Number: 1605 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 63** **Target Date: 30th June 2022**	**Current Risk Rating** 4 X 4 = 16
Objective: Screening for Fetal Growth Assessment in line with Gap-Grow (G&G)		**Director Lead**: Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality and Safety Committee	
Risk: There is not enough Ultrasound capacity within Swansea Bay UHB to offer all women serial ultrasound scan screening in the third trimester in line with the UK perinatal Institute Growth Assessment Programme (GAP). Welsh Government mandate fetal growth screening in line with the GAP programme. There is significant evidence of the increased risk for stillbirth or neonatal mortality/morbidity (hypoxic ischaemic encephalopathy (HIE)), where a fetus is growth restricted (IUGR) and/or small for gestational age fetus (SGA). Identification and appropriate management for IUGR/SGA in pregnancy will lead to improved outcomes for babies.		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x ~~5~~ 4 = ~~20~~ 16 Target: 3 x 4 = 12 **Level of Control** = 60% **Date added to the HB risk register** 1st August 2019		**Rationale for current score:** Although the frequency of stillbirth is low the health board are up to 10% above the national rate for stillbirth as published by MBRRACE. Although infrequent when IUGR/SGA baby is stillborn or diagnosed hypoxic ischaemic encephalopathy (HIE) which is deemed avoidable this impacts on: • the wellbeing of families • can lead to high value claims • loss of reputation and adverse publicity for the health board. *See also Progress Notes below* **Rationale for target score:** When the service is able to provide third trimester ultrasound scan in line with GAP recommendations we will be providing care in line with evidence based best national practice as mandated by Welsh Government.	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
All staff are required to complete the GAP e-learning on an annual basis. Compliance is monitored via the Training & Education forum. All staff have received an email to present their certificate for 2021/22 A local policy is in place to identify the priority risk factors for the offer of serial growth scans while there is not enough capacity Health board maternity ultrasound group convened to develop future services Training 4 midwives for an advanced practice role in ultrasound scanning to reduce capacity gap Introduction of midwife third trimester scan service will increase USS capacity by a minimum 2,200 scans per annum (50 scans per week/44 weeks) commencing April 2022 Two midwives have commenced Ultrasound training course in UWE January 2022, in order to ensure sustainable service provision Two additional ultrasound rooms are fully equipped toward increased scan capacity	All staff to submit GAP training certificates by 31/05/2022	Deputy Head of Midwifery	31/05/2022
	Administration for midwife sonographer clinics to be secured to ensure streamlined service	Maternity service business manager	30/06/2022
	Complete the governance framework for third trimester scanning to include CPD programme	Deputy Head of Midwifery	31/05/2022
	Two midwives to complete UWE course December 2022	Deputy Head of Midwifery	31/12/2022
Assurances (How do we know if the things we are doing are having an impact?) The third trimester ultrasound capacity will increase by a minimum 2200 scans per annum in year one increasing to 4400 in year 2. The detection rate of IUGR/SGA will increase leading to improved	**Gaps in assurance (What additional assurances should we seek?)** Assurance of maintaining a sustainable third trimester ultrasound service.		

antenatal management plans and intrapartum planning. We will report a reduced rate of stillbirth and/or neonatal mortality/morbidity with improved management of IUGR/SGA babies.	

Additional Comments / Progress Notes

March 2022 an all Wales group convened led by HEIW and National Imaging Academy (NIA), to support advance practice for ultrasound scan in Wales. SBU maternity services will be key stakeholders within this group to ensure ongoing USS service developments to meet future capacity & demand.

27/05/2022 - Midwife sonographer third trimester scanning lists have been added to WPAS, negotiations with central admin team to administer the clinics are ongoing.

There are now 2 fully functioning ultra-scan rooms with the ability to upload images to PACS. Lead midwife sonographer and radiology lead are developing a governance group who will link in to health board radiology governance group.

07/06/2022- due to the trained midwife sonographer role improved capacity for ultrasound scan referral within requisite timeframes with reduced incidents for non-completion of USS. Joint radiology/maternity operational governance group convened who will report into the health board radiology governance group and maternity Q&S group. USS scan schedules returned to pre-Covid pandemic schedules in line with local policy. Business case to be prepared for service in NPT on completion of current trainee midwife sonographers programme (December 2022). This will ensure equity of service across the HB and ensure women receive care close to their home.

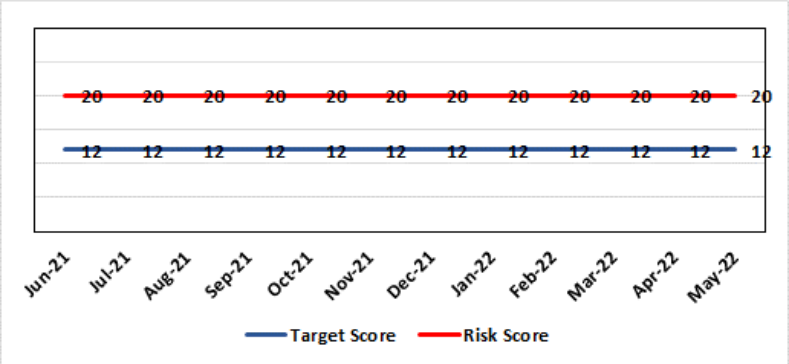
Datix ID Number: 2159 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**		**HBR Ref Number: 64** **Target Date: 31st October 2022**	**Current Risk Rating** **5 X 5 = 25**
Objective: Best Value Outcomes		**Director Lead:** Darren Griffiths, Director of Finance & Performance **Assuring Committee:** Health and Safety Committee	
Risk: Insufficient resource and capacity of the health, safety and fire function within SBUHB to maintain legislative and regulatory compliance for the workforce and for the sites across SBUHB. .		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 5 = 25 Target: 4 x 3 = 12		**Rationale for current score:** The Health Board received 12 Health & Safety Executive (HSE) improvement notices during 2019-20 covering various Health & Safety legislative breaches covering a range of areas. There is the potential for future multiple notices for not meeting legislative requirements. Possible reduction in score once two new posts are filled.	
Level of Control = 70%		**Rationale for target score:** Compliance with the notices and to have sufficient resources to implement a sustainable health and safety provision to support the legal requirements of the Health Board and demonstrate that suitable resources are in place to undertake the roles and responsibilities of the department, and to undertake suitable and sufficient training, provide corporate overview/audit to ensure practices are being employed in the workplace.	
Date added to the HB risk register September 2019			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Assistant Director of Health and Safety in post to support strengthening and develop the H&S function to support the organisation. Business case submitted for additional resources. • Health and Safety Operational Group and the Health and Safety Committee monitor compliance. Refreshed the Fire Safety Group with additional controls in place. • Fire risk assessments are being prioritised with temporary additional resources put in place in March 2021 to reduce the number of FRA overdue. • Fire training in place and fire wardens in place • Fire risk assessment schedule in place for the next 12 months to maintain 100% compliance of completion and is regularly reviewed	Health and safety structure review to be presented to the H&S Committee when funding has been agreed. The Target date has been adjusted to reflect this.	Assistant Director of H&S	30/09/2022
Assurances (How do we know if the things we are doing are having an impact?) • Monitoring through the appropriate group/committees (H&S committee) to receive assurance and or identify gaps for key compliance and adherence to applicable legislation. • Site visits/tours to identify compliance and gaps in compliances.	**Gaps in assurance (What additional assurances should we seek?)** Agreement of funding for resources identified in business case to implement structure in business case by Q2/3 2022/23 financial year.		

Additional Comments / Progress Notes

04.05.22 - It has been agreed by the health board to recruit one H&S Advisor and one Manual Handling Trainer/Advisor. Verifications form completed and post will be advertised in Q1 2022/23, with an end Q1 or beginning of Q2 for successful candidates to commence. Given that the posts will take time to have any impact on training and audit, it is possible that the risk score can be reduced slightly in 6 months' time after successful recruitment with a targeted reduction in Q4.

15.06.22 - H&S advisor and MH adviser/trainer will be uploaded to Trac in June, interview dates in July with targeted commencement in Aug/Sept 2022.

Datix ID Number: 329 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 65** **Target Date: 31st October 2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Digitally enabled Care		**Director Lead**: Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality & Safety Committee	
Risk: Misinterpretation of cardiotocograph and failure to take appropriate action is a leading cause for poor outcomes in obstetric care leading to high value claims. The requirement to retain maternity records and CTG traces for 25 years leads to the fading/degradation of the paper trace and in some instances traces have been lost from records which makes defence of claims difficult.		**Date last reviewed:** May 2022 **Rationale for current score:** The K2 central monitoring system has been purchased by the health board however is not yet installed. A project team is being established to ensure oversight of installation and training. Full use of the system will be available from December 2022 when the risk will reduce as appropriate.	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 5 = 20 Target: 4 x 2 = 8 **Level of Control** = 50% **Date added to the HB risk register** 31st December 2011		**Rationale for target score:** A central monitoring station will enable senior clinicians to support decision making across the service, and from home, leading to senior involvement in management decisions toward improved outcomes. All CTG traces will be stored electronically and therefore will not fade and cannot be lost.	
Controls (What are we currently doing about the risk?)		**Mitigating actions (What more should we do?)**	
All staff receive annual training in fetal surveillance as mandated by Welsh Government. SBU have appointed a midwife and obstetric lead for training and development of staff Compliance with training is reported annually in 2021/2022 the training year has been extended due to the service ability to release staff for training A "fresh eyes" protocol in place requiring intrapartum CTG classification hourly by two clinicians which is monitored via audit of records A "jump call" policy is available to request additional support where there is disagreement over CTG classification CTG prompt labels in use to support staff with CTG categorisation.		**Action**	**Lead** / **Deadline**
		Fetal surveillance leads to set up training team for transition to use of electronic labour record. TNA analysis to be completed for all staff	Fetal surveillance leads / 31/12/2022
		For the project Board to complete a risk assessment to manage the changeover from paper based to electronic monitoring to ensure all risks are captured	Project Board / 31/07/2022
Assurances (How do we know if the things we are doing are having an impact?) All Wales Fetal Surveillance Standards for 6hrs Fetal Surveillance Training per year		**Gaps in assurance (What additional assurances should we seek?)** Assurance all staff are able to transition to a new way of working	
Additional Comments / Progress Notes 27/05/2022 - Project board has held first meeting. Projected installation date December 2022- January 2023. SIGNAL installation to coincide in January 2023. 7/06/2022 – Project group have held first meeting, development of sub groups. Training sub group essential to ensure all staff are able to transition to new way of working. Highlighted as a key action.			

Datix ID Number: 1834 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 66** **Target Date: 31st January 2023**	**Current Risk Rating** **5 X 4 = 20**
Objective: Best values outcomes from high quality care		**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee:** Quality and Safety Committee	
Risk: The demand & complexity of planned treatment regime for cancer patients requiring chemotherapy currently exceed the available chair capacity, risking unacceptable delays in access to SACT treatment in Chemotherapy Day Unit with impact on targets and patient outcomes.		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 4 = 20 Target: 2 x 2 = 4		**Rationale for current score:** Reduced risk to 20 as plan agreed for homecare service and plan for increasing chairs going forward.	
Level of Control =			
Date added to the HB risk register 30/11/2019		**Rationale for target score:** Reduced delays in treatment will reduce risk of harm.	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Review of CDU by improvement science practitioner was completed in 2020. Resulted in change to booking processes to streamline booking process and deferral. Review of scheduling by staff to ensure all chairs used appropriately. Business case endorsed by CEO for shift of capacity to home care to be considered by the Management Board A Daily scrutinizing process in progress to micro manage individual cases, deferrals etc	Business Case for phase 2 home care expansion based on moving further treatments to community service. Paper with CEO for comments, prior to going to BCAG	Associate Service Group Director – Cancer Division	30th September 2022
	Paper to support extended day working every Saturday	Service Director Lead for Cancer	30th June 2022
	Relocation of SACT linked to AMSR programme and phase 2 of home care expansion case brought forward	Service Director Lead for Cancer	January 2023 (dependant on AMSR moving Sept 2022)

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Additional funding agreed to support increase in nurse establishment to appropriately staff the unit during its main opening hours. Additional scheduling staff also agreed. Pre-assessment process has been separated from start date in an attempt to fill deferral slots at short notice where possible. Improved communication between MDT to streamline booking and deferral process. Continue to monitor patient experience via friends and family and under our PTR procedures. Monitoring our waiting times against new SACT metrics, which is a measure based on treatment intent and is no longer reported as average waiting time so is more linked to expected outcomes	Capital & Revenue assumptions & resources for second business case for increasing chair capacity in 2022/23 to meet increased demand.

etc. This performanee metric is included in our Cancer Performance report we send to WG and Management Board and internally via governance arrangements with NPTSSG where Oncology services sit.	

Additional Comments / Progress Notes

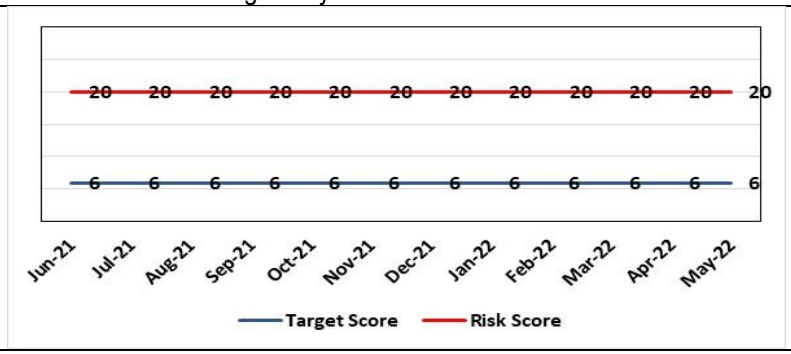
15.03.22 We now appointed a dedicated SACT QI practitioner to work with team. The post holder will be responsible for establishing efficient, effective and equitable pathways for SACT treatment with a focus on quality improvement to improve patient access for SACT treatments and compliance with performance metrics. Awaiting Start date provisional looking at June 22.
2 Actions closed - Business case endorsed by CEO for shift of capacity to home care to be considered by the Management Board (Phase 1 complete). A second business case is being developed to propose relocation of CDU to a vacant ward area, which would increase chair capacity.
11/05/22 - Phase 1 case still remains not fully recruited to, 1wte pharmacy post short have been out to advert twice, have gone back out to advert. In the meantime team have been asked to confirm how much of workload can be moved into Home care with current resources in post and whether this shift which was planned to commence in Qtr 2 is now locked down.
Phase 2 of the case is under full review as new Deputy Head of Nursing who commenced in post end of April has identified some internal efficiency gains linked to our booking process and our pre-assessment pathway both changes are being implemented. Booking process has commenced. Pre-assessment changes planned for end of May 2022.
19/05/2022 - New booking system implemented to avoid block booking treatment for dates in advance. Each treatment cycle will be booked 1 at a time to release capacity in the treatment diary.

Datix ID Number: 89 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 67** **Target Date: 31st October 2022**	**Current Risk Rating** **5 X 3 = 15**
Objective: Best values outcomes from high quality care		**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee:** Quality and Safety Committee	
Risk: Clinical risk-target breeches in the provision of radical radiotherapy treatment. Due to capacity and demand issues the department is experiencing target breaches in the provision of radical radiotherapy treatment to patients.		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 3 = 15 Target: 2 x 2 = 4		**Rationale for current score:** Waiting times deteriorating for elective delays patients, particularly prostates discussed in Oncology business meeting. Current Risk reduced to 15. At present 70 patients to be outsourced which increases capacity. New Linac building work underway, which will increase capacity in near future	
Level of Control =			
Date added to the HB risk register 30/11/2019		**Rationale for target score:** Reduced delays in treatment will reduce risk of harm	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Implementation of revised radiotherapy regimes for specific tumour sites, designed to enhance patient experience and increase capacity. Breast hypo fractionation in place. Requests for treatment and treatment dates monitored by senior management team. Protected capacity rate set as part of 2020/21 Operational Plan. Outsourcing of appropriate radiotherapy cases. Additional outsourcing for Prostate RT commenced June 2021.	New Linac required – Linac case agreed with WG	Service Manager Cancer Services	01/07/2022
Assurances **(How do we know if the things we are doing are having an impact?)** Performance and activity data is being monitored and monthly data shared with radiotherapy management meeting and cancer board. It is also now included in scorecard.	**Gaps in assurance** **(What additional assurances should we seek?)** Performance and activity data monitored, but delays to treatment continue while sustainable solutions found.		

Additional Comments / Progress Notes

15.03.22 -new linac replacement work remains on track to be clinically operational end of June 22
Still waiting on update from Hywel Dda around supporting prostate Hypo fractionation case. Decision received by Hywel Dda to enable us to proceed. Meeting set up with Surgical colleagues across Hywel Dda and SBU to plan the implementation of the revised pathway and for workforce to be appointed to. Plan to have first patient Hypo Fractionated by Sept 2022.
Action Complete - Explore the possibility of undertaking SABR treatment for lung cancer patients at SWWCC. First SABR patient to be treated in April.
Action complete - Hypofractionated Prostate - Business plan submitted for additional resources required to implement hypofractionated technique.

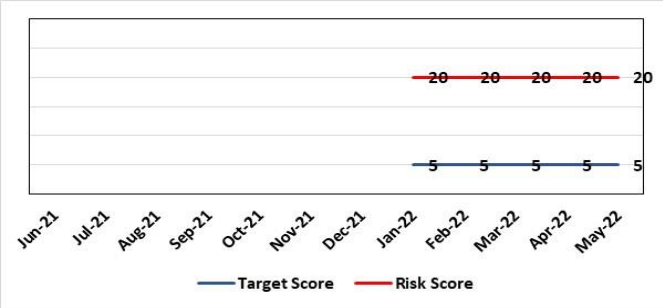
Datix ID Number: 1418 **Health & Care Standard: 5.1 Timely Access**		**HBR Ref Number: 69** **Target Date: 1st July 2022**	**Current Risk Rating** **5 X 4 = 20**
Objective: Best values outcomes from high quality care		**Director Lead**: Inese Robotham, Chief Operating Officer / Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality & Safety Committee	
Risk: Risk issues related to **adolescent patients being admitted to Adult MH inpatient wards**- Inappropriate settings resulting in 'Safeguarding Issues' The WG has requested that HBs identify Secondary Care in -patient facilities for the care of adolescents- in Swansea Bay University Health Board Ward F NPT hospital is the dedicated receiving facility with one bed identified.		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 2 x 3 = 6 Current:5 x 4 = 20 Target: 2 x 3 = 6		**Rationale for current score:** Every health board is required to have an admission facility for adolescent MH patients. Whilst ward F has been identified as the single point of access in SBU and a dedicated bed is ring-fenced for adolescent admissions it is a mixed sex adult ward. Therefore the facilities are less than ideal for young patients in crisis.	
Level of Control =			
Date added to the HB risk register 27/02/2020		**Rationale for target score:**	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Safeguarding Training for Staff, Joint protocol with Cwm Taf LHB [CAMHS] currently subject to review, Local SBUHB policy on providing care to young people in this environment. This includes the requirement for all such patients on admission to be subject to Level 3 Safe and Supportive observations. Only Adolescents within 16-18 age range are admitted to the adult ward. The health board works with CAMHS to make sure that the length of stay is as short as possible.	The service group will review the effectiveness of current controls.	MH&LD Head of Operations & Clinical Directors	1st July 2022
Assurances (How do we know if the things we are doing are having an impact?) Individual Rooms with en Suite Facilities, Joint working with CAMHS, Monitoring of staff training, Monitoring of admissions by the MH & LD SG legislative Committee of the HB. The ongoing issues with the risks presented by the use of this has recently been raised at an all Wales level with Welsh Government and a formal review is anticipated. The Service Group continues to flag the risk particularly in light of Ward F being identified as the SPOA for AMH in the HB which has resulted in an increase in acuity and a greater concentration of individuals who are experiencing the early crisis of admission - this has served to increase the already identified risks for young people in the environment.	**Gaps in assurance (What additional assurances should we seek?)**		

Additional Comments / Progress Notes

01/02/2022: Risk reviewed and score remains 20. Controls are in place to mitigate this risk as far as possible. The only alternative to the current arrangement of the emergency bed for CAMHS in each Board would be to open up the tertiary centre (Ty Lydiard) for these admissions. This would require agreement across all health boards and the assessment of demand to justify costs.

19/04/2022 – Nurse Director, Director of Strategy and Service Director have met with WHSCC colleagues to review recent admissions and identify lessons learned to include review and publication of admission criteria for Tier 4 CAMHS Unit.

Datix ID Number: 2449 **Health & Care Standard: 2.1.1 Managing Financial Risk**		**HBR Ref Number: 72** **Target Date: 30th September 2022**	**Current Risk Rating** **4 X 5 = 20**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Darren Griffiths, Director of Finance **Assuring Committee:** Performance and Finance Committee	
Risk: Reduced discretionary capital funds and reduced National NHS funds requiring a restricted Capital Plan for 2022-23		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 5 x 1 = 5		**Rationale for current score:** • The Health Board has been advised that its discretionary capital allocation for 2022/23 as been reduced from £11.1m to £8.5m. • The funding available within the Capital Resource Limit (CRL) will not meet the demands for capital investment. Discretionary capital is deployed to replace ageing medical devices & equipment; to address backlog maintenance of premises; and to support small scale, non-National service improvements with capital investments • The current Health Board assessment of the carry forward and previously agreed commitments for inclusion in the 2022/23 capital plan currently suggests a requirement for an additional £7.5m to balance the plan. • It is likely that due to slippage on capital schemes, this over-commitment will reduce. • There is potential for further capital requirements arising from service model changes which will need to be managed. • Potential consequences of this risk are the inability to achieve the ambitions set out within health board plans; the potential failure of ageing equipment leading to service disruption; the exposure to potential environmental health & safety risks. • The plan has been balanced with £5m of planned spend on hold. This spend could be released if slippage identified in year. CRL will be met but the funding remains insufficient to meet Health Board needs.	
Level of Control = 25%		**Rationale for target score:** The target score expresses the aspiration of the health board for addressing this risk. The target date indicated above reflects the point which the current actions are anticipated to reduce the risk, though knowledge of the actual funding available is required to reduce it further and this is not available until some months into the financial year.	
Date added to the risk register January 2022 (re-opened)			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
The Health Board is doing the following: - • Regular dialogue with Welsh Government regarding capital requirements. • Clear communication and reporting of the capital position, the risks and limitations. • Close management of all schemes to ensure slippage is understood along with the impact on service. • Clear prioritisation of any new requirements recognising the current constraints	**Action**	**Lead**	**Deadline**
	Routine review and flexing of plan as spending is committed through the year. Routine monitoring processes will identify any potential slippage and will deploy this on risk based basis.	Director of Finance & Performance	Monthly throughout financial year

• Routine assessment of local demands for discretionary capital spend through internal capital prioritization group which meets monthly.			
Assurances (How do we know if the things we are doing are having an impact?) The Health Board capital position is reviewed and monitored through: • Monthly capital prioritisation group • Performance and Finance Committee monthly finance report • Monthly Monitoring Returns to Welsh Government.	**Gaps in assurance (What additional assurances should we seek?)** Reporting on impact of constraints to the capital programme on service delivery.		
Additional Comments / Progress Notes The risks of not being able to deliver a balanced CRL has been mitigated through the Board-approved balanced plan. The ongoing risk reflected in this score relates to the capital available being considerably less than the expenditure required to meet the Health Board's needs in 2022/23. Actions complete – Apprise Welsh Government of content of revised capital plan to consider possibilities of support for key areas and formal review of existing capital plan to revise schemes and scheduling of schemes to move to balance.			

Datix ID Number: 2450 Health & Care Standard: 2.1.1 Managing Financial Risk	HBR Ref Number: 73 Target Date: 31st May 2022	Current Risk Rating 5 x 4 = 20
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Darren Griffiths. Director of Finance **Assuring Committee:** Performance and Finance Committee	
Risk: The Health Board underlying financial position may be detrimentally impacted by the COVID-19 pandemic. There is a potential for a residual cost base increase post COVID-19 as a result of changes to service delivery models and ways of working.	**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 5 x 1 = 5		**Rationale for current score:** • There is a potential for a residual cost base increase post COVID-19 as a result of changes to service delivery models and ways of working - Risk Rated 20 • The residual cost base risk remains difficult to assess as the Health Board continues to respond to the impact of the pandemic (a formal review was started in February 2022 of all costs and their ability to be managed out and this is being refreshed following receipt of more detailed guidance on COVID response costs handling received from Welsh Government on 14th March 2022). The outcome of this work will feed the funding request process for 2022/23. • As the Health Board moves out of direct COVID response and into COVID recovery there remains a real risk that some additional cost and some service change cost could be part of the run rate of the Health Board and this could be exposed when additional funding ceases. • Welsh Government has indicated that the funding available for COIVD response in 2020/21 and 2021/22 will be restricted only to vaccination, TTP and PPE for 2022/23 thereby rendering any cost remaining within the Health Board a matter for the Health Board to address.
Level of Control = 25%		
Date added to the HB risk register July 2020		**Rationale for target score:** Mitigating actions around delivering efficiency opportunities and service changes will reduce likelihood of the risk emerging alongside improved systems of control.

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
The Health Board is doing the following: - • Finance Review Meetings with Units to agree cost exit plans • Transparent exchange of position with Finance Delivery Unit & Welsh Government • Clear financial plan being developed for 2022/23	Appraise Welsh Government of content of revised revenue plan to consider possibilities of support for key areas.	DoF&P	Review with Welsh Government 03/02/2022 - Complete with the analysis informing National handling. Discussion will be held with WG and FDU following submission of HB 3-year plan. target for resolution 31st May 2022 .

	WG has informed HB's that reasonable COVID response costs can be assumed to be covered by additional financial allocation in 2022/23. This will be shared with WG and FDU through April 2022 and May 2022. Final outcome expected at the end of this period.	DoF&P	31/05/2022
Assurances (How do we know if the things we are doing are having an impact?) The Health Board financial performance is reviewed and monitored through: • Monthly financial recovery meetings • Performance and Finance Committee • Routine reporting to Board of most recent monthly position and financial forecasts	**Gaps in assurance (What additional assurances should we seek?)** Reporting on savings opportunities and service change impacts to be developed.		
Additional Comments / Progress Notes 31.03.2022: The risk remains at 20 as whilst WG has confirmed allocations can be assumed, this based on funding available for 5 categories of cost. The scrutiny of these categories of cost will inform the level of funding to be allocated. There remains a risk that the funds to be allocated may not meet the cost within the Health Board and this will affect the balance of the financial plan if it cannot be mitigated. Action complete - All Wales work through Directors of Finance to benchmark costs and work with WG on solutions.			

Datix ID Number: 2595 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**	**HBR Ref Number: 74** **Target Date: 31st October 2022**	**Current Risk Rating** **5 X 4 = 20**
Objective: Best Value Outcomes from High Quality Care	**Director Lead**: Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality and Safety Committee	
Risk: Delay in Induction of Labour (IOL) or augmentation of Labour Delays in IOL can introduce avoidable risk and unnecessary intervention which can lead to poor clinical outcome for mother and/or baby. Delays in IOL lead to increased complaints and decreased patient satisfaction.	**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 4 = 20 Target: 2 x 3 = 6 **Level of Control** = 60% **Date added to the HB risk register** 30th April 2021		**Rationale for current score:** Delay in IOL is a frequent occurrence in maternity care (all delays are linked to the RR) and is multifaceted including; 1. High acuity 2. Maternity staffing levels 3. Neonatal staffing levels While adverse outcomes as a result of delay in care are infrequent, there may be long term consequences for mother and/or baby leading to high value claims. Avoidable harm is damaging to the reputation of the HB and can lead to adverse media coverage. **Rationale for target score:** IOL delays are minimal with increased patient flow, increased patient satisfaction and prevent avoidable poor outcomes

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
IOL rate is static at around 30% Maintain a maximum number of IOLs on a daily basis with emergency slot. Daily obstetric consultant ward round to review all women undergoing IOL. Ongoing/regular monitoring by cardiotocograph for fetal wellbeing during IOL on hold. Labour ward coordinator and labour ward obstetric lead ensure women on ward 19 for IOL are factored into daily planning of workload on labour ward. Obstetric consultant review when IOL on hold for appropriate pan of care. The MDT (Obstetric, Neonatal and Midwifery) consider individual risk factors and Escalation Policy is implemented. Neighbouring maternity units are contacted to ask if they are able to support by accepting the transfer of women. Daily acuity is gathered and sent to the senior midwifery management team who can anticipate potential problems and support the clinical team. The matron of the unit is contacted in office hours and the senior midwife manager on call is contacted out of hours. If required midwifery staffing are redeployed including the specialist midwives and the community midwifery on call team.	Prepare midwifery workforce paper to present recommendation for future staffing levels in the obstetric unit to ensure adequate staffing each shift.	Head of Midwifery	30/06/2022
	Complete Birthrate+ Cymru assessment for future workforce needs on the obstetric unit	Head of Midwifery	30/06/2022

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
There will be minimal delays in IOL. We will reduce the number of clinical incidents related to this risk. We will receive fewer complaints related to IOL as womens experience will be improved. We will not report avoidable harm related to IOL process.	Workforce plan in preparation to include review of staffing on the Obstetric unit to reduce risk related to midwifery staffing and high acuity

Additional Comments / Progress Notes

08.03.22 - Recruitment of Band 6 midwives underway. Introducing NICE guidelines for IOL (being managed by AN Forum). Working with NN to ensure capacity issues for maternity & NN services are managed appropriately.

20/04/22- Recruitment of Band 6 midwives unsuccessful. Will need to re-advertise. Streamlining for graduate midwives in 2022 has closed and shortlisting commenced. 23/05/2022 – 12 graduate midwives will be appointed through streamlining process. Advert for band 6 midwives on TRAC. 7/06/2022 – 11 graduate midwives have accepted the offer of a preceptorship programme in SBU. Advert for band 6 midwives closed 1st June 2022. Potential two band 6 midwives for interview

Datix ID Number: 2522 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 75** **Target Date: 31/07/2022**	**Current Risk Rating** **5 x 2 = 10**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Inese Robotham, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee	
Risk: Whole-Service Closure Risk that services or facilities may not be able to function if there is a major incident or a rising tide that renders current service models unable to operate		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 2 = 10 Target: 5 x 1 = 5		**Rationale for current score:** Risk reflects transition to business as usual as part of living with covid strategy. BCP plans in place.	
Level of Control = 25%		**Rationale for target score:** The strategy of moving towards living with Covid will eventually lower the risk level to target.	
Date added to the HB risk register May 2021			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Sites have business continuity plans and the impact of one site being overwhelmed by COVID demand has been reviewed. • Monitoring of associated risks has been being transferred to appropriate forums such as UEC Board, Elective Care Board and Nosocomial Group with overall oversight by Management Board.	**Action**	**Lead**	**Deadline**
	Ongoing surveillance of epidemiology data for early warning and further change to risk level.	COO	31/07/2022
Assurances (How do we know if the things we are doing are having an impact?) Monitored via Management Board for early warning signs.	**Gaps in assurance (What additional assurances should we seek?)**		

Additional Comments / Progress Notes

03/05/22: Covid GOLD & SILVER have been stood down. Ongoing monitoring assimilated into business as usual.

Datix ID Number: 2377 **Health & Care Standard: Staff & Resources 7.1 Workforce**		**HBR Ref Number: 76** **Target Date: 30th September 2022**	**Current Risk Rating** **5 x 2 = 10**
Objective: Partnerships for Care		**Director Lead:** Debbie Eyitayo, Director of Workforce & OD **Assuring Committee:** Workforce & OD Committee, Health & Safety Committee	
Risk: Partnership Working There are some remaining tensions between the Health Board and some trade union partners within SBUHB particularly in response to the supply of PPE which has the potential to create unrest in the workforce and hamper an effective response to COVID-19.		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 2 = 10 Target: 5 x 1 = 5		**Rationale for current score:** From the beginning of the Covid outbreak staff side including the BMA have been extremely critical of the HB position and demanded that the HB operate outside of national guidance, demanding widespread use of higher levels of PPE than the all Wales position allows. They engaged with external media and voiced their concerns in very direct and critical terms, threatening to involve the Minister. Whilst the degree to which these interjections continue to be raised in the health board Partnership Forum and Local Negotiating Committee has reduced, their position has not fundamentally changed. As Wales learns to manage in a post Pandemic environment this risk is expected to reduce further. There had been a local campaign actively encouraging union members to raise retrospective Datix incident for any staff who had a positive Covid test. This has generated circa 1600 Datix entries. LPF meetings had increased in frequency during the height of the pandemic and as of March 2022 are reducing to normal bi-monthly arrangements. This risk will be reviewed in a month's time to take account of the new revised risk assessment which is to be published imminently as well as plans to manage Covid as an endemic.	
Level of Control = 25%		**Rationale for target score:** Ideally staff side would support the HB position re PPE in line with PHW guidance. In doing so they would reassure staff and reduce their levels of general concern and anxiety regarding Covid Protection.	
Date added to the HB risk register May 2021			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• After a near two years of fortnightly and then monthly meetings the frequency of PF has recently reverted to normal bimonthly arrangements as the Covid related content has now reduced	Develop an effective working relationship	Assistant Director of Workforce & OD	31/05/2022

significantly. Sub group meeting frequency is unchanged and will service to fill any gap or need to provide more frequent contact between staff side and HB management. • Employees continue to ~~will~~ be encouraged to raise concerns via existing mechanisms. • HB will continue to utilise the briefings process to be transparent about issues such as PPE to improve confidence in the supply and availability. • Chief Executive and other Executive Directors will attend HB Partnership Forum on a regular basis. Partnership principles and ways of working will be emphasised as the most effective approach to secure progress. • The Health Board will continue to develop an effective working relationship with all trade union partners and collectively via the agreed HB Partnership Forum. Frequent meetings will continue to take place, supplemented by local discussions when required.			
Assurances (How do we know if the things we are doing are having an impact?) • Monitored through range of contact points with staff side organisation mainly LPF and other routine meetings interaction with staff side. Reduction in direct action by staff side and the issue of PPE not being consistently raised through formal channels media etc.	**Gaps in assurance (What additional assurances should we seek?)** N/A		
Additional Comments / Progress Notes. 01.04.22 – Two actions completed - The Health Board will continue to develop an effective working relationship with all trade union partners and collectively via the agreed HB Partnership Forum. Commission IPA services to provide a series of Partnership workshops for senior managers and Reps to explore the relationship and develop plan for improvement. 20.04.22 - Staff side sub-group action complete - Two facilitated sessions took place in October 2021 with Staff side Colleagues, HR colleagues, Executives and Service Groups reps, on what partnership working in SBU looks like and any improvements that are required. An action plan was derived on the back of the sessions which has been agreed and signed off by the Director of Workforce and OD and the Staff Side Chair. The action plan has been taken through Health Board Partnership Forum and will be overseen through that forum. Further work has also been undertaken on the Health Board Partnership Forum with clear escalation framework produced for agenda items. 17.05.2022 - As the HB moves to manage Covid as endemic we have still seen some concerns raised at PF by staff side covering PPE issues in this transitional period. However these concerns have not been on the same scale or intensity as previously seen at the height of the pandemic. The risk score has not been adjusted but over the coming months the score is expected to reduce and the risk as framed reviewed with a view to closure.			

Datix ID Number: 2569 **Health & Care Standard: Staff & Resources 7.1 Workforce**		**HBR Ref Number: 77** **Target Date: 30th September 2022**	**Current Risk Rating** **3 x 4 = 12**
Objective: Excellent Staff		**Director Lead:** Debbie Eyitayo, Director of Workforce & OD **Assuring Committee:** Workforce & OD Committee	
Risk: Workforce Resilience Culmination of the pressure and impact on staff wellbeing - both physical and mental relating to Covid Pandemic. Local prevalence of Covid infections increasing positive testing and the debilitating effect of the second wave impacting staff. Impact direct in terms of Covid / related sickness (symptomatic Absence) and self-isolation (Asymptomatic). Increased staff absence impact on the pressures for those still in work.		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 3 x 4 = 12 Target: 5 x 2 = 10		**Rationale for current score:** Whilst direct Covid related absence has reduced in recent months the HB still has a significant number of staff who either caught Covid or were directly impacted either due to self-isolation and or the impact of being Clinically Extremely Vulnerable (CEV). Some 350 staff are still not yet back into a substantive role. Although sick absence levels have reduced the proportion of that % relating to stress has increased. It is still too early to be sure that long term impacts of the pandemic will have already manifested itself. The health board has a number of staff with long Covid whose return to work is not certain and whose sick pay protection will end later this year.	
Level of Control = 25%		**Rationale for target score:** All organisations would wish for their staff to be resilient to the impact of working within their organisation. The significant ongoing impact of Covid would never be zero but through a range of interventions in place we would hope to minimise the impact on staff to an acceptable level.	
Date added to the HB risk register May 2021			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Additional recurrent Wellbeing funding support gained (1/4/22) as a result of successful Business Case to aid delivering the Staff Post-Covid Wellbeing Strategy. This focuses on enhanced interventions for individual trauma support, group support and related training for the team. A TRiM (trauma risk management) team has been established to roll out TRiM to priority areas and support services after adverse and critical events. 45 staff have been trained and over 1200 staff have undertaken the REACT MH training. • Additional resource to support the Occupational Health Long Covid clinics has also been gained (currently until March 31st 2023) to support staff to manage their health and return to work with bespoke advice and adjustments, as appropriate. • 530 wellbeing Champions trained to support and signpost staff to wellbeing services. • Occupational health providing advice for staff return to work after Covid-19 and supporting the WF risk assessment.	Covid Risk Assessment tool has been reviewed by WG, this will now be used to reassess appropriate staff.	Professional Head of Staff Health & Wellbeing/AD of Workforce & OD - Ops	30/06/2022
	OH Case conferences to be introduced to improve dialogue with all parties to support employees.	Professional Head of Staff Health & Wellbeing	30/06/2022

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Monitoring of Sick absence (long, short term and Covid related), staff impacted by CEV and the numbers of staff seeking to access the supporting mechanisms already in place.	**N/A**

Additional Comments / Progress Notes

Update 22.02.2022 – New action added.
Update 21.03.2022 – Recurrent additional funding for OH and Staff Wellbeing means the HB can continue to meet the diverse needs of staff as the organisation and its staff recover from the pandemic.
20.05.2022 – Two actions completed - Continued Implementation of TRiM across priority areas. Occupational Health Long Covid clinics established to support staff with long Covid symptoms

Datix ID Number: 2521 (& COV_Strategic_017) **Health & Care Standard: 2.4 Infection Prevention and Control (IPC) and Decontamination**	**HBR Ref Number: 78** **Target Date: 31st October 2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Richard Evans, Executive Medical Director **Assuring Committee:** Quality & Safety Committee	
Risk: Nosocomial transmission Nosocomial transmission in hospitals could cause patient harm; increase staff absence and create wider system pressures (and potential for further harm) due to measures that will be required to control outbreaks.	**Date last reviewed:** May 2022	
	Rationale for current score: Score of 20 retained given planned communication to families regarding learning from nosocomial COVID.	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 5 = 20 Target: 3 x 4 = 12		
Level of Control = 40%	**Rationale for target score:** Measures in place will require regular review and scrutiny to ensure compliance. Levels of community incidence or transmission may change and the HB will need to respond. Vaccination programme on going but not complete.	
Date added to the HB risk register May 2021		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
A nosocomial framework has been developed to focus on: (a) prevention and (b) response. Preventative measures are in place including testing on admission, segregating positive, suspected and negative patients, reinforcing PPE requirements, and a focus on behaviours relating to physical distancing. As part of the response, measures have been enacted to oversee the management of outbreaks.	Following dissolution of Gold and Silver COVID command structures, the function of monitoring nosocomial spread and implementing preventative actions will be taken on by the IP&C committee.	Executive Medical Director & Deputy Director Transformation	Monthly ongoing
Process established to review nosocomial deaths. Audit tools developed to support consistency checking in key areas re: PPE, physical distancing. Testing on admission dashboard in use. Further guidance on patient cohorting produced.	Nosocomial Death Reviews using national toolkit. Need to ensure outcomes are reported to the HB Exec and Service Groups with lessons learnt	Executive Medical and Nursing Director	Monthly ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Monitor Outbreaks throughout the HB / Review Nosocomial Deaths and lessons learnt	Audit compliance of sustainable IPC practices and training compliance Implement lessons learnt from outbreaks and death reviews.

Additional Comments / Progress Notes

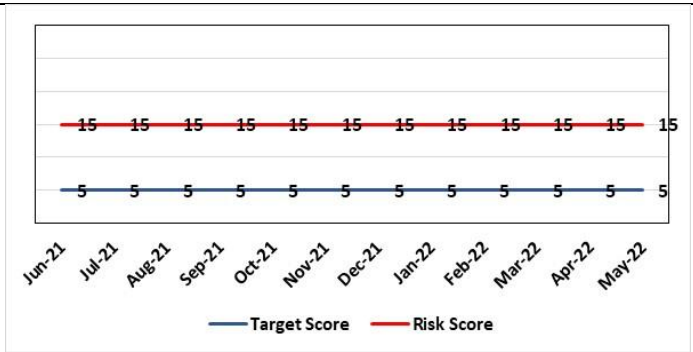
Update 02.05.2022 - Following dissolution of Gold and Silver COVID command structures, the function of monitoring nosocomial spread and implementing preventative actions will be taken on by the IP&C committee.

Datix ID Number: 2739 Health & Care Standard: 2.1.1 Managing Financial Risk	HBR Ref Number: 79 Target Date: 31st May 2022	Current Risk Rating 5 x 3 = 15
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Darren Griffiths. Director of Finance **Assuring Committee:** Performance and Finance Committee	
Risk: The COVID-19 pandemic has affected services in many different ways, in this risk specifically the impact on access to services, such as OP, diagnostic tests, IP&DC and therapy services. The recovery of access times will require additional human, estates and financial resource to support it. There is potential for resource available is below the ambition of the board to provide improved access.	**Date last reviewed:** May 2022	

Risk Rating
(consequence x likelihood):
Initial: 5 x 3 = 15
Current: 5 x 3 = 15
Target: 5 x 1 = 5

Level of Control
= 25%

Date added to the HB risk register
May 2021



Rationale for current score:

- Significant backlog for patients to access across elective and cancer care in the following areas, diagnostics, OP, IP&DC, therapy, Oncology
- Welsh Government has set aside resource for the recovery of the health system with the areas above a clear area of focus. This is known as recovery funding and the Health Board has been allocated £21.6m recurrently for this purpose
- A prioritisation process is currently underway to determine the areas to be funded against the recovery money in the context of the overall Health Board financial plan for 2022/23 and beyond.
- Score reflects the high impact of not being able to address the access backlog due to affordability reasons, whilst the likelihood is 3 as resource is anticipated.

Rationale for target score:
The Health Board funding requirement is in excess of the funding available and therefore choices will need to be made on priority schemes for funding. The full list of ambitions/schemes is not affordable.

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

The Health Board is doing the following: -

- Working with specialists to develop plans to maximise Health Board capacity safely and within extant COVID guidelines
- Developing more advanced service models to test scenarios to allow for accurate demand and capacity plans to be developed
- Ensuring that financial controls are in place to enable swift decisions to be made on allocation of additional resource but also ensuring that the commitment made do not exceed the allocation sum (when known)

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Undertake a robust prioritisation exercise with clinical leaders to identify core service areas to be funded. This will be informed by modelling work to be carried out by the Healthcare Science Engineering Team.	Chief Operating Officer & Executive Medical Director	31/05/2022

• Transparent reporting to Performance and Finance Committee and Quality and Safety Committee on progress and plan development. • Prioritising key services via clinical leaders.	Ensure that overall financial plan for 2022/23 can accommodate as much clinical capacity as possible by delivering savings and taking a risk assessed approach.	Director of Finance	30/06/2022
Assurances **(How do we know if the things we are doing are having an impact?)** The Health Board financial performance is reviewed and monitored through: • Monthly financial recovery meetings • Performance and Finance Committee • Routine reporting to Board of most recent monthly position and availability of national funding support recovery	**Gaps in assurance** **(What additional assurances should we seek?)** Management of access is prioritised based on clinical risk management.		
Additional Comments / Progress Notes The financial element of this plan will be managed to within the £21.6m COIVD recovery allocation received by the Health Board. The impact of the schemes identified within the £21.6m is currently being modelled and this will inform the Board of the forecast waiting times position through 2022/23. This will need to be considered by the Board and the risk adjusted to meet the outcome of the modelling and the discussion on impact on overall waiting times and waiting numbers. 1 Action completed - Develop a final annual plan setting out recovery plans and			

Datix ID Number: 1832 **Health & Care Standard: : 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 80** **Target Date: 31/07/2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Inese Robotham, Chief Operating Officer **Assuring Committee:** Quality & Safety Committee	
Risk: If the health board is unable to discharge clinically optimised patients there is a risk of harm to those patients as they will decompensate, and to those patients waiting for admission.		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 2 = 8		**Rationale for current score:** • Sustained levels of clinically optimised patients leading to overcrowding within ED, use of inappropriate or overuse of decant capacity in ED and delays in accessing medical bed capacity, clearly emerged as themes. • Constraints in relation to all patient flows out of Morriston to a more appropriate clinical setting, identified and included in an expanded risk. • Delay in discharge for clinically optimised patients can result in deterioration of their condition.	
Level of Control = 25%		**Rationale for target score:**	
Date added to the HB risk register May 2021			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Clinically optimised numbers are monitored and reviewed weekly by the MDU. Delays are reported and escalated to try to ensure timely progress along a patient's pathway. • Review on a patient by patient basis – with explicit action agreed in order to progress transfer to appropriate clinical setting. • Critical constricts in relation to access/time delays for social workers and assessment for package of care and social placement – lead times in excess of 5 weeks. • Patient COVID-19 status has added an additional level of complexity to decision making. • The health board has procured 63 additional care home beds to provide additional discharge capacity.	We will engage with WG in the social care taskforce to look for alternative ways to provide out of hospital care.	COO/EMD	31/07/22

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
• Patient level dashboard allows breakdown by delay type • Close management of utilization of additional care home beds	

Additional Comments / Progress Notes

03.05.22: Third procurement round concluded. However, due to Covid and staffing levels in care homes we have access routinely to 50-55 beds on average.
Action complete: "Undertake another procurement round with the aim of increasing additional care home beds to 100".
08.06.22: The extension of transitional bed scheme to November 2022 has been approved by Board.

Datix ID Number: 2788 **Health Care Standards: 7.1 Workforce**		**HBR Ref Number: 81** **Target Date: 31st October 2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Best value outcomes		**Director Lead:** Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality & Safety Committee **For Information:** Workforce & OD Committee	
Risk: Critical staffing levels – Midwifery Midwifery absence rates are outside of 26.9% uplift leading to difficulty in maintaining midwifery rotas in the hospital and community setting.		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 4 = 16		**Rationale for current score:** Midwifery absence fluctuating between 35 and 39% in April 2022. Vacancies exist within the service however two rounds of recruitment for Band 6 midwives have failed to appoint to the vacancies available. There is an increase in attrition rates for promotion and opportunities in neighbouring health boards. A national RCM survey reports an increasing in the number of midwives retiring and leaving the profession which is reflected in SBUHB.	
Level of Control = %		**Rationale for target score:** We can provide assurance of fully funded and appointed rotas other than for short term sickness reports.	
Date added to the risk register 12/10/2021			

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• All midwives are working at the hours they require up to full time. • Specialist midwives and management redeployed to support clinical care as required • Escalation meeting twice a week to review rotas and reallocate staff as required • Morning safety huddle for community midwifery teams • Recruitment for experienced band 6 midwives. 5.2 in train. • Advertisement for further experienced midwves on TRAC • Recruitment of graduate midwives via streamlining in train. 12 Midwives due to be employed October 2022 • Daily Midwifery acuity prepared and circulated to senior midwifery management • All additional shifts offered via Bank, additional hours and overtime • Continue to suspend services in the FMU at NPT • Offer of additional support worker shifts particularly in the postnatal area for additional support for women	Shortlist for band 6 midwifery vacancies following closure date	Deputy Head of Midwifery	10/05/2022
	Complete recruitment for band 6 midwives	Deputy Head of Midwifery	30/06/2022
	SBAR to be prepared for vacancy panel to advertise for Band 5 midwives where band 6 recruitment cannot be achieved	Head of Midwifery	31/05/2022
	Complete workforce paper with HR and finance to establish vacancy position and develop vacancy tracker going forward	Head of Midwifery	30/06/2022
	Complete Birthrate+ Cymru assessment	Head of Midwifery	30/06/2022

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
We will be able to maintain safe staffing rotas and women and families will receive safe and effective care wherever they chose to birth. We will report increased staff satisfaction. We will have a reduction in complaints to the service. we will have reduced sickness rates. We will be able to effectively support	Incorporate Birthrate+ Cymru required staffing levels when available. To restructure the management SIP for robust management and governance including succession planning for management roles in line with RCM

secondments for staff development without depleting the clinical service. Long term sickness and maternity leave will not impact on our ability to sustain staffing levels within the clinical areas.	recommendations Evidence has shown midwifery led intrapartum services have high value from reduced intervention rates and improved satisfaction/experience as well as financial benefits as births in midwifery led intrapartum care has lower financial cost to obstetric unit births. SBU are reporting an increase in the caesarean section rates year on year.

Additional Comments / Progress Notes

- HoM working with WG and BR+ as a stakeholder for BR+ Cymru project.
- Representatives for the WG Digital Cymru project for single maternity information system to reduce duplication and thereby introduce time savings.
- National Midwifery Workforce summit being held 30th May 2022 led by CMO due to national midwifery staffing position and models of care

Update 03.05.2022 - staff unavailability remains over 30%. Recruitment undertaken 3.2wte appointed with a further 1.0wte interview to be undertaken w/c 3/05/2022. further appointment to Infant feeding coordinator role will release seconded midwife back to service. Recruitment in progress with regular updates. Band 5 graduate midwives remain on uplift hours up to full time. Staff escalation meeting now three times weekly. Staff engagement event for NPT Birth centre on 26/04/2022. Plan to reopen birth centre 23/05/2022. Email circulated by HOM for information. Further meeting arranged with Service Group to consider way forward w/c 9/05/2022. Outcome of meeting to be communicated with staff.

Datix ID Number: 2554 **Health & Care Standard:** Standard 5.1 Timely Access	**HBR Ref Number: 82** **Target Date: December 2023**	**Current Risk Rating** 4 x 4 = 16
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Richard Evans, Executive Medical Director **Assuring Committee**: Performance & Finance Committee **For Information**: Quality & Safety Committee, Workforce & OD Committee	
Risk: Risk of closure of Burns service if Burns Anaesthetic Consultant cover not sustained There is a risk that adequate Burns Consultant Anaesthetist cover will not be sustained, potentially resulting in closure to this regional service, harm to those patients would require access to it when closed and the associated reputational damage. This is caused by: • Significant reduction in Burns anaesthetic consultant numbers due to retirement and long-term sickness • Inability to recruit to substantive burns anaesthetic posts • The reliance on temporary cover by General intensive care consultants to cover while building work is completed in order to co-locate the burns service on General ITU • Reliance on capital funding from Welsh Government to support the co-location of the service	**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 ~~5~~ x 4 = 16 ~~20~~ Target: 3 x 1 = 3 **Level of Control** = **Date added to the HB risk register** December 2021		**Rationale for current score:** This risk was increased due to closure of the Burns Unit due to staffing levels, and reduced from 25 to 20 having secured the agreement of the general ITU consultants to provide cross-cover while enabling capital works are completed. Propose reduce risk to 16 now and reduce to 12 when funding confirmed by WG. **Rationale for target score:** This is a small clinical service with staff with highly specialised skills. While a small service may always be vulnerable to challenges (eg staff) the intention will be to operate a more resilient clinical model that is supported by other clinical groups.

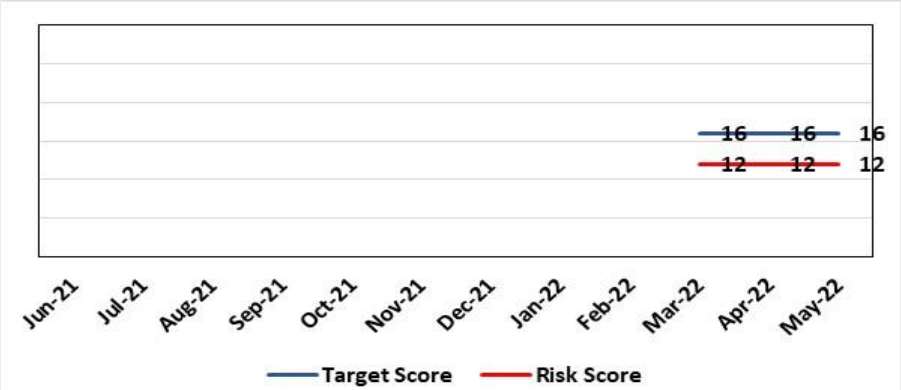
Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• The general ITU consultants to support the Burns service on a temporary basis, supporting the remaining burns anaesthetic colleagues to provide critical care input for burns patients • The agreement reached is that they will cover the current Burns Unit on Tempest ward at Morriston hospital for 6-9 months while capital work is underway on general ITU to enable co-location of the service • The capital works will be in two phases (1) to co-locate in a smaller footprint in GITU, followed by (2) larger-scale capital work to accommodate complete co-location by mid-2023. • WHSSC as commissioners of the service have been kept fully informed, as has the South West (UK) Regional Burns Network • Other UK burns units have ICU co-located with Burns ICU, removing the need for dual certified consultants	**Action**	**Lead**	**Deadline**
	Submit bid for capital funding to Welsh Government for both phases of work required	Morriston Service Group	31st May 2022
Assurances (How do we know if the things we are doing are having an impact?) Effect on patients of the temporary closure of the burns service in Swansea is mitigated by maintaining an urgent assessment/stabilisation service for patients in Wales with severe burns, with onward transfer for inpatient care	**Gaps in assurance (What additional assurances should we seek?)**		

to another unit in the UK following the initial assessment. The service reopened fully on 14/02/2022.	
Additional Comments / Progress Notes 31.03.22: The service reopened fully on 14/02/2022. Action completed - Securing the agreement of GITU consultants to cover pending completion of capital work. 13/05/22: Scoping document submitted to WG; meeting 17/05/22 to agree timescale for submission of business case. Risk score reviewed – interim arrangements working well; no concerns raised. Propose reduce risk to 16 now and reduce to 12 when funding confirmed by WG.	

Datix ID Number: 2961 **Health & Care Standard: 2.1.1 Managing Financial Risk**		**HBR Ref Number: 83** **Target Date: 30th November 2022**	**Current Risk Rating** **5 x 4 = 20**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Darren Griffiths, Director of Finance **Assuring Committee:** Performance and Finance Committee	
Risk: Release of Bed Capacity Savings (A savings risk, not a bed modelling or AMSR delivery risk) There is a risk that the health board will not be able to release sufficient bed capacity to meet the requirements of savings schemes predicated on bed release. The main causes of this are: length of stay above benchmark; the unavailability of beds in the community to support discharge; the impact of COVID patients on the overall bed plan; clear ambition of the health Board to reduce exceptionally high occupancy which affects flow The potential consequence is that savings plans will not be achieved, increasing the risk of failure to achieve overall financial outturn target.		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 5 x 1 = 5		**Rationale for current score:** • A reduction in bed day consumption was identified as part of the benefits realisation for the Health Board's investment plan in 2021/22 • The bed day release was aggregated and a financial assessment of the budget that could be saved as a result of this release was made. This saving then features in the saving plans for the Board spread across service groups • The bed release has not been possible to date as a result of slower implementation of plans than was anticipated, the move of the AMSR plan into 2022/23, COVID pressures and workforce pressures • The Health Board's savings plan for 2021/22 requires recurrently delivery and failure to release the bed savings would reduce the recurrent delivery by circa £6m	
Level of Control =		**Rationale for target score:** The consequence is very significant given the financial settlement for 2022/23 and beyond. At present there is no safe service plan which would allow the bed reduction making likelihood very high. There is a significant amount of mitigation work underway to reduce likelihood but this is yet to formulate into a plan	
Date added to the risk register January 2022			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Extensive bed modelling and benefits realisation checks being carried out in February 2022 • Change in front door model at Morriston to reduce admissions • Escalation of length of stay improvement via performance framework • Monitoring COVID patient numbers and cohorting of patients to reduce surge requirements • Commissioning additional care home beds	**Action**	**Lead**	**Deadline**
	Focus on front door redesign to manage patients away for admission to alternative services	COO	30/06/2022
	Agree occupancy level to support the modelling	COO	31/05/2022
	Delivery AMSR	COO	30/09/2022

	Delivery of Virtual Ward model across all clusters	COO	29/04/2022
Assurances (How do we know if the things we are doing are having an impact?) • Length of stay reduction • Fewer admissions • Reduced COVID patients in beds • Reduction in surge bed numbers	**Gaps in assurance (What additional assurances should we seek?)** • Signed off plan of beds to be decommissioned		
Additional Comments / Progress Notes Update 12.04.2022 - Savings risk on 2021/22 outturn has been mitigated by other savings being identified. Risk remains open whilst the bed requirements for the Acute Medical Services Redesign (AMSR) takes place as savings should be realisable over time and are a requirement from a return on investment perspective in terms of the benefits realisation of those investments. For clarity, this is a savings risk and not a bed modelling or AMSR delivery risk.			

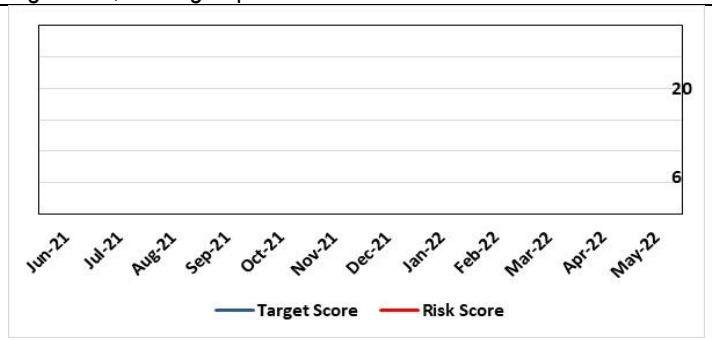
Datix ID Number: 3036 **Health Care Standards: 4.1 Dignified Care, 2.1 Managing Risk & 7.1 Workforce**		**HBR Ref Number: 84** **Target Date: 31st December 2022**	**Current Risk Rating** **4 x 4 = 16**
Objective: Best value outcomes		**Director Lead:** Richard Evans, Executive Medical Director **Assuring Committee:** Quality & Safety Committee	
Risk: Cardiac Surgery – A Getting It Right First Time review identified concerns in respect of cardiac surgery (including patient pathway/process issues) that present risks to ensuring optimal outcomes for all patients. Potential consequences include the outlier status of the health board in respect of quality metrics, including mortality following mitral valve surgery and aortovascular surgery. This has resulted in escalation of the service by WHSSC.		**Date last reviewed:** May 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 4 x 4 = 16 Target: 4 x 3 = 12		**Rationale for current score:** De-escalation of service by WHSSC from Stage 4 to Stage 3 Assurance of processes in place through implementation of the improvement plan.	
Level of Control = %		**Rationale for target score:** Cardiac surgery is frequently high-risk surgery and an element of risk will remain.	
Date added to the risk register March 2022			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Invited Service Review by Royal College of Surgeons to advise on outcomes, good practice and areas for improvement; • Implementation of local action plan to address areas of concern; widespread engagement among clinicians in the department. • All surgery is now only undertaken by consultants and mitral valve repair surgery is undertaken by two mitral valve specialists; a third consultant undertakes mitral valve replacements as agreed with WHSSC. • Complex heart valve MDT established to make decisions on appropriate surgery including MV repair and MV replacement and to direct to the appropriate consultant. • Internal review of deaths following mitral valve surgery. • High Risk MDT implemented, outcome decision documented on Solus. • Dual surgeon operating mandated for complex cases (determined by the MDT) to improve outcomes. • MDT discussion to be undertaken for all patients who develop deep sternal wound infections. • Quality & Outcomes database established capture case outcome metrics in real time.	Implementation of local improvement plan targeting areas of concern and implementing actions to reduce variation	Executive Medical Director	30/04/2022
	Develop actions for improvement as advised by RCS	Executive Medical Director	31/08/2022
Assurances (How do we know if the things we are doing are having an impact?) • An improvement plan has been developed in conjunction with WHSSC and agreed. Progress is monitored by Gold Command arrangements. • Quality & Outcomes database established capture case outcome metrics..	**Gaps in assurance (What additional assurances should we seek?)** Assurance sought via RCS Invited Review on outcomes and governance in the department		

Additional Comments / Progress Notes
WHSSC have de-escalated the service to Stage 3 following an agreed pathway for aorta-vascular cases. Update 14.04.22 - The Royal College of Surgeons undertook a review of the service in March 2022; formal report anticipated in 8-10 weeks' time. Action completed - Commission an Invited Review of Service with support from Royal College of Surgeons. Update 11/05/22: The Royal College of Surgeons undertook a review of the service in March 2022. Interim letter received with feedback; formal report anticipated in 6-8 weeks' time.

<table>
<tr><td colspan="2">Datix ID Number: 2561 New Risk
Health & Care Standard: Effective Care 3.1 Safe & Clinically Effective Care</td><td>HBR Ref Number: 85
Target Date: 30th September 2022</td><td>Current Risk Rating
4 x 5 = 20</td></tr>
<tr><td colspan="2">Objective: Best value outcomes</td><td colspan="2">Director Lead: Director of Therapies & Health Sciences
Assuring Committee: Quality & Safety Committee</td></tr>
<tr><td colspan="2" rowspan="2">Risk: Non-Compliance with ALNET Act
There are risks to the Health Board's ability to meet its statutory duties and establish the effective collaborative arrangements required by the ALN Act, which is being implemented through a phased approach.
This risk is caused by:
• Lack of staff resource needed to carry out the additional work needed to comply with the ALN Act for operational services, especially those in the PCST Service Group, though the size of the gap in terms of staff resource is currently unclear.
• Gaps in the structure and processes needed to meet the requirements of the ALN Act leading to slippage against a previous ALN work plan. There is a need to identify and progress the work needed for 2022/23, and without adequate planning capacity, existing staff will not be able to make the progress what is needed.
• Issues around multi-agency working which may impact on levels of demand on operational services, and on existing SLAs through which the Health Board delivers some services to partner LAs.
• Aspects of the requirements on Health Boards which are currently ambiguous and uncertainty regarding the implementation timetable.

Potential consequences of this risk are: parent / carer and young peoples' dissatisfaction leading to complaints, Educational Tribunals and Judicial Reviews (this is new legislation with many points of ambiguity and is highly likely to be legally 'tested'); reputational impact; and children failing to access the multi-agency support that they need with their learning needs, leading to poor outcomes.</td><td colspan="2">Date last reviewed: May 2022

Rationale for current score:
Risk score reflects that while controls are in place, there are multiple areas of risks (relating to compliance with legislation; governance and assurance; workforce and OD; and sustainable services); and high probability (especially given multiple risk areas) of at least one of these areas of risk being realised. Caused by implementation timetable for the ALN Act, slippage against plan and need for strengthened governance (as described in 'Risk' section).</td></tr>
<tr><td colspan="2">Rationale for target score:
As the ALN Act is new legislation, there remains some ongoing likelihood of risk events during the initial phases of implementation, though with lessened consequences as a result of mitigating actions.</td></tr>
<tr><td>Risk Rating
(consequence x likelihood):
Initial: 5 x 5 = 25
Current: 4 x 5 = 20
Target: 2 x 3 = 6</td><td rowspan="3"> 
</td><td colspan="2" rowspan="3"></td></tr>
<tr><td>Level of Control
=</td></tr>
<tr><td>Date added to the HB risk register
14/05/2022</td></tr>
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<tr><th colspan="2">Controls (What are we currently doing about the risk?)</th><th colspan="3">Mitigating actions (What more should we do?)</th></tr>
<tr><td rowspan="4">Progressing the necessary work within an appropriate structure (see under ‘ACTIONS’) are constrained by financial and/or service delivery pressures.
DECLO (Designated Educational Clinical Lead Officer) is in post - this is a statutory requirement.
Health Board ALN Steering Group has been established, with structure agreed for Operational Group working under the governance of this
Work is being progressed with Local Authority partners to ensure that activity relating to the ALN Act is grounded in a shared vision and principles to support collaborative working.
Initial operational processes relating to statutory processes (through which Local Authorities access Health Board involvement) have been established and are in effect and work is being progressed with partners to refine this approach.
Advice has been received from WG regarding some areas of particular ambiguity relating to Health Board duties under the Act, and dialogue is ongoing to resolve other areas of uncertainty.
Regarding demand / capacity and staffing resource challenges, WG has a phased implementation timetable for the Act which offers short-term, partial mitigation of risks. An update is expected imminently regarding the implementation timetable post-September 2022.
Awareness has been raised at Board level through Development session and an update is being provided to the Quality and Safety Committee.</td><td>Action</td><td>Lead</td><td>Deadline</td></tr>
<tr><td>Under the governance of the ALN Steering Group, an ALN Operational Group will be formed. Its first task will be development of an ALN work plan for 2022/23.</td><td>DECLO</td><td>31/5/2022</td></tr>
<tr><td>Work with LA partners to be progressed to establish a prudent, longer-term operational model through which statutory referrals / requests to the Health Board will be made</td><td>DECLO</td><td>30/5/2022</td></tr>
<tr><td>Development, based on updated WG implementation guidance and current data, of the additional staffing resource required to meet the requirements of the ALN Act for the next period and develop an initial business case.</td><td>DECLO</td><td>31/6/2022</td></tr>
<tr><td colspan="2">Assurances (How do we know if the things we are doing are having an impact?)
• There is regular reporting in respect of the ALN Act through the Quality and Safety Committee.
• ALN Steering Board has been established, ensuring oversight at a senior level within all impacted operational and corporate areas
• DECLO meets regularly with ADOTHS / DoTHS of the 3 health boards of South-West and Mid Wales for update and assurance.</td><td colspan="3">Gaps in assurance (What additional assurances should we seek?
• Extent of gap in staffing resource (gap between work required and capacity available) has not been quantified yet. Actions above aim to address this.</td></tr>
<tr><td colspan="5">Additional Comments / Progress Notes</td></tr>
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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