Meeting Date	**25 November 2021**	**Agenda Item**	**2.3**
Report Title	**Risk Management Report**		
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Report Sponsor	Pam Wenger, Director of Corporate Governance		
Presented by	Neil Thomas, Assistant Head of Risk & Assurance		
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 was last presented to the Board in July 2021. • Since these meetings, Executive Directors have reviewed and refreshed risk entries. The latest iteration of the register incorporates updates to the middle of October endorsed by the Management Board on 20th October 2021 and reported to the Audit Committee on 9th November. In response to recent comments and queries following review of the register at Board Committees and by the Chief Executive, Executive Directors have reviewed and revised some risks further in November. In particular, key aspects of the highest scoring risks have been updated. In some cases, reviews undertaken have confirmed the position without change. • The HBRR currently contains 39 risks, of which 21 have risk scores at, or above, the health board's current appetite of 20. • The Covid-19 risk register is managed within the Covid-19 Gold Command structure. It has not been included in recent reports as its operational risk scores were below the Board's current appetite of 20. In recent weeks, scores have risen for two risks to meet this threshold – COV004 *Covid-related Sickness Absence* and COV009a *Workforce Shortages*. These risks are summarised within this report for information.		

Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☒	☒	☒	☒

Recommendations	Members are asked to: • **NOTE** the updated Health Board Risk Register and process ongoing to enhance and refresh its content;

	• **CONSIDER** whether further assurance is required on action to address risks identified or to enhance the register entries; • **APPROVE** the extension of the risk appetite score of 20 for the next Quarter (indicating risks assessed at a score of 20 or above should be addressed as a priority) and the low tolerance to risks with a high impact on the quality and safety of staff and patient care.

HEALTH BOARD RISK REPORT

1. INTRODUCTION

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

2. BACKGROUND

2.1 Risk Management Framework

The Audit Committee is responsible for overseeing the overall operation of the risk management framework and providing assurance 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, with the intention that committee work programmes be aligned so that progress made to address key risks is reviewed in depth. Regular HBRR update reports are submitted to the Health Board and the committees of the Board to support this.

Executive Directors are responsible for managing risk within their area of responsibility.

Risk Register management is supported by a Risk Management Group (RMG) which 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 meets quarterly and it last met in May 2021.

Additionally, a Risk Scrutiny Panel meets monthly, and is responsible for moderating new risks and escalated risks to the Health Board Risk Register (HBRR) and Board Assurance Framework (BAF), engaging and advising Executive Directors as appropriate regarding the escalation and de-escalation of risks.

2.2 Risk Appetite

Risk appetite and tolerance set out how risk and reward are to be balanced, as well as providing clarification on the level of risk the Board is prepared to accept.

Prior to the Covid-19 Pandemic, the Board's risk appetite required action should be taken as a priority to address risks scored at 16 and above. There is a low tolerance to taking risk where it would have a high impact on the quality and safety of care being delivered to patients.

Following the onset of the Covid-19 pandemic, members of the Board agreed that the risk appetite score would increase to 20 and above for an initial period of 3 months. The risk appetite of 20 and above has remained in place since the start of the pandemic. 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 key 'live' extreme risks facing the Health Board and the actions being taken to mitigate them.

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

The Covid-19 risk register is managed within the Covid-19 Gold Command structure. It has not been included in recent reports as its operational risk scores were below the Board's current appetite of 20. In recent weeks, scores have risen for two risks to meet this threshold – COV004 *Covid-related Sickness Absence* and COV009a *Workforce Shortages*. These risks are summarised within this report for information.

3. MANAGEMENT OF HEALTH BOARD RISK REGISTER (HBRR)

3.1 Action to Update the HBRR

Since the Health Board Risk Register was last presented to the Board in July 2021, the top five risks have been considered at Risk Management Group in August and feedback shared with the Management Board at its meeting on 1st September 2021.

Executive Directors have reviewed and refreshed risk entries. The latest iteration of the register attached at **Appendix 1**, incorporates updates to the middle of October (key changes are highlighted in red font) and has been endorsed by the Management Board on 20th October 2021, and reported to the Audit Committee on 9th November. In response to recent comments and queries following review of the register at Board Committees and by the Chief Executive, Executive Directors have reviewed and revised some risks further in November. In particular, key aspects of the highest scoring risks have been updated. In some cases, reviews undertaken have confirmed the position without change eg following query at Quality & Safety Committee the scores of risks within Maternity Services have been reviewed and supported staff within the service.

The Risk Scrutiny Panel 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. It last met on 26th August 2021 for routine business, but met again in October to review the Estates risk register.

The Panel has considered risks rated as 20 and above (reflecting the Health Board's raised risk appetite of 20) received from the service groups and corporate directorates for consideration for inclusion on the Health Board Risk Register (HBRR). At the August meeting, risks were escalated from the following service groups / directorates:

- Mental Health & Learning Disabilities Service Group

- Primary Community & Therapies Service group
- Neath Port Talbot & Singleton Service Group
- Maternity Services

Additional risks escalated via the Risk Scrutiny Panel have also been shared with Executive Directors for consideration. One has been approved for addition to the Health Board Risk Register; others require further information / development before they are reconsidered for addition. Feedback is provided to service groups following Scrutiny Panel meetings.

3.2 Risk Summary

The September 2021 HBRR attached at **Appendix 1** 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 Board meeting, 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 (dates are those of the HBRR) as it has been received at the last three meetings (inclusive of this meeting):

Table 1: Summary of Risk Assessment Scores

Risk Analysis	Number of Risks (Apr 2021)	Number of Risks (Jun 2021)	Number of Risks (Sep 2021)
High Risk (>= appetite): Risk Score of 20-25 (Red)	19	20	21
High Risk (< appetite): Risk Score of 16-19 (Red)	8	9	8
Moderate Risk: Risk Score 9-15 (Amber)	5	8	9
Manageable Risk: Risk Score of 5-8 (Yellow)	0	1	1
Acceptable Risk: Risk Score of 1-4 (Green)	0	0	0
Total	**32**	**38**	**39**[1]

Further detail on the above risks can be found within the Risk Register at **Appendix 1.** While the total number of risks at and above the Health Board appetite score of 20 is the same as previously reported, the following movements are noted:

- One new risk has been added to the register. It has a risk score of 25 (ref HBR81).
- One risk has increased from 16 to 25 following re-assessment by the Executive lead (ref HBR1).
- Three risks previously recorded with scores of 25 have been reviewed and the scores reduced by the Executive leads (refs HBR 50, 66, 67).

[1] This will reduce to 38 following the closure & remove from the register of risk HBR49 signalled within this report.

- One risk has been proposed for closure by the Executive lead (ref HBR 49) – it has been endorsed for closure at the last Management Board meeting and will be removed from the next iteration of the register.

Section 3.3 below expands on these and other changes.

3.3 New Risks, Increasing & Decreasing Risks

There is one new risk added to the HBRR:

Table 2: New Risks

Risk Ref	Risk	Source	Lead Exec Director	Current Score
81	**Critical Staffing Levels: Midwifery** ***Unplanned absence resulting from Covid-19 related sickness, shielding and isolation, alongside other current absences, has resulted in critical staffing levels, further reductions in which could result in unsafe service provision, poor patient outcomes and/or experience. In turn, poor service quality or reduction in services could impact on organisational reputation.*** See section 3.4 (Action on Highest Risks) for details of controls in place and actions taken to address this risk.	New risk (from Service Group)	Executive Director of Nursing	25

There is one risk with an increased score since the HBRR was received by the Management Board in July 2021.

Table 3: Risks with Increased Scores

Risk Ref	Risk	Lead Exec Director	HBBR Score Jun 2021	HBRR Score Sep 2021
1	**Access to Unscheduled Care Service** ***If we fail to comply with Tier 1 target – Access to Unscheduled Care – then this will have an impact on patient and family experience. Challenges with capacity /staffing across the Health and Social care sectors.***	Chief Operating Officer	16	25

Three register entries have been re-assessed by Executive leads has having decreased levels of risk:

Table 4: Risks with Decreased Scores

Risk Ref	Risk	Lead Exec Director	HBBR Score Jun 2021	HBRR Score Sep 2021
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.***	Chief Operating Officer	25	20
66	**Delays in Access to SACT** ***The demand & complexity of planned treatment regimes for cancer patients requiring chemotherapy currently exceed the available chair capacity, risking unacceptable delays in access to SACT treatment in Chemotherapy Day Unit with impact on targets and patient outcomes.***	Executive Medical Director	25	20
67	**Delays in Provision of Radical Radiotherapy Treatment** ***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.***	Executive Medical Director	25	15

Additionally, risk ref HBR49 (*Trans-catheter Aortic Valve Implementation - TAVI*) which had a score that had reduced to its target risk score of 12 has been closed by the Executive Medical Director following formal confirmation of its de-escalation by WHSSC. This will be removed from the register following its receipt by the Board in November.

Further detail on each of the above risks can be found at **Appendix 1**.

3.4 Action on Highest Risks (Score=25)

There were five risks with scores of 25 recorded at the July 2021 meeting. Three of them are amongst those noted above as having been re-assessed by their lead Executive has having reduced risk scores:

- HBR50 *Access to Cancer Services (Backlog of referrals exceeding capacity)*
- HBR66 *Delays in Access to SACT*
- HBR67 *Delays in Provision of Radical Radiotherapy Treatment*

There are four HIGH risks with a score of 25 currently. Two remain of the five reported previously (HBR 16 & 64); the two additional risks are the new risk relating to *Critical Staffing Levels in Midwifery* added by the Executive Director of Nursing above, and the increased risk relating to *Access to Unscheduled Care*:

Table 5: Action on Risks with Score=25

Risk Ref	Risk, Key Update & Action	Lead Executive Director
1	**Access to Unscheduled Care** ***If we fail to comply with Tier 1 target – Access to Unscheduled Care – then this will have an impact on patient and family experience. Challenges with capacity /staffing across the Health and Social care sectors.*** Previous Action: Implementation of Phone First for ED as one the initiatives set out in the National Unscheduled Care Programme – six goals. Lead: Chief Operating Officer Target: 31st October 2021 - Completed Previous Action: Phased implementation of the Acute Medical Services Redesign. Business case for ambulatory care element of service redesign submitted WG. Lead: Chief Operating Officer Target: 31st October 2021 – Completed Risk remains high. Additional actions: Actions: Joint working with WAST Lead: Chief Operating Officer Targets: • 24/7 ambulance triage nurse – in place • Zero tolerance of over 6 hours handover delays implemented; to be brought down to 4 hours – November 2021 • Ambulance offload and cohorting area – November 2021 • Identification of patient pathways that can bypass ED – December 2021 Action: Redesign of Acute Medical Services including Same Day Emergency Care Lead: Chief Operating Officer Target: December 2021	Chief Operating Officer

Risk Ref	Risk, Key Update & Action	Lead Executive Director
	Action: Commissioning of up to 100 care home beds Lead: Chief Operating Officer Targets: 1st phase up to 55 beds from November 2021, second phase December 2021 Action: Establishment of 4 virtual wards aligned to GP clusters Lead: Chief Operating Officer Target: December 2021	
16	**Access & Planned Care** ***There is a risk of harm to patients if we fail to diagnose and treat them in a timely way.*** Actions have been refreshed: Action: Implement demand management initiatives between primary and secondary care to reduce the number of new patients awaiting outpatient appointments. Lead (S): Service Directors Target: 31/12/2021 Theatre activity has now increased to pre-Covid levels across the three sites and further sessions are planned (in orthopaedics initially) with support from an insourcing companies for staff and additional elective sessions in Singleton Hospital. In addition, outsourcing to independent hospital has commenced with the further provision of theatre sessions in private facilities to be utilised by surgeons and anaesthetics from November onwards. An additional ophthalmology day case theatre in Singleton will also be operational early in 2022. Further action: Welsh Government has provided funding for the Health Board to develop and 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. Lead(s): Service Group Directors Target: 31/11/2021.	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.*** Health and safety department structure has been reviewed and proposals & business case produced. Action: Discussion ongoing to determine funding. Lead: Assistant Director of Health & Safety	Executive Director of Nursing

Risk Ref	Risk, Key Update & Action	Lead Executive Director
	Target: 31st December 2021 In meantime, agreement has been given to advertise 2 fire safety officer posts. The two fire safety posts will be advertised W/C 15/11/21, with interviews scheduled for December 21, with posts being filled between January - March 2022. This is only one discipline within the H&S team and awaiting confirmation of funding for the remainder of the posts in the business case. There will be no reduction in the risk rating initially, but potential to reduce the risk rating by 31 July 2022. Action: Health and safety structure review to be presented to the H&S Committee when funding has been agreed. Lead: Assistant Director of Health & Safety Target: 31st January 2022 (updated to follow action above)	
81	**Critical Staffing Levels: Midwifery** ***Unplanned absence resulting from Covid-19 related sickness, shielding and isolation, alongside other current absences, has resulted in critical staffing levels, further reductions in which could result in unsafe service provision, poor patient outcomes and/or experience. In turn, poor service quality or reduction in services could impact on organisational reputation.*** This is a new risk to the Health Board risk register. The register controls & additional comments sections list a number of measures & actions already taken to manage the risk. Further actions are listed below: Action: On-boarding new Band 5 recruits (expected all complete by mid-November) Lead: Deputy Head of Midwifery Target: Mid November 2021 – the on-boarding is underway currently. A supernumerary period will be required before they will make an impact on the risk. Action: 14 Band 5 graduates from 2020 – preceptorship completion plan (2 have completed, 9 due by end of December) Lead: Deputy Head of Midwifery Target: End December 2021 (for majority) Action: Due to review suspension of the Birth Centre and Home Births Lead: Deputy Head of Midwifery Target: End October 2021 Action: Midwifery bank & agency SOP has been developed and will be approved this month (already in use). Lead: Deputy Head of Midwifery Target: 20th October 2021	Executive Director of Nursing

Risk Ref	Risk, Key Update & Action	Lead Executive Director
	Actions taken and planned for December are anticipated to reduce risk to a target score of 16 by the end December. The decentralization of services in Q4 may assist to reduce the risk further. A new target for additional reduction of the risk will be considered in January.	

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 of 20.

3.5 Covid 19 Risk Register – Highest Risks

At the Gold Command meeting on 12th October, scores for two risks on the Covid-19 risk register were increased, reaching the Health Board's risk appetite score of 20. These risks are highlighted briefly below for information:

Table 6: Covid 19 Risk Register – Highest Risks

Covid-19 Register Ref	Risk Detail	Current Risk Score
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.	20
COV 009a	**Workforce Shortages** Risk to service provision, deployment plans and Health Board strategic workforce related developments i.e. 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, Outbreaks. Key risk areas where specific workforce shortages impact is the greatest e.g. ITU, A&E, Covid wards are reflected in the overall score.	20

Risks remaining on the Covid-19 register are overseen by Gold Command and reviewed weekly.

4. GOVERNANCE AND RISK

4.1 Risk Appetite & Tolerance Levels

As noted earlier, members of the Board agreed that the risk appetite, whilst dealing with Covid-19, would increase to 20 and above for an initial period of 3 months. There is a low tolerance to taking risk where it would have a high impact on the quality and safety of care being delivered to patients. While it has been subject to ongoing review, the risk appetite limit of 20 and above has remained in place since the start of the pandemic.

Feedback from the September 2021 meeting of the Health & Safety Committee has indicated that in addition to expressing a low tolerance to risk affecting patient care, it should also reflect a low tolerance to risks to the safety of staff.

The Board will need to approve the extension of its risk appetite limit at 20 for the next Quarter (indicating risks assessed at a score of 20 or above should be addressed as a priority) and its low tolerance to risks with a high impact on the quality and safety of staff and patient care.

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. RECOMMENDATION

Members are asked to:

- **NOTE** the Health Board Risk Register and process ongoing to enhance and refresh its content;
- **CONSIDER** whether further assurance is required on action to address risks identified or to enhance the register entries;
- **APPROVE** the extension of the risk appetite score of 20 for the next Quarter (indicating risks assessed at a score of 20 or above should be addressed as a priority) and the low tolerance to risks with a high impact on the quality and safety of staff and patient care.

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	• Adapted from report to Management Board on 20th October 2021, with adjustments approved by Executive risk leads. • Adapted from report to Audit Committee 9th November, with updates agreed with Executive Directors
Appendices	• Appendix 1 – Health Board Risk Register (HBRR)

HEALTH BOARD RISK REGISTER
September 2021

(Revised to reflect updates on highest risks up to November)

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 – September 2021

Impact/Consequences						
	5			**53:** Compliance with Welsh Language Standards **76:** Partnership Working **79**: Finance Recovery of Access Times **67:** Access to Cancer Services – Radiotherapy Reduced from 25	**51:** Compliance with Nurse Staffing Levels (Wales) Act 2016 **60:** Cyber Security **66:** Access to Cancer Services – SACT Reduced from 25 **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) **75:** Whole Service Closure **77:** Workforce Resilience	**01:** Access to Unscheduled Care Service Increased from 16 **16:** Access to Planned Care **64:** H&S Infrastructure **81:** Critical Staffing Levels: Midwifery New
	4			**13:** Environment of Health Board Premises **27:** Sustainable Clinical Services for Digital Transformation **37:** Operational and strategic decisions are not data informed ~~**49:** TAVI Service~~ Closed **52**: Engagement & Impact Assessment Requirements	**36:** Electronic Patient Record **39:** IMTP Statutory Responsibility **41:** Fire Safety Regulation Compliance **43:** DOLS Authorisation and Compliance with Legislation **48:** Child & Adolescence Mental Health Services **57:** Non-compliance with Home Office Controlled Drug Licensing requirements **61:** Paediatric Dental GA Service – Parkway **78**: Nosocomial	**03:** Workforce Recruitment of Medical and Dental Staff **04:** Infection Control **50:** Access to Cancer Services Reduced from 25 **58:** Ophthalmology Clinic Capacity **63:** Screening for Fetal Growth Assessment in line with Gap-Grow (G&G) **65:** CTG Monitoring in Labour Wards **68:** Pandemic Framework **70:** Data Centre outages **80:** Inability to Transfer Patients
	3		**54:** No Deal Brexit			
	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** Failure to comply with Tier 1 target for Unscheduled Care could impact on patient and family experience of care.	20	25	↑	→	November 2021	Performance and Finance Committee
	4 (739)	**Infection Control** Failure to achieve infection control targets set by Welsh Government could impact on patient and family experience of care.	20	20	→	→	September 2021	Quality and Safety Committee
	13 (841)	**Environment of HB Premises** Failure to meet statutory health and safety requirements.	16	12	→	→	September 2021	Health and Safety Committee
	16 (840)	**Access to Planned Care** Failure to achieve compliance with waiting times, there is a risk that patients may come to harm. Also, financial risk not achieving targets.	16	25	→	→	November 2021	Performance and Finance Committee
	37 (1217)	**Information Led Decisions** Operational and strategic decisions are not data informed.	16	12	→	→	September 2021	Audit Committee
	39 (1297)	**Approved IMTP – Statutory Compliance** Failure to have an approvable IMTP for 2022/23 then we will lose public confidence and breach legislation.	16	16	↓	→	September 2021	Performance and Finance Committee

[1] This trend reflects the change since the June 2021 HBRR that was received by the Management Board in July 2021.

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	41 (1567)	**Fire Safety Compliance** Fire Safety notice received from the Fire Authority – MH&LD Unit. Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance.re safety regulations.	15	16	↓	→	November 2021	Health and Safety Committee
	43 (1514)	**DoLS** If the Health Board is unable to complete timely completion of DoLS Authorisation, then the Health Board will be in breach of legislation and claims may be received in this respect.	16	16	→	→	September 2021	Quality and Safety Committee
	48 (1563)	**CAMHS** Failure to sustain Child and Adolescent Mental Health Services (CAHMS).	16	16	→	→	September 2021	Performance and Finance Committee
	49 (922)	**Trans-catheter Aortic Valve Implementation (TAVI) CLOSED** Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI)	25	12	↓	→	September 2021	Quality and Safety Committee
	50 (1761)	**Access to Cancer Services** Failure to sustain services as currently configured to meet cancer targets could impact on patient and family experience of care.	20	20	↓	→	September 2021	Performance and Finance Committee
	57 (1799)	**Controlled Drugs** Non-compliance with Home Office Controlled Drug Licensing requirements.	20	16	→	→	September 2021	Audit Committee
	63 (1605)	**Screening for Fetal Growth Assessment in line with Gap-Grow** Due to the scanning capacity there are significant challenges in achieving this standard.	12	20	→	→	September 2021	Quality and 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	→	→	November 2021	Health and Safety Committee
	66 (1834)	**Access to Cancer Services** Delays in access to SACT treatment in Chemotherapy Day Unit	25	20	↓	→	September 2021	Quality and Safety Committee
	67 (89)	**Risk target breaches – Radiotherapy** Clinical risk – Target breeches of radical radiotherapy treatment	16	15	↓	→	September 2021	Quality and Safety Committee
	69 (1418)	**Safeguarding** Adolescents being admitted to adult MH wards	20	20	→	→	September 2021	Quality & Safety 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	→	→	September 2021	Performance and Finance Committee
	74 (2595)	**Induction of Labour (IOL)** Delay in IOL or augmentation of Labour	20	20	→	→	September 2021	Quality and Safety 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	20	→	→	September 2021	Performance and 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	16	→	→	September 2021	Quality and Safety Committee

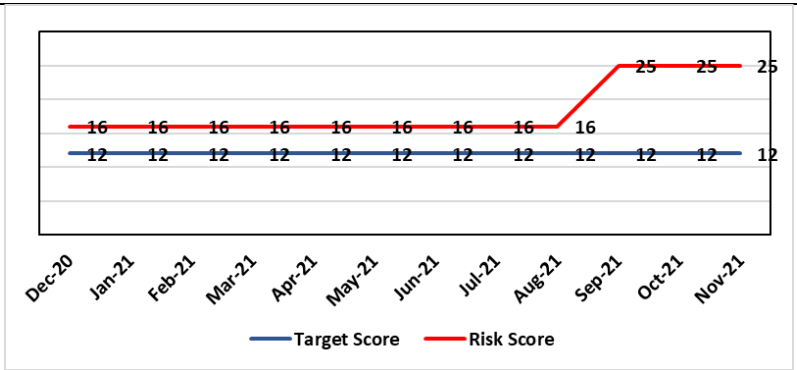
Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	79 (2739)	**Finance - Recovery of Access Times** Potential risk that resource available is below the ambition of the board to provide improved access.	15	15	→	→	September 2021	Performance and Finance Committee
	80 (1832)	**Inability to Transfer Patients** Avoidable harm as a result of inability to transfer patients out of Morriston Hospital including medically fit patients.	20	20	→	→	September 2021	Quality & Safety Committee
	81 (2788)	**81: Critical Staffing Levels: Midwifery NEW** Unplanned absence resulting from Covid-19 related sickness, shielding and isolation, alongside other current absences, has resulted in critical staffing levels, further reductions in which could result in unsafe service provision, poor patient outcomes and/or experience. In turn, poor service quality or reduction in services could impact on organisational reputation.	25	25	New[2]	New	November 2021	Quality & Safety Committee
Excellent Staff	3 (843)	**Workforce Recruitment** Failure to recruit medical & dental staff	20	20	→	→	September 2021	Workforce and OD Committee
	51 (1759)	**Nurse Staffing (Wales) Act** Risk of Non Compliance with the Nurse Staffing (Wales) Act	16	20	→	→	September 2021	Workforce and 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	15	→	↓	September 2021	Workforce and OD Committee

[2] Escalated from Service Group operational risk register

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	20	→	↓	September 2021	Workforce and OD Committee
Digitally Enabled Care	27 (1035)	**Sustained Clinical Services** Inability to deliver sustainable clinical services due to lack of digital transformation.	16	12	→	↓	September 2021	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	→	→	September 2021	Audit Committee
	60 (2003)	**Cyber Security – High level risk** The level of cyber security incidents is at an unprecedented level and health is a known target.	20	20	→	→	September 2021	Audit Committee
	65 (329)	**CTG Monitoring on Labour Wards** Risk associated with misinterpreting abnormal CTG readings in delivery rooms.	16	20	→	→	September 2021	Quality & Safety Committee
	70 (2245)	**National Data Centre Outages** The failure of national systems causes severe disruption across NHS Wales, affecting Primary and secondary care services.	20	20	→	→	September 2021	Audit Committee
Partnerships for Improving Health and Wellbeing	58 (146)	**Ophthalmology - Excellent Patient Outcomes** There is a failure to provide adequate clinic capacity to support follow-up patients within the Ophthalmology specialty.	12	20	→	→	September 2021	Quality and Safety Committee

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend[1]	Controls	Last Reviewed	Scrutiny Committee
	61 (1587)	**Paediatric Dental GA Service – Parkway** Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morriston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies.	15	16	→	→	September 2021	Quality and Safety Committee
	68 (2299)	**Pandemic Framework** Risk of declared pandemic due to Coronavirus Infectious Disease outbreak 2020.	20	20	→	→	September 2021	Quality and Safety Committee
Partnerships for Care	52 (1763)	**Statutory Compliance** The Health Board does not have sufficient resource in place to undertake engagement & impact assess in line with Statutory Duties	16	12	→	→	September 2021	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	→	→	September 2021	Health Board (Welsh Language Group)
	54 (1724)	**Brexit** Failure to maintain services as a result of the potential no deal Brexit	20	6	→	↓	September 2021	Health Board (Emergency Preparedness Resilience and Response Group)

Risk Schedules

Datix ID Number: 738 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 1** **Target Date: 31st March 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: If we fail to comply with Tier 1 target – **Access to Unscheduled Care** then this will have an impact on patient and family experience. Challenges with capacity /staffing across the Health and Social care sectors.		**Date last reviewed:** November 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: ~~4~~5x~~4~~5=~~16~~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	Implementation of Phone First for ED as one the initiatives set out in the National Unscheduled Care Programme – six goals.	Chief Operating Officer	~~31st October 2021~~ Completed
	Phased implementation of the Acute Medical Services Redesign. Business case for ambulatory care element of service redesign submitted WG.	Chief Operating Officer	~~31st October 2021~~ Completed
	Joint working with WAST • Zero tolerance of over 6 hours handover delays implemented; to be brought down to 4 hours • Ambulance offload and cohorting area • Identification of patient pathways that can bypass ED	Chief Operating Officer	November 2021 November 2021 December 2021
	Redesign of Acute Medical Services including Same Day Emergency Care	Chief Operating Officer	December 2021
	Commissioning of up to 100 care home beds. 1st phase up to 55 beds from November 2021. 2nd phase December 2021	Chief Operating Officer	1st phase: November 2021 2nd phase: December 2021

	Establishment of 4 virtual wards aligned to GP clusters	Chief Operating Officer	December 2021

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

Risk transferred to Urgent & Emergency Care Board to task 11.05.2021.
Update 12.11.2021: Actions refreshed by management.

Datix ID Number: 843 **Health & Care Standard: Staff & Resources 7.1 Workforce**		**HBR Ref Number: 3** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Excellent Staff		**Director Lead:** Debbie Eyitayo, Interim Director of Workforce and OD **Assuring Committee:** Workforce and OD Committee	
Risk: Workforce recruitment of medical & dental staff		**Date last reviewed:** September 2021	
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: • Unable to recruit sufficient numbers of trainees to fulfil rotas on all sites • Unable to attract non training grades to complete rotas • Unable to fill Consultant grade posts in some specialties with adverse effects on patient safety and industrial relations. Unable to recruit sufficient registered nursing staff.	
Level of Control = 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.	**Action**	**Lead**	**Deadline**
	Medical training initiatives pursued in a number of specialties to ease junior doctor recruitment	Interim Director W&OD.	31st March 2022
	The Medical Workforce Board continues to monitor recruitment and junior doctor's rotas.	Interim Director W&OD.	31st March 2022
	Continue to recruit internationally.	Interim Director W&OD.	31st March 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?)**
• General situation monitored through W&OD Committee • Communication with Deanery • Recruitment campaigns • Monitoring by Executive Teams and specialty based local workforce boards	Locum cover Adequate supply of doctors who can work in this country Ability to flexibly deploy doctors in training.

Additional Comments

Risk covers all hospitals and multiple specialties. Participated in BAPIO rounds. Working with Medacs to replace long term locums. Invest to Save Bid for international overseas recruitment for nursing to upscale for 20/21. Recruitment remains a challenge but is also a national problem. During the pandemic we are still recruiting staff from overseas but have had to provide hotel accommodation for them to quarantine. Supply issues to the COVID areas have used doctors from other specialties where demand is currently low. We are over established locum posts in medicine, ITU and Anaesthetics. International medical recruitment - In progress but this has been delayed due to Covid. New approaches from Spring 21 onwards.

Datix ID Number: 739 **Health & Care Standard: 2.4 Infection Prevention & Control & Decontamination**		**HBR Ref Number: 4** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality and Safety Committee	
Risk: Failure to achieve Welsh Government infection reduction goals, and a higher incidence of Tier 1 infections than average for NHS Wales. Risk of nosocomial transmission of infection.		**Date last reviewed:** September 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 =12		**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 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%			
Date added to the HB risk register January 2016		**Rationale for target score:** 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.	

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

- 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.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Ensure maintained, clean and safe patient care environments, equipment/devices.	Facilities, Support Services & Service Group Directors	31st March 2022
Review feasibility of increasing single room capacity.	SGD, Operational Services & Patient Flow	31st March 2022
Reduce bed occupancy & patient moves.	SGD, Operational Services & Patient Flow	31st March 2022
Use timely data to drive QI programmes.	HoN IPC, Digital Intelligence & SGD	31st March 2022

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

- Clear Corporate and Service Group IPC Assurance Framework in place.
- Ongoing monitoring of infection control rates, with weekly feedback corporately & to Service Groups.

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

Review single room capacity. Poor condition of hospital estate requires investment. High activity limits access for planned preventative maintenance and necessary HTM validation/compliance checks. Seek improved Corporate and Service Group

• Infection Control Committee receives assurance reports, monitors infection rates, and identifies key actions to drive improvement. • Training compliance. • IPC, antimicrobial, decontamination and cleaning audit programmes. • Compliance and validation systems for water safety, ventilation systems and decontamination.	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

17/05/21 - The Health Board continues to have amongst the highest incidence of the Tier 1 infections in Wales. When improvements have been achieved, it has been challenging to sustain these improvements.

Clinical teams require renewed focus on:

• Antimicrobial stewardship - prudent use of broad-spectrum antibiotics; compliance with 72 hour review; reduction in overall use.

• prudent use of, and monitoring of continued need for, invasive devices, including evidence of compliance with insertion & maintenance bundles.

This risk has been reviewed and revised post-COVID, and has taken into account 2020/21 Tier 1 HCAI performance. Improvement will require IPC-related quality priorities to be integrated into crosscutting service plans.

Register content has been refreshed substantially by the Head of Nursing (Infection, Prevention & Control).

05/10/21 – Current service pressures are high, and surge capacity is being utilised, leading to instances of over-occupancy, which increases risks.

Currently ventilation in majority of clinical wards does not provide the recommended 6 air changes per hour, particularly required in areas where patients with viral respiratory infections are cared for. Mitigation currently has to be by the use of natural ventilation, facilitated by opening windows where possible. This may reduce environmental temperatures for patients, to potentially uncomfortable levels.

Lack of isolation facilities is exacerbated over winter months due to the increased incidence of seasonal viral infections, such as Influenza, Respiratory Syncytial Virus, and Norovirus.

Increased length of stay and staff shortages increase potential infection risks.

Datix ID Number: 841 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**		**HBR Ref Number: 13** **Target Date: 31st March 2022**	**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:** September 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 =12 Target: 4 x 3 = 12		**Rationale for current score:** HSE issued ten improvement notices in 2012 relating to accommodations not meeting statutory/health and safety requirements. This could have an adverse impact on citizens, staff, financial and operational performance.	
Level of Control = 90%		**Rationale for target score:** Risk assessments of premises.	
Date added to the HB risk register April 2012			

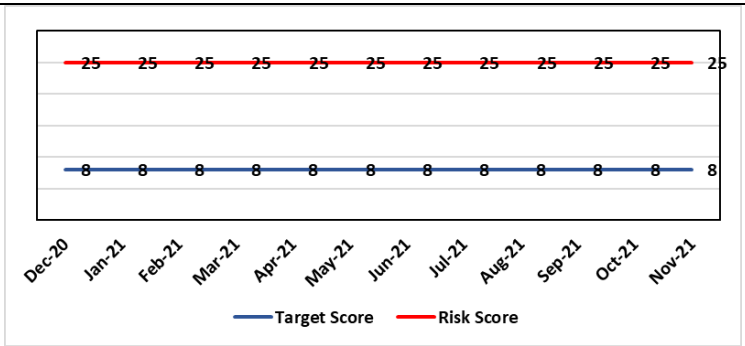
Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Key areas where performance linked to health & safety/fire issues. Health & Safety and Quality & Safety Committees and agreed actions to mitigate impacts. • Actions addressed through site meetings trade improvements on the 2 acute hospital sites. • Primary Care premises, audits commissioned and delayed due to covid.	~~Develop a strategy to improve primary & community services estate.~~	~~Service Group Director P&C~~	~~31/07/2021~~
	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 (Estates) & Assistant Director of Strategy (Capital)	31/03/2022
	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 (Estates)	31/03/2022
	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	31/12 2021
	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 (Estates), ADoStrategy (Capital) and ADoH&S	31/03/2022

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

Planned interviews to take on board a SCP 1ST / 2ND Week of November 20. 3 months to undertake verification of our design by the SCP then submit to the WG for approval and funding. Action completed 17.08.21 (development of BJCs to improve infrastructure of 2 acute hospital sites) – This is an ongoing 10 year programme. Paper presented to Health & Safety committee 1st April 2021, the committee were asked to note:

- Capital Bids had been submitted to WG for backlog maintenance
- The requirement for funding for 6 facet survey
- The identified backlog maintenance works highlighted in the report & resources section of admin control.

Datix ID Number: 840 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 16** **Target Date: 31st March 2022**	**Current Risk Rating** **5 x 5 = 25**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** 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:** November 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 5 = 25 Target: 4 x 2 = 8 **Level of Control** = 90% **Date added to the HB risk register** January 2013		**Rationale for current score:** All non-urgent activity was cancelled due to response to the Covid-19 pandemic and has increased the backlog of planned care cases across the organisation. Whilst mitigating measures such as virtual clinics have been put in place new referrals are still being accepted which is adding to the outpatient backlog particularly in Ophthalmology and Orthopaedics. The significant reduction in theatre activity is obviously increasing the number of patients now breaching 36 and 52 week thresholds. **Rationale for target score:** There is scope to reduce the likelihood score to reduce the Risk to an acceptable level	

Controls (What are we currently doing about the risk?)	**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. • The annual plan is based on specialty level capacity and demand models at specialty level that set out the baseline capacity and identify solutions to bridge the gap. Non-recurring pump – prime funding is available to support initial recovery measures. Monthly performance reviews track progress against delivery. • A focused intervention is in train to support to the 10 specialties with the longest waits.	~~Develop and implement a full range of '**treat while you wait'** interventions at specialty level to minimise harm.~~	~~Service Directors~~	~~30th September 2021~~
	Implement demand management initiatives between primary and secondary care to reduce the number of new patients awaiting outpatient appointments.	Service Directors	31/12/2021
	Welsh Government has provided funding for the Health Board to develop and 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	31/11/2021

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

15.07.2021 - Theatre activity has now increased to over 85% pre-Covid levels and further sessions will be commissioned with support from an insourcing companies for staff. In addition outsourcing to independent hospital has commenced with the further provision of theatre sessions to be utilised by surgeons and anaesthetics from Sept 2021. Update 13.10.21 Theatre activity has now increased to pre-Covid levels across the three sites and further sessions are planned (in orthopaedics initially) with support from an insourcing companies

for staff and additional elective sessions in Singleton Hospital. In addition, outsourcing to independent hospital has commenced with the further provision of theatre sessions in private facilities to be utilised by surgeons and anaesthetics from November onwards.
Update 12.11.21: An additional ophthalmology day case theatre in Singleton will also be operational early in 2022.
Actions refreshed by management.

Datix ID Number: 1035 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**		**HBR Ref Number: 27** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 3 = 12**
Objective: Digitally enabled care		**Director Lead:** Matt John, Director of Digital **Assuring Committee:** Audit Committee	
		Date last reviewed: September 2021	
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.		**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- Significant growth in digital adoption during 20/21 has resulted in more digital solutions and devices to support with same resources. Disaggregation of the CTM SLA has commenced – unable to reduce resources required to provide services to SBUKB due to economies of scale.	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 = 12 Target: 5 x 2 =10 **Level of Control** = 50% **Date added to the HB risk register** 2012		**Rationale for target score:** C – Of failure will increase as the reliance and proliferation of the use of digital solutions increases. L – Investment will mean the support mechanisms, rate of failure and ability to deliver solutions that meet the needs of users will improve sustainable digital services. There will however always be an inherent risk of failure of IT solutions.	

Controls (What are we currently doing about the risk?)	**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	Establish 5year financial plan for Digital including the risks of the termination of the CTM SLA.	Head of Digital Services Business Management	31st March 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?)**
• 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

Submitted two bids for HEPMA and TOMS for funding 2021/22.
Update 14.07.21 - Risk has been reviewed and the likelihood score has been reduced from 4 to 3 bringing the overall score down from 16 to 12.
Update 18.08.21 – A funding letter for HEPMA has been issued to WG and accepted/approved by the Health Board. Update 15.09.21 – No update for this month's submission

Datix ID Number: 1043 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**		**HBR Ref Number: 36** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 4 = 16**
Objective: Digitally enabled care		**Director Lead:** Matt John, Director of Digital **Assuring Committee:** Audit Committee	
Risk: Paper Record Storage: Lack of a single electronic record means there is greater reliance on the provision of the paper record. If we fail to provide adequate storage facilities for paper records, then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if there is poor records management in some wards. There is an increased fire risk where medical records are stored outside of the medical record libraries.		**Date last reviewed:** September 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 4 = 16 Target: 3 x 3 =9		**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	
Level of Control = 70%		**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.	
Date added to the HB risk register June 2016			

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 improved storage solution for both paper and digital records.	Head of Health Records & Clinical Coding	31st March 2022
	Complete convergence with WCP (replace ABMU Clinical Portal with Welsh Clinical Portal at all inpatient locations)	Director of Digital	29th October 2021

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.

Action - All SDU and corporate leads

Health Records Department are working with HB colleagues to develop a case for improved storage solution both for paper record
are now as follows:

A scoping exercise has been undertaken across the Health Board to quantify the storage issues for All types of records as it has been evident for some time that the current capacity available to store records both within the main hospitals and off site storage areas is insufficient, and that current practices cannot continue, and a Health Board wide solution is required.

The outcome of the scoping exercise will be shared with the Health Board Space Management Work Stream. Once completed, a Business Case will be written, to document the scale of the issues that the Health Board is facing in storing all types of records on an indefinite basis. These updates are also being provided as part of the Health records papers that are submitted to IGG.

Within the Acute Health Records Service and across numerous Health board services that manage and store their records separately from the acute record thousands of records continue to be moved off site to a third party storage supplier called the Maltings at a significant cost to the Health Board due to a lack of capacity on-site to store the records.

Investigations have identified that other Health Boards are destroying records where appropriate digital solutions are in place. This will therefore be taken forward in the options appraisal of the business case. (See action above).

Action complete 31.05.21 - Establish the legalities around the scanning and destruction of paper records in relation to the Blood Enquiry.

Action complete 14.07.21 – Implementation of WNCR completed at NPTH.

15.09.21 – No Updates for this month's submission.

Datix ID Number: 1217 **Health & Care Standard: Effective Care 3.1 Safer & Clinically Effective Care**		**HBR Ref Number: 37** **Target Date: 31st March 2022**	**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:** September 2021	
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?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• 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.	Investment and implementation of system to record patient outcome measures	Head of Digital Intelligence	24th September 2021
	Produce BI strategy implementation plan	Head of Digital Intelligence	~~30th September 2021~~ 15th October 2021
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 PROMS being collected in Lung Cancer (Morriston, Cataracts, Hip & Knee (Morriston), and Breast Cancer using PKB, also Heart failure, in one Community Clinic. COVID19 Dashboards Developed and are being used to inform the decision making process at Gold. Management Board have approved the investment for 4 BI partners to work with the SDGs to become more data driven. Update 14.07.21 – Action closed - Produce Business Intelligence Strategy and get signed off by the Board. This action has been closed down and encompassed into a new action. Update 18.08.21 – BI partner roles have been funded – Interim 6 month posts recruited to until formal recruitment takes place – introductory meetings and priority areas being captured by BI Partners in conjunction with SDG's to support the SDG's to become more data driven. Update 15.09.21 - Action 2 - Draft Business Intelligence Strategy presented to Management Board in July 2021 for comment, which includes detail on the proposed BI governance structure to be put in place. A subsequent BI operational implementation plan will be produced following feedback and further engagement, (timescale changed from 30/9/2021 to 15/10/2021 due to the Head of Business Intelligence being on Jury Service). This risk will be reviewed over the coming month, in light of the 4 new BI partners that have been recruited into the team with a view to re -score the risk.	

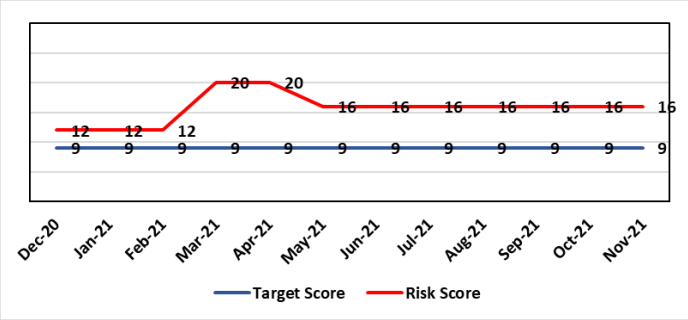
Datix ID Number: 1297 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**		**HBR Ref Number: 39** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 4 = 16**
Objective: Demonstrating Value and Sustainability .		**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee**: Health Board ,Performance and Finance Committee	
Risk: Operational and strategic decisions are not data informed: Failure to have an approvable IMTP for 2022/23 then we will lose public confidence and breach legislation.		**Date last reviewed:** September 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 4 x 2 = 8		**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 has been submitted to WG on 30.06.21 and includes a balanced financial plan.	
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?)**		
	Action	**Lead**	**Deadline**
• Welsh Government written statement published on the 7 October 2020 advising that SBUHB been de-escalated from targeted intervention status to 'enhanced monitoring' status. • A draft Annual Plan within 3 year context was considered by the Board In Committee in March 2021 and submitted to WG. • The final Annual Plan was approved by the Board on 23 June 2021 and submitted to WG on 30 June 2021. • The Health Board is developing a 3 – 5 Recovery and Sustainability Plan which will provide the foundation to deliver an agreed IMTP for 2022/23.	Development of draft Recovery and Sustainability Plan for approval by the Board	Dir of Strategy & Dir of Finance	30th September 2021

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Recovery and Sustainability Working Group has been established, chaired by CEO with independent members and Executive leads. 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. Robust programme arrangements have been put in place to execute the 21/22 Annual Plan.	

Additional Comments

08.07.21 Update – Two actions closed – Development of draft Annual Plan and Annual Plan to be finalised. New action done. Updates also to controls, assurances, rationale for current score.

Datix ID Number: 1567 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**	**HBR Ref Number: 41** **Target Date: ~~31st March 2022~~ ~~30th November 2023~~ February 2024**	**Current Risk Rating** **4 x 4 = 16**
Objective: Best Value Outcomes	**Director Lead:** Gareth Howells, Executive Director of Nursing **Assuring Committee:** Health and Safety Committee	
Risk: Fire Regulation Compliance – ~~one improvement notice received relating to MH&LD Unit~~. Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations.	**Date last reviewed:** November 2021	
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 4 x 4 = 16 Target: 3 x 3 = 9		**Rationale for current score:** ~~Improvement notice in relation to MH&LD Unit.~~ Cladding applied to Singleton Hospital front flank is not compliant with fire regulations. General compliance with fire regulations and WHTM/WHBN requirements. Risk reduced from 20 to 16.
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?)

- 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.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Change in fire evacuation plans and alarm and detection cause and effect	Head of Health & Safety	~~31st October 2021~~ ~~30th November 2023~~ 28th February 2024
Replacing the existing cladding and insulation with alternative specifications and inserting 30 minute fire cavity barriers where appropriate	Service Improvement Manager	~~31st October 2021~~ ~~30th November 2023~~ 28th February 2024

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

- 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

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

Cladding removal has commenced and will be a 2-3 year project. Working closely with NWSSP-SES (Authorised Engineer for Fire). Regular contact with MWWFRS. Reviewing fire warden numbers and training. Reviewing all fire risk assessment actions. Funding agreed for 2021-22 for updating automated fire system; fire door replacement; fire compartmentation works; lift call control. Potential of MWWFRS to inspect site, with a risk of enforcement action due to non-compliance to fire regulations.
The health & safety team have secured temporary resources to assist with reducing the number of overdue fire risk assessments, this includes those on the Singleton site to ensure all fire risk assessments are up to date and as of 10th May all risk assessments are up to date.
In addition a survey of fire compartmentation lines has been completed for the west block, with the next phase being the development of fire compartmentation drawings.

Due to the extent of the works and given current resources, this will have an impact on the support being able to be provided. The AD H7s is currently based at Singleton one day per week to assist the service group with fire safety enquiries/ challenges.
Update 28.06.21 - The flank walls were completed in 2019, it is the main façade of the tower block that is being replaced and is programmed to be completed in October 2023. There are no additional risks identified. Regular site and project updates taking place.
Update 01.07.21 - The main façade (cladding) to the tower block will be replaced with fully compliant cladding on a phased programme. The scaffolding for phase1 & 2 was completed in March 2021, with actual removal works commenced in April 2021. The target programme completion date is October/November 2023. The risk will be managed throughout the programme with regular site visits and project meetings.
Update 29.09.21 – As part of the stripping back to the building asbestos has been found and has to be removed, this coupled with expert witness investigations required to review works have impacted on the overall project. The completion date has been adjusted, with a new completion date of December 2023. This is and will continue to be monitored by the cladding project board.
11/11/21: Due to ongoing expert investigations and the additional asbestos removal, plus adverse weather conditions the overall program has had to be reviewed, with a new completion date of February 2024. It is possible this may slip further if the expert investigations are required throughout all phases. As the fire integrity of the building will not be completed until 2024 or later, this will impact on the ability to reduce the risk rating at present and will be continually reviewed.
Historical risk relating to improvement notice in MH&LD service had been addressed previously, so the risk description has been refreshed accordingly.

Datix ID Number: 1514 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**		**HBR Ref Number: 43** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 4 = 16**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality and Safety Committee	
Risk: If the Health Board is unable to complete timely completion of DoLS Authorisation then the Health Board will be in breach of legislation and claims may be received in this respect.		**Date last reviewed:** September 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 3 x 2 = 6		**Rationale for current score:** Although processes have been planned or implemented, the impact is yet to be measured over a longer term, and the challenges of managing a large backlog of breaches.	
Level of Control = 40%			
Date added to the HB risk register July 2017		**Rationale for target score:** Consequences of DoLS breaches for the Health Board will not change. With controls in place, over time likelihood should decrease.	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Supervisory body signatories in place BIA rota now implemented but limited uptake due to inability to release staff 2 x substantive BIA posts and additional admin post in place DoLS database updated and DoLS dashboard devised to enable more accurate monitoring and reporting Regular reporting to Mental Health and Legislative Committee (MHLC) (Nov 20) QIA completed for re-introduction of DoLS BIAs attending Ward as part of Reset and Recovery April 2021 QIA reviewed and service stood down in light of increased COVID incidence Oct 2020, service recommenced April 2021 Managing and supporting all referrals remotely New legislation changes expected in April 2022 which will require a different service model, business case to meet existing and future requirements will be progressed March 21. Expertise, advice and support available to wards via substantive BIAs	Delivery of DOLS Action plan reviewed monthly (change coding above also)	Director Primary & Community	Monthly Review
	DoLS dashboard in place, monitoring applications and breaches via dedicated BIAs and Admin.	UND Primary and Community	Monthly Review
	Report to Mental Health and Legislative Committee advising cessation of DoLS assessors visiting wards to minimise spread of COVID.	UND Primary and Community	Monthly Review
	Business case for revised service model. Report around changes from DoLS to LPS on track. Discussions with Corporate Nursing in progress to agree next steps	UND Primary and Community	31st July 2021

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Regular scrutiny at Safeguarding Committee and by DoLS Internal Audit; monitoring via DoLS Dashboard this will provide real-time accurate data. Update report to MHLC, impact of COVID and focus on urgent cases via virtual process and plan to progress business case by year end.	

Additional Comments

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

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

Datix ID Number: 1563 **Health & Care Standard: Safe Care 5.1 Access**		**HBR Ref Number: 48** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 4 = 16**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee:** Performance and Finance Committee, Health Board **For information:** Quality & Safety Committee	
Risk: Failure to sustain Child and Adolescent Mental Health Services		**Date last reviewed:** September 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 4 x 2 = 8		**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 agreed and being established by Summer 2019 which should give further stability to service.	Additional investment expected - from Welsh Government	CAMHS network	~~30th September~~ 31st March 2022
	Staffing of service being strengthened & supplemented by agency staff	CAMHS network	~~30th September~~ 31st December 2021

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

Additional Comments

Cwm Taf achieved the non-urgent 28 day target for specialist CAMHS and primary CAMHS in 2020, with performance deteriorating due to staff being relocated to Ty Llydiard to support 763pandemic. Performance has improved in 2021 towards achievement of targets.

01.04.21 – Action update – Additional demands as a result of Covid expected and will need additional investment either from MH development monies or from direct Welsh Government funding.

04.10.21 - CAMHS services have experienced increases in demand due to the pandemic. Plans are in place to address the backlog of cases but are dependent on agreement with CTM to use additional staff time / payments which is outstanding. Progress expected by end of December 2021.

Datix ID Number: 922 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**		**HBR Ref Number: 49 CLOSED** **Target Date: 31st July 2021**	**Current Risk Rating** **4 x 3 = 12**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Richard Evans, Medical Director **Assuring Committee:** Quality and Safety Committee	
Risk: Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI)		**Date last reviewed:** September 2021	
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 4 x 3 = 12 Target: 3 x 4 = 12		**Rationale for current score:** External review undertaken by Royal College of Physicians which will likely indicate that patients have come to serious harm as a result of excessive waits. Remains significant reputational risk to the Health Board.	
Level of Control = 50%		**Rationale for target score:** External review by the Royal College of Physicians will provide a view on improvement required immediately and for sustainability.	
Date added to the HB risk register July 2016			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• TAVI Recovery Plan implemented and backlog has been cleared. • Plan is supported with Executive oversight at fortnightly TAVI has been prioritised in next year's WHSSC ICP for 2020/21. • Royal College of Physicians have provided reports on the service and action plans have been developed and implemented	Continued oversight of outcomes by the Executive Medical Director, reporting to Quality and Safety committee regularly	Executive Medical Director	30th Sept 2021

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Reduction in waiting times for TAVI. Executive Medical Director Oversight of improvement plans. Development of Quality and Safety Dashboard. Oversight and scrutiny by Quality and Safety Committee	

Additional Comments

Reports now received from RCP on (1) initial casenote review (2) site visit in July 2019 (3) second cohort casenote review; action plans implemented in response
Improvement activity continues to have oversight of the Executive Medical Director at fortnightly Gold Command meetings. Regular briefings and reports are provided to key stakeholders including WHSSC, Welsh Government and Hywel Dda UHB.
WHSSC have de-escalated the TAVI service from its current Stage 3 to Stage 2, in recognition of significant improvement in the service.
Recommend reduction in risk score from 16 to 12.
Update 04.10.21 - Notification from WHSSC today that they have formally de-escalated TAVI; RCP have also formally signed-off and ended their involvement.
The risk score is now at the target score and it's been agreed that risk can now close. Closure endorsed by Management Board on 20/10/2021.

Datix ID Number: 1761 **Health & Care Standard: Timely Care 5.1 Access**		**HBR Ref Number: 50** **Target Date: 31st March 2022**	**Current Risk Rating** **5 x 4 = 20**
Objective: Best Value Outcomes from High Quality Care		**Director Lead**: Inese Robotham, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee **For information:** Quality & Safety Committee	
Risk: Access to Cancer Services – ~~There is a risk of harm to patients with cancer due to delayed presentation, referral, diagnosis or treatment.~~ A backlog of patients now presenting with suspected cancer has accumulated during the pandemic, creating an increase in referrals into the health board which is greater than the current capacity for prompt diagnosis and treatment. Because of this there is a risk of delay in diagnosing patients with cancer, and consequent delay in commencement of treatment, which could lead to poor patient outcomes and failure to achieve targets.		**Date last reviewed:** September 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 5 x ~~5~~ 4 = ~~25~~ 20 Target: 4 x 3 = 12		**Rationale for current score:** There has been a reduction in presentation and referrals for cancer. The cancer backlog has increased and treatment times have got longer due to Covid-19 related reductions in surgical capacity. Enhanced monitoring & weekly monitoring of action plans for top 6 tumour sites in place.	
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 ~~unscheduled care (USC)~~ Urgent Suspected Cancer Pathway. Enhanced monitoring & weekly monitoring of action plans for top 6 tumour sites. • Initiatives to protect surgical capacity to support USC pathways have been put in place in RGH and PCH to protect core activity. • Additional investment in MDT consideration, with 5 cancer trackers appointed in April 2021. • Prioritised pathway in place to fast track USC patients. • Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. • Weekly cancer performance meetings are held at both Singleton and Morriston Delivery Units. • The tumour sites of concern is in development. One of the areas is Lower GI where clinic capacity has increased by 4 times in April. • Endoscopy contract has been extended.	Phased and sustainable solution for the required uplift in endoscopy capacity that will be key to supporting both the Urgent Suspected Cancer backlog and future cancer diagnostic demand on Endoscopy Services. Harm review process to be implemented.	Service Group Manager	1st November 2021
	To explore the possibility of offering SABR RT for high risk lung cancer patients in SWWCC. Business case with WHSCC – expect response by end Nov 2021	Service Manager Surgical Services	~~30th September 2021~~ 30th November 2021

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
~~General improvement (sustained) trajectory. Need to continue improvement actions and close monitoring.~~	Clear current funding gap.

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

Additional Comments

The need to deliver sustained performance.
Whilst every effort is being made to maintain cancer treatment, surgical cancer activity in particular is being impacted upon by both the reduction in elective theatre capacity and availability in critical care beds due to the COVID-19 outbreak.
Covid screening is in place for all patients starting their 1st cycle of SACT and for all Lung RT patients.
Action - Establishment of mobile unit to carry out PET/CT scans for Swansea and South West Wales patients. – Completed
Action - Continue to expand our Surgery capacity to allow our complex cancer surgeries to deal with any backlog of patients – Completed
01.03.21: Action Completed – Introduce COVID testing for Oncology and Haematology
15.07.2021: The analysis of cases in top six cancer sites has been completed and a plan to resolve these was agreed in Management Board on 7th July 2021.

Datix ID Number: 1759 **Health & Care Standard: Staff & Resources 7.1 Workforce**		**HBR Ref Number: 51** **Target Date: 31st March 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:** September 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 4 = 20 Target: 4 x 2 = 8		**Rationale for current score:** • Improved risk as COVID position improves. Risk remains high due to registered nursing vacancies • Service groups (Morriston, Singleton and Neath Port Talbot) remain high with a score of 20	
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: • Workforce Plans have been developed by Unit Nurse Directors & Each Delivery Group to agree staffing in light of escalation to surge & super surge due to COVID-19, with consideration of all reasonable steps • Approved Registered Staff who have retired from the Nursing Midwifery Council Register in the last three years have been contacted with a view to return to practice and into the Health Board workforce. • Delivery Units have appropriately deployed of ward nurses to key areas. And also administration staff utilised to release nurses into providing care. • Student nurses have returned to clinical practice which has been supported corporately. • 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 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 • Three yearly caveated Welsh Government paper and Annual Assurance paper presented a Health Board in May 2021 • Health Board continues with workforce planning & redesign, training and development. recruitment and retention - Transformation • Scrutiny panels are held for each SDU following the submission of acuity templates • Impact assessment work is being undertaken to prepare for further roll out of the Act, extension of the Act to Paediatrics	The Ward Sister / Charge Nurse and Senior Nurse should continuously assess the situation and keep the designated person formally appraised.	Executive Director of Nursing	~~4th October~~ 1st November 2021 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.	Executive Director of Nursing	~~1st October~~ 1st November 2021
	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.	Executive Director of Nursing	~~4th October~~ 1st November 2021
	Risk register to be reviewed monthly to ensure compliance	Executive Director of Nursing	~~5th October~~ 1st November 2021 Monthly ongoing
Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance**		

• 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 of planned roster. • At least Yearly Board reports outlining compliance and any key risks.	**(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.

Additional Comments

7.5.21 - Discussed in Nurse Staffing Act Meeting formally agreed to maintain score of 20 based on evidence provided from Delivery Groups
Morriston Singleton & NPT Risk Score remains at 20 - Roster Scrutiny Panels operate to ensure the rostering Policy and Standards are fully implemented and are being reviewed to encompass triangulation with key quality indicators. Overseas recruitment remains a key priority.
Action Complete - Daily Staffing Tool has been agreed across the Delivery Groups to maintain a consistent approach.
13.07.2021 - Risk discussed at Health Board Nurse Staffing Steering Group, Service Groups Morriston Hospital, Singleton and Neath Port Talbot Hospitals score remains at 20. Corporate score also remains at 20. Vacancies remain high, nursing staff continue to shield, COVID related absence continues, although at a lower rate than in the Winter. All reasonable steps implemented across the HB.
Update 29.09.21 – NSA risk scores discussed monthly at HB NSA meeting. MH, NPTSSG and Corporate risk remain at 20. MH and NPTSSG stating increases to 25 occasionally, during week 13th Sept to 20th Sept.
Weekly Workforce meeting re-instated on 20th Sept, risk discussed and scores given by all service groups. w/c 13th September: All non-essential meetings cancelled. Vacancy rate is high - on 14th Sept reported as Band 5 311.66 WTE, Band 2 83.64 WTE vacancies. Student streamlining will improve situation. Support for newly qualified staff, induction plans underway. Daily staffing huddles and daily staffing tool completed daily within service groups, escalated to Corporate team as necessary. Nursing staff needing to shield and COVID related absences continue. All reasonable steps are being utilised across the HB. Enhanced overtime rates and off contract arrangements have been utilised.
Student streamlining will help improve vacancies, plans to support newly qualified nurses are in place. Solution around suitable venue for induction is being sort. Overseas recruitment continues. Wellbeing and support for staff continues.
Scrutiny panels were carried out in September, all Section 25B wards have been discussed using the triangulated methodology, establishments have been agreed and rosters have been altered to commence any changes from 21.11.2021.
Extension of 'the Act' into Paediatrics will start on 1st October 2021, paper has been discussed in Quality and Safety on 28.09.2021. This paper and the three-year report to Welsh Government will go to board on 7th October 2021.

Datix ID Number: 1763 **Health & Care Standard: Staff & Resources 7.1 Workforce**		**HBR Ref Number: 52** **Target Date: 31st March 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:** September 2021	
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?)**		
• 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.	**Action**	**Lead**	**Deadline**
	Conclude work on exec equalities portfolios	Interim Assistant Director of Strategy	31st ~~August~~ December 2021

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

As at 19.5.21 there has been no progress to create a IIA post.
Update 04.07.21 – Action completed - Appoint to agreed Planning posts. Funding agreed for Planned care post - acute care and planned care posts appointed to.
The Annual Plan for 2021/22 has a significant engagement elements taking place around changes to services for Older People's Mental Health Services and the roles of our Hospitals. This is placing significant pressures on the dept.
The additional capacity due to commence w/c 5/7 has not materialized, placing further pressures on the dept.
Risk to be reviewed in September.

Datix ID Number: 1762 **Health & Care Standard: Staff & Resources 7.1 Workforce**		**HBR Ref Number: 53** **Target Date: 31st March 2022**	**Current Risk Rating** **5 x 3 = 15**
Objective: Partnerships for Care		**Director Lead**: Pam Wenger, 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:** September 2021	
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?)

- 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.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
~~Recruitment of a Welsh Language Officer (WLO)~~	~~Head of Compliance~~	~~30th September 2021~~
Ensure the Board is fully sighted on the UHB's position through regular reporting to the Health Board.	Head of Compliance	30th November 2021
Review and update the Welsh Language Standards Action Plan. In doing so, reflect the findings of the independent assessment	Head of Compliance	31st December 2021
Reinstate quarterly meetings of the Welsh Language Delivery Group.	Head of Compliance	31st January 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

The resignation of the Welsh Language Officer in December 2020 has adversely impacted upon our ability to progress mitigating actions, notably the reinstatement of the Welsh Language Delivery Group meetings. These actions will now be progressed following the recruitment of the new WLO. 04.10.21 – Action completed – Welsh Language Officer now in post.

Datix ID Number: 1724 **Health & Care Standard: Safe Care 2.1 Managing Risk & Health & Safety**		**HBR Ref Number: 54** **Target Date: 31st December 2022**	**Current Risk Rating** **3 x 2 = 6**
Objective: Partnerships for Care		**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee:** Health Board (EPRR Group)	
Risk: Failure to maintain services as a result of the potential no deal Brexit		**Date last reviewed:** September 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 3 x 2 = 6 Target: 3 x 2 = 6		**Rationale for current score:** The initial risk assessment is based on the fact that significant work needs to take place to understand the risks in terms of the Health Board's ability to maintain business as usual. This has been undertaken, but given that there remain some unknowns in terms of future agreements, some are being reviewed during the summer of 2021, the current risk rating has reduced but remains in place.	
Level of Control = 70%		**Rationale for target score:** By undertaking the actions highlighted it is anticipated that the arrangements put in place will ensure business as usual even if some future trade agreements pose some risks to some services and business continuity plans have been updated to include the required mitigations.	
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**
• Emergency Preparedness resilience and response, (EPRR) work programme in relation to the 6 statutory duties is monitored via the EPRR Strategy Group; this includes emergency planning, risk assessment, collaboration, sharing of information, warning and informing and business continuity. • The Health Board continues to respond to the C-19 pandemic and has been in response since 31.01.21. In addition, there have been a number of concurrencies that the Health Board has responded to; emphasising the need for a continued cycle of EPRR. There is an EPRR risk register as well as a Brexit specific risk register and full risk assessment process, as well updated business continuity plans. There is national oversight of Procurement specifically for Brexit and continued HB engagement. • Welsh Government has put in place national communication and co-ordination arrangements for Brexit and most are now in dormancy. The Local Resilience Forum meets monthly to discuss Brexit specific risks • EPRR Work programme monitored via EPRR Strategy Group.	Plans were exercised during 2018 for a no deal Brexit. Continued planning remained in place and a constant review of risk assessments. In addition, the Health Board has invoked its business continuity arrangements a few times whilst responding to the pandemic and the most was in relation to disruption to supplies of blood science products. The learning from this incident is being taken forward to ensure critical stocks and supplies of just in time products is more robust.	Head of Emergency Preparedness, Resilience & Response	Monthly EPRR meetings occur for continued monitoring

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
• Work programme in place and monitored via EPRR Strategy Group • All services have up to date business continuity plans • Robust risk management system in place • Preparedness and response assurance procedure specifically for Brexit • Horizon scanning process in place for issues that may arise later during 2021	None

Additional Comments

BREXIT has now occurred with a "deal". There were requirements for data adequacy arrangements for the UK to be approved by end of June 2021, and for the settled status scheme to be implemented. Both of these are now complete. There is one further requirement due for resolution in Dec 2022, and it is therefore proposed to reduce the risk to 3 x 2 = 6 until this is closed.

Datix ID Number: 1799 **Health & Care Standard: Controlled Drug 2.6 Medicines Management**	**HBR Ref Number: 57** **Target Date: 31st December 2021**	**Current Risk Rating** **4 x 4 = 16**
Objective: Best Value Outcomes of High Quality Care	**Director Lead**: Richard Evans, Executive Medical Director **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 re future service change compliance.	**Date last reviewed:** September 2021	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 2 = 8 **Level of Control** = 40% **Date added to the HB risk register** January 2019		**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. **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	~~1st Sept 2021~~ 1st March 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	~~1st Sept 2021~~ 1st March 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	~~1st Sept 2021~~ 1st March 2022
	Apply for a HO CD License for HMP Swansea.	CD Lead, PCT	~~1st Sept 2021~~ 1st March 2022

Assurances **(How do we know if the things we are doing are having an impact?)** The HB policy on HO CD licenses is referred to when issues are raised in order to provide consistency in arrangements.	**Gaps in assurance** **(What additional assurances should we seek?)** 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

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 in September 2021.

Datix ID Number: 146 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**		**CRR Ref Number: 58** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Excellent Patient Outcomes		**Director Lead**: 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:** September 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 5 = 20 Target: 4 x 1 = 4		**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. • Additional IS capacity secured to increase activity from July 2021, implementation plan under development. Welsh government funding secured for 2021.	An overall Regional Sustainability Plan to be delivered	Service Group Manager Surgical Specialties	31st March 2021 (Bi-weekly 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?)**
• Deputy COO in regular liaison with IS on contract progress.	Regular liaison with patients on extended waiting list/times and validation.

Additional Comments

Routine appointments were suspended since the advent of the Covid-19 outbreak the following essential Eye services have been maintained during Covid 19.

- AMD treatments
- Retina services
- Rapid Access Eye clinic (RACE - Eye Casualty)

Some clinically urgent Cataract operations have also been undertaken.

14.04.21 - Additional glaucoma clinic capacity now available in Wellbeing Centre, Swansea University. Work ongoing with Hywel Dda HB on regional solutions commence in July 2021.

Datix ID Number: 2003 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**HBR Ref Number: 60** **Target Date: 31st March 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.	**Date last reviewed:** September 2021	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 5 x 3 = 15		**Rationale for current score: C and L** The level of cyber security incidents is higher than it has ever been and recently the Ireland Health Service were subjected to a ransomware attack (May 2021). The increase in users and devices increases the threat landscape. Mandatory training not adopted to date.
Level of Control		**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
Date added to the HB risk register July 2019		

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. • 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.	Adopt mandatory Cyber training across SBUHB, or identify alternative options.	Cyber Security Manager	17th December 2021
	Undertake Cyber Assessment as part of annual NIS compliance work with Cyber Resilience Unit in DHCW	Cyber Security Manager	15th October 2021

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.

Additional Comments

Papers on the progress of Cyber Security are being sent annually to the Senior Leadership Team, Audit committee and Health Board meetings.
A paper will be sent to the Management Board in September 2021 to gain approval to make cyber security training mandatory.
Update 15.09.21 - Options are being explored with colleagues in IG to establish whether Cyber Security Training can be combined with the current mandatory IG training programme.

Datix ID Number: 1587 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 61** **Target Date: 31st March 2022**	**Current Risk Rating** **4 X 4 = 16**
Objective: Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the 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:** September 2021	
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?)**		
	Action	**Lead**	**Deadline**
• Consultant Anaesthetist present for every General Anaesthetic clinic. • Assurance Documentation supplied by Parkway Clinic including confirmation of arrangements in place with WAST and Morriston Hospital for transfer and treatment of patients • New care pathway implemented - no direct referrals to provider for GA. • Multi-drug sedation ceased from Sep 2018 in line with WHC 2018 009 • Revised SLA/Service Specification • HIW Inspection Visit Documentation provided to HB • All extended GA cases require approval from paediatric specialist prior to treatment	Transfer of services from Parkway.	Interim Head of Primary Care	31st May 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?)**
• RMC collate referral and treatment outcome data for review by Paediatric Specialist • Regular clinical meeting arranged with Parkway to discuss individual cases/concerns • Regular clinical/ management meeting for CDS/primary care management team to discuss service pathway /concerns/issues arising • Roll out of new pathway to encompass urgent referrals	ToR for the task and finish group should continue to include consideration of the pressures on the POW special care dental GA list and this service is considered alongside any plans for the Parkway contract.

Additional Comments

Task & Finish Group continue to progress transfer of service to Morriston.

Action moved to May 2021 due to Covid pressures. However, PWC have now given the Health Board notice that they wish to terminate the contract at the end of January 2021. Transfer of this service to Morriston is not feasible by the end of January and given the limitations on staffing and theatre capacity is not achievable by May 2021 therefore T&F Group are looking at the other options available to deliver the service which, includes extending the contract with PWC through to March 2022 or transferring the service the NPTH. A paper setting the options will be

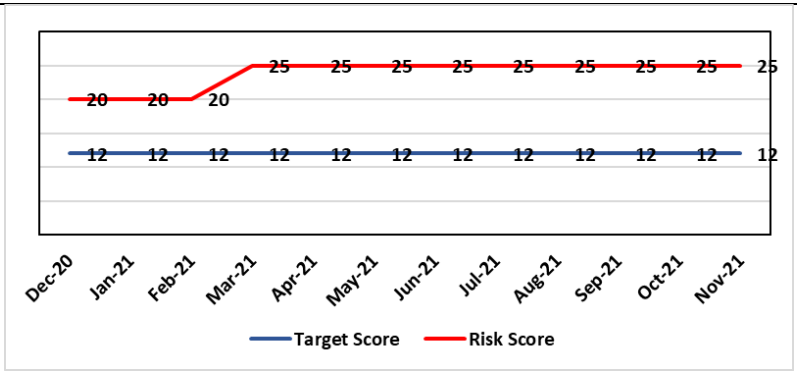
presented to the Senior Leadership on 18 November 2020. Risk remains - for review in November following meeting with Senior Leadership on 18th November 2020. Task and Finish Group re-established first meeting on 1st December to progress transfer to Morriston Hospital by 31st May 2021. The limited theatre capacity available due to Covid restrictions has resulted in an extension of the contract with Parkway until June 2022 being negotiated.

Datix ID Number: 1605 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 63** **Target Date: 31st March 2022**	**Current Risk Rating** **4 X 5 = 20**
Objective: Screening for Fetal Growth Assessment in line with Gap-Grow (G&G)		**Director Lead**: Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality and Safety Committee	
Risk: There is evidence a growth restricted/small for gestational age fetus (SGA), has an increased risk of intra-uterine death before or during the intrapartum period. Identification and appropriate management for SGA in pregnancy should lead to improved outcomes. GAP & Grow standards were implemented to contribute to the reduction of stillbirth rates in wales. Obstetric USS scan appointments are at capacity leading to delays in obtaining required appointments. In addition, the guidance from Gap & Grow is for women requiring serial scanning with a risk factor for a growth restricted baby must have 3 weekly scans from 28 to 40 week gestation. Due to the scanning capacity there are significant challenges in achieving this standard.		**Date last reviewed:** September 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 5 = 20 Target: 3 x 4 = 12		**Rationale for current score:** CSFM's leading on audit reviewing records of all women where SGA not identified in antenatal period. Scanning capacity under increasing pressure. Meeting arranged with radiology management to discuss introduction of midwife sonographer third trimester scanning. Staff to be informed to submit Datix incident where scan not available in line with standards.	
Level of Control = 60%			
Date added to the HB risk register 1st August 2019		**Rationale for target score:** Compliance with Gap & Grow requirements.	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
All staff have received training on Gap & Grow and detection of small for gestational babies. Obstetric scanning capacity across the HB is being reviewed and compliance with criteria for scanning is being monitored. Ultrasound are assisting with finding capacity wherever possible in order to meet standards for screening and complying with Gap & grow recommendations.	Adherence to Gap/Grow Standards	Deputy Head of Midwifery	31st December 2021
Assurances **(How do we know if the things we are doing are having an impact?)** Audit of compliance with guidance being undertaken, detection rates of babies born below the 10th centile is being monitored via Datix and audited by the service. Ultrasound are assisting with finding capacity wherever possible in order to meet standards for screening and complying with Gap & grow recommendations.	**Gaps in assurance** **(What additional assurances should we seek?)**		

Additional Comments

Training currently being provided by appropriately trained obstetrician and the two trainee midwife sonographers are making good progress in their university course and practical skills training.
Trainer role currently on Trac (2 year fixed term). 2 current trainee sonographers progressing well through training.
Ensure SBAR for recruitment for two further trainee sonographers is completed and presented to NPTSSG group for approval.
Update 07.07.21 - Sonography trainer appointed, start date to be confirmed. UWE course now anticipated to be completed for 2 midwifes by ~~September 2021~~ early 2022. Business case for 2nd cohort to be completed.

Datix ID Number: 2159 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**		**HBR Ref Number: 64** **Target Date: ~~31st March 2022~~** **31st August 2023**	**Current Risk Rating** **5 X 5 = 25**
Objective: Best Value Outcomes		**Director Lead:** Gareth Howells, Executive Director of Nursing **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:** November 2021	
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	
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?)

- 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 2021to reduce the number of FRA overdue.
- Fire training in place and fire wardens in place

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Health and safety department structure reviewed and proposals & business case produced. Discussion ongoing to determine funding.	Assistant Director of H&S	31st December 2021
The two fire safety posts will be advertised W/C 15/11/21, with interviews scheduled for December 21, with posts being filled between January - March 2022.	Assistant Director of H&S	31st March 2021
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	31st January 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

The health and safety team has been allocated temporary resource to assist in addressing the overdue fire risk assessments, with a plan in place to reduce the number of overdue fire risk assessment. Actions include completion of the health & safety team resource business case to address resource issues within the H&S team to enable the HB to address its legal obligations. The additional resources required have been included in the HB annual plan. Resources when approved will be phased in over 2021/22 and 2022/23 financial years. This will enable the risk level to be reduced when implemented potentially to a score of 20. A further reduction may be possible at the end of 2023 when infrastructure work has been completed. Update 28/06/2021: Business case has been submitted and awaiting confirmation on resource allocation as outlined in the business case. 15/07/2021: There is no change to the current risk score as a decision on funding has not been agreed yet.
23/09/2021: Agreement to advertise 2 fire safety officer posts in September 2021. There is no change to the current risk score as resources remain a challenge and await decision for funding in line with the business case resources submission.
11/11/21: The two fire safety posts will be advertised W/C 15/11/21, with interviews scheduled for December 21, with posts being filled between January - March 2022. This is only one discipline within the H&S team and awaiting confirmation of funding for the remainder of the posts in the business case. There will be no reduction in the risk rating initially, with the potential to reduce the risk rating by 31 July 2022

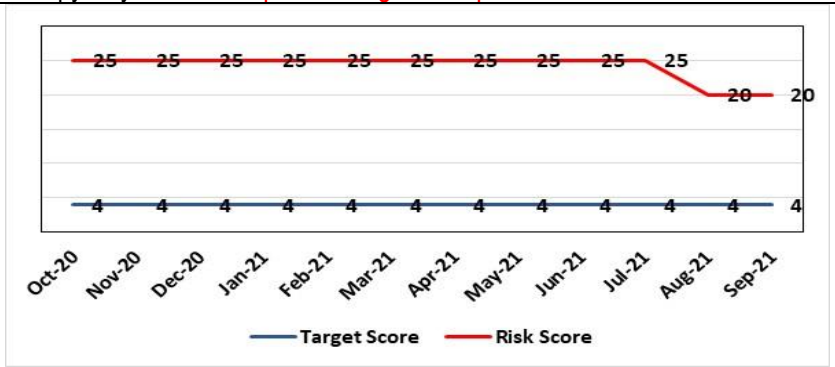
Datix ID Number: 329 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 65** **Target Date: 31st March 2022**	**Current Risk Rating** **4 X 5 = 20**
Objective: Digitally enabled Care		**Director Lead**: Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality & Safety Committee	
Risk: Risk associated with misinterpreting abnormal cardiotocography readings in the delivery room. A central monitoring station would enable multi-disciplinary viewing and discussion of the readings to take place, and reduce the risk of a concerning CTG trace going unidentified. Provisionally scored C4 (irrecoverable injury) x L3= 12. The central monitoring system has a facility to archive the CTG recordings: currently these tracings are only available as a paper copy, which can be lost from the maternity records. There is also a concern that the paper tracings fade over time which makes defending claims very difficult.		**Date last reviewed:** September 2021 **Rationale for current score:** Meeting with K2, IT, finance, procurement and midwifery team on 30/09/2019. System viewed and IT needs identified. Final costing to be assessed prior to resubmission to IBG in Oct or November 2019.	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 5 = 20 Target: 4 x 2 = 8		**Rationale for target score:** Funding for central monitoring approved for 2021/22 Meeting to be arranged with provider and key stakeholders in SBU to commence the project toward installation and training.	
Level of Control = 50%			
Date added to the HB risk register 31st December 2011			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Current controls include all staff undertaking RCOG CTG training and competency assessment. Protocol in place for an hourly "fresh eyes" on 'intrapartum CTG's' and jump call procedures. CTG prompting stickers have been implemented to correctly categorise CTG recordings. Central monitoring is also expected to strengthen the HB's position in defending claims. K2 fetal monitoring system has been identified as the best option for a central monitoring system.	Business case prepared for Central monitoring system to store CTG recordings of fetal heart rate in electronic format.	Deputy Head of Midwifery	31st December 2021
	Procurement meeting to agree costings	Deputy Head of Midwifery	30th ~~July~~ September 2021

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

Additional Comments

04.05.21 – Update – Awaiting final sign off for purchase of central monitoring. Walk around planned for 12th May 2021 for estates and I.T to cost up the infrastructure aspect of the bid.
07.07.21 – Update – Business case being updated and once finalised will be submitted to BCAG.

Datix ID Number: 1834 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 66** **Target Date: 31st March 2022**	**Current Risk Rating** **5 X 4 = 20**
Objective: Best values outcomes from high quality care		**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee:** Quality and Safety Committee	
Risk: The demand & complexity of planned treatment regimes for cancer patients requiring chemotherapy currently exceed the available chair capacity, risking unacceptable delays in access to SACT treatment in Chemotherapy Day Unit with impact on targets and patient outcomes.		**Date last reviewed:** September 2021	
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x ~~5~~ 4 = ~~25~~ 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 Increase nursing staff x 1 at risk, to ensure all nurses are working appropriately. Review of scheduling by staff to ensure all chairs used appropriately. ~~Looking at options around expansion of home care delivery to free up chair capacity in CDU~~	Business case endorsed by CEO for shift of capacity to home care to be considered by the Management Board.	~~Executive Medical Director~~ Service Director Lead for Cancer	29th October 2021
	A second business case is being developed to propose relocation of CDU to a vacant ward area, which would increase chair capacity.	~~Executive Medical Director~~ Service Director Lead for Cancer	29th October 2021
	Subject to approval of the above relocation will progress with aim of completion by April 2022.	Service Director Lead for Cancer	1st April 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?)**
~~Extra nurse in place reliant on agency. Senior team meeting to review findings of service review paper. Additional funding agreed to support increase in nurse establish to appropriately run the unit during their main opening hours.~~ Following completion of the Medical move to Morriston from Singleton following population engagement, assurance reports on activity and improved chair waiting times will be monitored through monthly Cancer Improvement Group	Capital & Revenue assumptions & resources for second business case for increasing chair capacity in 2022/23 to meet increased demand.

Additional Comments

Working with MSD/GE around potential partnership agreement to look at C&D mapping and best practice elsewhere. Covid has impact on demand for chairs due to need to socially distance. Loss of 3 Chairs (due to IPC controls for COVID) has impacted on capacity. Currently running alternate Saturdays in CDU to mitigate loss. Current wait time for SACT >21 days for the majority of patients. Business case for shift of capacity to home care to be considered by the Management Board in July. Second business case to increase chair capacity in development. Action Completed - Expansion of home care delivery and additional chair capacity - SACT group. Update 02.08.21 – Paper on home care expansion with CEO for agreement on next steps. 16.09.2021 - Chairs closed during Covid have been reintroduced so the likelihood has been reduced accordingly. Current score reduced from 25 to 20 accordingly. 04.10.21 SACT expansion paper for home care agreed in BCAG on 08.09.21, this will mitigate loss of 3 chairs due to Covid.

Datix ID Number: 89 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 67** **Target Date: 31st March 2022**	**Current Risk Rating** **5 X 3 = 15**
Objective: Best values outcomes from high quality care		**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee:** Quality and Safety Committee	
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:** September 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x ~~5~~ 3 = ~~25~~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.	Hypofractionated Prostate - Business plan submitted for additional resources required to implement hypofractionated technique.	Service Manager Cancer Services	31st December 2021
	Explore the possibility of undertaking SABR treatment for lung cancer patients at SWWCC. Awaiting confirmation from WHSSC on whether they will commission SABR from SBUHB.	Executive Medical Director	8th September 2021
	New Linac required – Linac case agreed with WG	Service Manager Cancer Services	31st July 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?)**
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.	Performance and activity data monitored, but delays to treatment continue while sustainable solutions found.

Additional Comments

27.04.21 Update - Risk remains 25 due to limited CT and LINAC capacity. Wait time for RT >28 days for the majority of patients.
Exploration of further opportunities to (a) increase hyperfractionation for other diseases (b) opportunity to outsource.
New CT due to be operational mid-May 2021. If on schedule and additional capacity (hyperfractionation and outsourcing) is confirmed, risk should reduce to 16.

16.06.21 Update – Started sourcing for prostate RT – 70 pts over 6 months. Hypo fractionation case for prostate with CEO for consideration.
02.08.21 Update – Still waiting on hypo fractionation case – outsourcing continues.
31.08.21 Update - Hypofractionated Prostate - Awaiting outcome of business case. Hypofractionated Prostate - Awaiting outcome of business case. No longer in a position to join the PACE C Trial. (high recruitment). Hypofractionated Pancreas - Meeting with clinicians and physics next week, progressing well. Outsourcing - Currently 4 patients attended Rutherford for RT. Current Wait time - artificially low due to drop in demand over summer (as expected) demand already rising for mid-September onwards. Lin B/C replacement - Building work starting September.
06.09.21 Update - Discussed at RTMM. Current Risk reduced to 15. At present 70 patients to be outsourced which increases capacity. Hypofractionated pancreas does not require additional business case. New Linac building work underway, which will increase capacity in near future.
Action complete 27.09.21 – Additional Rx Capacity – Outsourcing to Rutherford - NEW Action being taken forward as part of Covid RT Recovery plan.
04.10.21 Update - 7 Patients have now been sent to the Rutherford for treatment, slow start due to the summer holidays. Lung SABR case discussed in WHSSC management meeting and supported. plan to take to WHSSC management board for approval. With plan to support from Qtr 4 onwards. Prostate RT case issue with getting financial support from Hywel Dda, Director of Strategy written formally to Hywel Dda for clarity on situation. Work continues with Lin C replacement no concerns noted.

Datix ID Number: 2299 **Health & Care Standard: 2.4 Infection Prevention and Control (IPC) and Decontamination**		**HBR Ref Number: 68** **Target Date: 31st March 2022**	**Current Risk Rating** **4 X 5 = 20**
Objective: Best Value Outcomes from High Quality Care **Risk:** Risk of declared pandemic due to Coronavirus Infectious Disease outbreak 2020 leading to disruption to Health Board activities.		**Director Lead**: Keith Reid, Director of Public Health **Assuring Committee:** Quality and Safety Committee **Date last reviewed:** September 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 3 x 2 = 6 **Level of Control** = **Date added to the HB risk register** 27/02/2020		**Rationale for current score:** Separate risk register capturing the specific Covid-19 risks which the Health Board are managing with high risks relating to: • COVID Equipment – inc PPE • COVID Workforce • COVID Medicines • COVID Capacity **Rationale for target score:**	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• HB Response now in place. • Command and Control structure stood up. • Non-COVID19 activity curtailed. • Staff exclusions and testing in place. • PPE guidance in place. • Engagement with all Wales planning and delivery functions. • Field hospitals developed and commissioned. • Primary Care models adapted to current situation. • Work with local authorities on maintaining care sector. • Acting in concert with Local Resilience Forum to manage wider community risks.	Pandemic Plans invoked	Director of Public Health Wales	Monthly Ongoing

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
• Community testing arrangements are active - Early detection. • PPE training and procurement centrally co-ordinated. • Command and control structures are monitoring effectiveness of corporate response. • Engagement with All wales co-ordinating groups - alignment of local and national responses. • Activation of local resilience forum arrangements.	Visibility and scrutiny of local plans at Executive/Board level.

Additional Comments

Mitigation as follows to identify and reduce risks of spread of infection:
Pandemic plans invoked
Command, Control and Coordination arrangements in place with Strategic, Tactical and bronze Groups in place to ensure Health Board wide engagement and instigate required planning including:

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

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

Datix ID Number: 1418 **Health & Care Standard: 5.1 Timely Access**		**HBR Ref Number: 69** **Target Date: 31st March 2022**	**Current Risk Rating** **5 X 4 = 20**
Objective: Best values outcomes from high quality care		**Director Lead**: 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:** September 2021	
Risk Rating (consequence x likelihood): Initial: 2 x 3 = 6 Current:5 x 4 = 20 Target: 2 x 3 = 6		**Rationale for current score:** Risk score increased to 20.	
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.	Long Length of Stay reduction programme in Mental Health	Service Director	~~30th September~~ 31st December 2021

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance** **(What additional assurances should we seek?)**
Individual Rooms with en Suite Facilities, Joint working with CAMHS, Monitoring of staff training, Monitoring of admissions by the MH & LD 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.	

Additional Comments

09.06.21 Update - The risk remains at 20 as while the provision is not ideal no other alternative has been identified. Welsh Government Mental Health Improvement monies have been bid for to extend CAMHS crisis and hospital liaison services to be 24/7, which if successful should enhance the support available in such circumstances.
As of 05.08.21 there have been 10 admissions to Ward F of a CAMHS patient.
Action update 04.10.21 - Due to outbreak status, no reviews of Ward F currently being undertaken. RM to tie in with risk assigner about the need for this to be completed.

Datix ID Number: 2245 **Health & Care Standard: 3.1 Clinically Effective Care**		**HBR Ref Number: 70** **Target Date: 31st March 2022**	**Current Risk Rating** **4 X 5 = 20**
Objective: Digitally enabled care		**Director Lead**: Matt John, Director of Digital **Assuring Committee:** Audit Committee	
Risk: 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).		**Date last reviewed:** September 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 2 = 8		**Rationale for current score:** **C** -The number of outages in 2018 and impact across NHS Wales resulted in a review of NWIS services including the wider Informatics services in NHS Wales. In the June 2019 outage, caused by air conditioning failure in BDC, some services took as long as 2 weeks to recover. **L** -There have been a number of multi system outages over the last 2 years with a number of factors causing outages or resulting in extended outages. Therefore there is a likelihood of a recurrence in the future.	
Level of Control =			
Date added to the HB risk register 27/02/2020		**Rationale for target score:** **C** – As reliance on digital solutions for the provision of clinical services grows the impact of outages will also grow. Whilst controls will be put in place to mitigate against the impact of outages this will be offset by the growth in the importance of digital solutions. As a result the consequence score will remain at 4. **L** – The likelihood of national data centre outages will never be fully eliminated. The current score of 5 is based on the fact there have been WLIMS outages over recent years. The implementation of the new National data centre will reduce the likelihood of outages due to environmental issues in Blaenavon once complete and score will reduce to 2.	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• SBU Representation at IMB and NSMB to hold DHCW to account for service provision • Digital Services Representation at EPRR for escalation and Digital Service Management Group to report progress. • The impact of outages is partly mitigated by the Business Continuity plans that are in place within the Service Delivery Units to allow operational services to continue during a data centre service outage	**Action**	**Lead**	**Deadline**
	Implementation of the new National data centre by DHCW	Head of ICT Operations	3rd October 2021 Monthly ongoing
	Monitoring availability of national services through IMB, NSMB and DSMG. On stable operations agree to address this risk in DSMG.	Head of ICT Operations	On quarterly reviews
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

NWIS have a Programme of works to upgrade out of date equipment. The network upgrade Programme was completed this year at 2 national data centres i.e. Newport (NDC) and Blaenavon (BDC).

The final report on the BDC outage has been received and recommendations put in place to increase maintenance levels and monitoring and monitoring in the BDC and replace equipment. In addition, it is recommended that serious consideration should be given to identifying and funding an alternative Tier 3+ facility (in line with the NDC) to host these critical systems which is agreed and migration will complete this year to Church Village Data Centre (CDC).
WLIMS was upgraded in December 2020 which consists of new hardware and software and monitoring availability is ongoing.
Update 18.08.21 - The Data centre transition to CloudCentres Data Centre is due to complete on 3rd October 2021. Once the transition is complete, the SBU Digital Services Team will monitor national service performance closely and will hopefully be in a position to reduce the National Data Centre risk score during Q4 21/22.
Audit Committee Update
DHCW are leading the National Data Centre Project to transition all NHS Wales digital services hosted at BDC to CloudCentres Data Centre (CDC) outside Cardiff. This aim is to provide a smooth transition to an improved data centre environment. The BDC is a tier 2 data centre where is CDC is tier, which means it provides far more redundancy for power and cooling and uptime maintenance capabilities.
Whilst the project is large scale and complex, the approach taken by the project team has been to focus on risk mitigation and maintaining uptime. Services that are resilient across the two Data Centres (i.e. Critical Services) will continue to operate from the Newport Data Centre (which will remain) whilst the infrastructure is transitioned from BDC to CDC. Whilst being transitioned, the geographic resilience for these Services is removed but every effort will be made to ensure the physical infrastructure is transitioned safely, securely and in a timely manner to minimise impact to resilience.
There are some services that are not classed as “critical” which do not have resilience across the two data centres. For these DHCW are liaising with relevant stakeholders to ensure contingencies are in place during transition. Health Board Digital Service Leads are working in collaboration with DHCW to fully understand the logistics of the plan and ensure SBU colleagues are informed and have the necessary business continuity plans in place.
During April the project suffered a significant setback to the implementation of its network connectivity, which was needed before the transition of services could start. The original moves were scheduled for eight consecutive ‘transition weekends’ beginning at the end of May. Despite all attempts to compress timescales with Third Party Suppliers, the project team accepted that change was inevitable and
started exploring the most assured way of altering the plan. Following a full impact assessment, new dates were communicated as 30th July through to 3rd October. This allows the project to still meet the deadline of vacating BDC by the end of October 2021, but with less contingency. However, the latest project update for June (appendix 1) indicates that DHCW are still confident of this schedule within weeks of the transition commencing.
Once the transition is complete, the SBU Digital Services Team will monitor national service performance closely and will hopefully be in a position to reduce the National Data Centre risk score during Q4 21/22.
Update 15.09.21 – No amendments for this month’s submission.

Datix ID Number: 2450 Health & Care Standard: 2.1.1 Managing Financial Risk	HBR Ref Number: 73 Target Date: 31st March 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:** September 2021	

Risk Rating
(consequence x likelihood):
Initial: 5 x 4 = 20
Current: 5 x 4 = 20
Target: 5 x 1 = 5

Level of Control
= 25%

Date added to the HB risk register
July 2020

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
- As the Health Board moves out of direct COVID response and into COVID recovery there remains a real risk that some additionality 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.

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?)

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 in place for 2021/22
- Review all of KPMG pipeline savings opportunities to test whether these can be accelerated in the light of COVID-19 impact.
- System of internal control proposed and will be implemented in quarter 1 2021/22

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Impact of reset and recovery to be assessed through QIA process to ensure clear understanding of impact on underlying cost base.	COO	30th September 2021 Monthly ongoing

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

None.

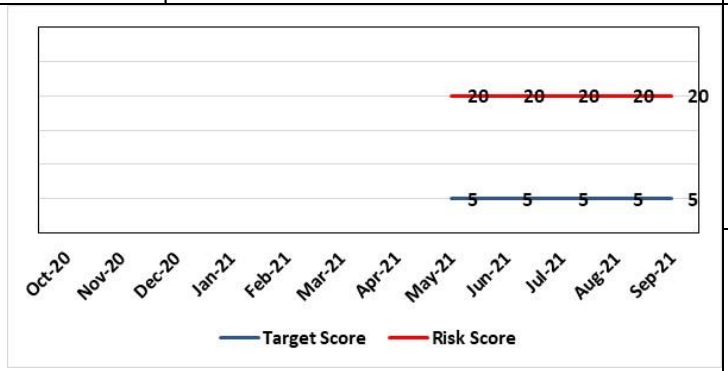
Datix ID Number: 2595 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 74** **Target Date: 31st March 2022**	**Current Risk Rating** **5 X 4 = 20**
Objective: Best Value Outcomes from High Quality Care		**Director Lead**: Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality and Safety Committee	
Risk: Delay in Induction of Labour (IOL) or augmentation of Labour Swansea BAY UHB have developed a local guideline for the management of IOL based on NICE guidance. Women are booked for IOL by a senior obstetrician either for clinical reasons (which may be for fetal or maternal factors) and for prolonged pregnancy at 41+6 when spontaneous labour has not occurred.		**Date last reviewed:** September 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 4 = 20 Target: 2 x 3 = 6 **Level of Control** = 60% **Date added to the HB risk register** 30th April 2021		**Rationale for current score:** 15 linked records since January 2021 where IOL was placed on hold. No significant poor outcomes resulted from the cases identified in the linked records. The IOL is booked and it is anticipated this should take place as planned within the standards set. However, for reasons of acuity in either maternity services or neonatal services, admission for IOL, continuation of IOL that has commenced or augmentation of labour is not possible. **Rationale for target score:**	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Diary is maintained for booking of IOL with agreed numbers of IOL per day. Daily obstetric consultant ward round to review all women undergoing IOL. Ongoing/regular monitoring by cardiotocograph for fetal wellbeing. Labour ward coordinator and labour ward obstetric lead ensure women on ward 19 for IOL are factored into daily planning of workload on labour ward. If IOL's/ Augmentation of labour are put on hold/delayed the women are reviewed by the MDT to assess for any potential risk to mother or baby. The MDT (Obstetric, Neonatal and Midwifery) discuss and consider the impact of delay for each woman. Escalation to the appropriate senior staff takes place and the Escalation Policy is implemented. Daily acuity is gathered and sent to the senior midwifery management team who can anticipate potential problems and support the clinical team. The matron of the unit is contacted in office hours and the senior midwife manager on call is contacted out of hours. The senior midwife will review staffing across all areas and deploy staff if possible including the specialist midwives and the community midwifery on call team. Neighbouring maternity units are contacted to ask if they are able to support by accepting the transfer of women.	Ongoing review of risk	Head of Midwifery	30th ~~July~~ September 2021

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Review of midwifery staffing on ward 19 (antenatal ward), during recent birthrate plus assessment. This will ensure women receive effective midwifery support and reassurance of fetal wellbeing.	

Additional Comments

28.06.21 Update - An electronic diary is being prepared for booking IOL. This will allow all staff easy access to the diary to prevent overbooking and will improve waiting times in antenatal clinic. The updated BR+ assessment has been received into the HB and the review of Ward 19 staffing is incorporated for an additional midwife to support the IOL clinical area to reduce delays. 7.7.21: Impact of BR+ shortfall will impact on the ability of the service prevent delay in IOL. BR+ shortfall compounded by high level of maternity leave and continue to support midwives who are shielding. Newly qualified midwives will join the workforce in September 2021.

Datix ID Number: 2522 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 75** **Target Date: 31st March 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	
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:** September 2021	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 5 x 1 = 5		**Rationale for current score:**	
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**
• Sites have business continuity plans, however, there is a need to review the impact of one site being overwhelmed by COVID demand. In particular, the impact of a closure of one or more hospital front doors may require additional BC plans to be developed. Operational Silver will review BC arrangements.	Business Continuity plans in place to be reviewed by operational silver command.	Singleton Group Director/Morriston Service Director	31st March 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

(This risk is being reviewed currently)

Datix ID Number: 2377 **Health & Care Standard: Staff & Resources 7.1 Workforce**		**HBR Ref Number: 76** **Target Date: 31st March 2022**	**Current Risk Rating** **5 x 3 = 15**
Objective: Partnerships for Care		**Director Lead:** Debbie Eyitayo, Interim Director of Workforce & OD **Assuring Committee:** Workforce & OD Committee, Health & Safety Committee	
Risk: 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.		**Date last reviewed:** September 2021	
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 3 = 15 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 us of higher levels of PPE than the all Wales position allows. They have engaged with external media and voiced their concerns in very direct and critical terms, threatening to involve the Minister. Their position has not changed and this issue is raised at every LPF meeting. The risk score has reduced in line with the prevalence of Covid and thus the likely actions of staff although staff side have recently been involved in a local campaign actively encouraging their members to raise retrospective Datix incident for any staff who had a position Covid test. This has generated circa 1600 Datix entries.	
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**
• Frequent meetings will continue to take place, supplemented by local discussions when required. • Employees will be encouraged to raise concerns via existing mechanisms and directly to the Chief Executive. • We will continue to utilise the daily briefings 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. Employees will be encouraged to raise concerns via existing mechanisms and directly to the Chief Executive. We will continue to utilise the daily briefings 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	The Health Board will continue to develop an effective working relationship with all trade union partners and collectively via the agreed HB Partnership Forum.	Assistant Director of Workforce & OD	31st March 2022

Forum on a regular basis. Partnership principles and ways of working will be emphasised as the most effective approach to secure progress. • Despite extensive discussions at PF staff side formally raised a number of issues in writing indicating they have not accepted the information provided.			
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. Group discussed consistently high position of risk score leaving no room for further escalation should situations worsen. Noted that sufficiently robust mitigating actions required if the score is to remain this high. JRQ reluctant to support reduction of the score in light of recent difficulty in relations with TUs, who have been threatening instigating Ministerial action. JRQ to discuss this with KJ Discussion at Gold 12.04.21: No alteration to post-MA risk score required currently. KJ to review and see if downgrade to score of 20 is possible. Discussion at Gold 20.04.21 JRQ noted that this risk should have been reduced to 20 and cannot be reduced any further currently due to a number of ongoing issues. Risk score reduced to reflect immediate impact only. Significant tensions remain. Access to all Wales support to help reduce concerns under consideration.			

Datix ID Number: 2569 **Health & Care Standard: Staff & Resources 7.1 Workforce**		**HBR Ref Number: 77** **Target Date: 31st March 2022**	**Current Risk Rating** **5 x 4 = 20**
Objective: Excellent Staff		**Director Lead:** Debbie Eyitayo, Interim Director of Workforce & OD **Assuring Committee:** Workforce & OD Committee	
Risk: Workforce Resilience (risk description refreshed July 2021) Risk covers two issues: Part 1 The present direct impact (wave 3) in terms of Covid / related sickness including Long Covid (symptomatic Absence) and self-isolation (Asymptomatic), and risks associated with CEV staff. Then how those levels of absence impact on the pressures for those still in work. Part 2 Culmination of the pressure and impact on staff wellbeing in terms of both physical and mental stress linked to the Covid Pandemic. How that stress may have a delayed significant and longer term impact on some staff.		**Date last reviewed:** September 2021	
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 4 = 20 Target: 5 x 2 = 10		**Rationale for current score:** Covid related absence has increased by 50% in recent weeks, 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. Enquiries to OH increasing in recent weeks.	
Level of Control = 25%		**Rationale for target score:** Covid related absence is increasing as we enter wave 3. All organisations would wish for their staff to be resilient to the impact of working within their organisation. The significant ongoing impact of Covid seen by a number of our staff would never be zero but through a range of interventions in place we would hope to minimise the impact on staff.	
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 Wellbeing support facilitated by limited L&D Coaches and Wellbeing team. – the model developed aims to increase awareness of the staff wellbeing service and National support offer a 'listening ear' approach with interventions to support and increase resilience of line-managers. Commitment from Nurse Directors and MGH Matron's to increase line-manager presence physically rather than virtually on wards and to utilise staff unable to work on wards to deliver, 'Taking Care Giving Care' rounds to colleagues.	Additional Wellbeing support facilitated by limited L&D Coaches and Wellbeing team.	Assistant Director of Workforce & OD	31st March 2022
	Occupational Health open over the bank holidays to support staff testing, urgent advice giving and contact tracing.	Assistant Director of Workforce & OD	31st March 2022

• Staff Psychological Wellbeing Cell established – partnership working with MH Psychology, Chaplaincy, Comms and L&D. • Staff WB and OH – 7 day services to support staff. • 30 staff deployed to OH and resource to support WB service. • Trained 140+ 'Taking Care Giving Care' facilitators to support team wellbeing. • 240+ TRiM 'React MH' LM's to support staff MH & trauma. • Trauma/bereavement pathways for staff developed. • OH Long Covid service developed. • Supporting HB wide Wellbeing/Resilience days with Senior Nursing colleagues. • 400+ Wellbeing Champions supporting teams and services. • ESF funded 'In Work Support' team supported local SME employee's/teams. • SBU 'double winners' in UK OH&WB Awards for Covid response.	See Controls for summary of OH/WB support	Director of Workforce & OD	In place
Assurances (How do we know if the things we are doing are having an impact?) 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.	**Gaps in assurance (What additional assurances should we seek?)** **N/A**		
Additional Comments Risk added to Gold Command 16 December 2020 Discussion at Gold 20.04.2021: No alteration to post-MA risk score required currently. Further discussions required regarding impact and liability – update under consideration. Post Covid Well Being Strategy established and presented to WF&ODC. Whilst there are no signs of an underlying increase in risk absence there are indications that stress related absence % has increased in some areas. There remains risk that impact will only emerge over time.			

Datix ID Number: 2521 **Health & Care Standard: 2.4 Infection Prevention and Control (IPC) and Decontamination**	**HBR Ref Number: 78** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 4 = 16**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Richard Evans, Executive Medical Director **Assuring Committee:** Quality & Safety Committee	
Risk: Nosocomial transmission Nosocomial transmission in hospitals could cause patient harm; increase staff absence and create wider system pressures (and potential for further harm) due to measures that will be required to control outbreaks.	**Date last reviewed:** September 2021	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 3 x 4 = 12 Chart updated to reflect change	**Rationale for current score:** Outbreak remains in Morriston Service Group and evidence has shown that sustainability of IPC processes are challenging. EMD and Director of Public Health considers this should be increased again to 16 – reflecting less effective track-and-trace measures and indications that testing is not as effective on staff who have been fully vaccinated.	
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**
Nosocomial transmission Silver established to report to Gold. A nosocomial framework has been developed to focus on: (a) prevention and (b) response. Preventative measures are in place including testing on admission, segregating positive, suspected and negative patients, reinforcing PPE requirements, and a focus on behaviours relating to physical distancing. As part of the response, measures have been enacted to oversee the management of outbreaks. Process established to review nosocomial deaths. Audit tools developed to support consistency checking in key areas re: PPE, physical distancing. Testing on admission dashboard in use. Further guidance on patient cohorting produced.	Nosocomial transmission Silver established to report to Gold. A nosocomial framework has been developed to focus on: (a) prevention and (b) response.	Executive Medical Director & Deputy Director Transformation	Monthly ongoing
	Nosocomial Death Reviews using national toolkit. Need to ensure outcomes are reported to the HB Exec and Service Groups with lessons learnt	Executive Medical and Nursing Director	Monthly ongoing

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

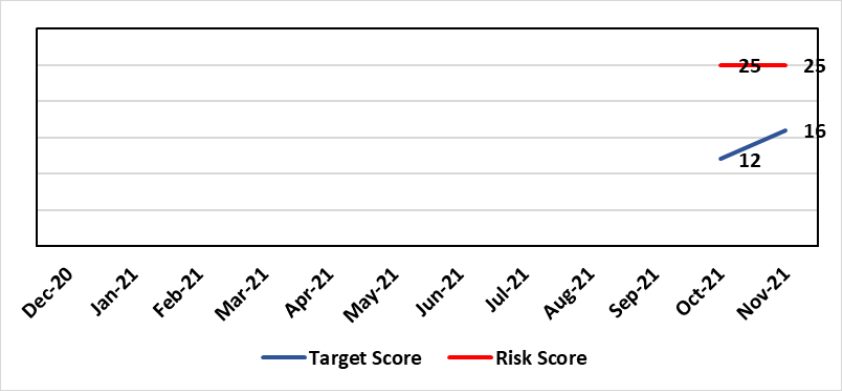
July 2021: Review by the EMD and Director of Public Health considers this should be increased to 16 – reflecting less effective track-and-trace measures and indications that testing is not as effective on staff who have been fully vaccinated.

Datix ID Number: 2739 **Health & Care Standard: 2.1.1 Managing Financial Risk**		**HBR Ref Number: 79** **Target Date: 31st March 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 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:** September 2021	
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. • The Health Board has submitted bids against a first tranche of funding available from Welsh Government but this is not yet allocated • 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:** Securing resources to meet the ambition of the Health Board in terms of access recovery will recue this risk which is an affordability, rather than a service delivery risk.	

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: - • 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 • Working with Welsh Government to access additional funding based on the modelling carried out to date • 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) • Transparent reporting to Performance and Finance Committee and Quality and Safety Committee on progress and plan development.	Develop a final annual plan setting out recovery plans	Director of Finance and Director of Strategy	23rd July 2021
	Prioritise limited Health Board internal capacity and resource in a risk assessed way.	COO	30th July 2021 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?)**
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	Management of access is prioritised based on clinical risk management.
Additional Comments	
None.	

Datix ID Number: 1832 **Health & Care Standard: : 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 80** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Inese Robotham, Chief Operating Officer **Assuring Committee:** Quality & Safety Committee	
Risk: There are high numbers of clinically optimised patients who are unable to be discharged from a medicine bed due to various issues/delays. The number is now returning to pre-COVID level of +50.		**Date last reviewed:** September 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 2 = 8 **Level of Control** = 25% **Date added to the HB risk register** May 2021		**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. **Rationale for target score:**	
Controls (What are we currently doing about the risk?)		**Mitigating actions (What more should we do?)**	
• 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.		**Action** To be agreed	**Lead** / **Deadline**
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 None.			

Datix ID Number: 2788 NEW **Health Care Standards: 7.1 Workforce**	**HBR Ref Number: 81** **Target Date: 31st December 2021**	**Current Risk Rating** **5 x 5 = 25**
Objective: Best value outcomes	**Director Lead:** Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality & Safety Committee	
Risk: Critical staffing levels – Midwifery: Unplanned absence resulting from Covid-19 related sickness, shielding and isolation, alongside other current absences, has resulted in critical staffing levels, further reductions in which could result in unsafe service provision, poor patient outcomes and/or experience. In turn, poor service quality or reduction in services could impact on organisational reputation.	**Date last reviewed:** November 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 5 x 5 = 25 Target: 4 x 4 = 16 **Level of Control** = % **Date added to the risk register** 12/10/2021		**Rationale for current score:** Centralisation of community services has broken down continuity of carer which means women will see many midwives through pregnancy. There is evidence that shows the outcome for women is better with lower interventions when continuity of carer is maintained. This is particularly relevant for women with perinatal mental health issues and for safeguarding. Singleton Hospital working with on average 10 /11 midwives w/c 22/08/2021. The lowest staffing number being 8 instead of 13 midwives. **Rationale for target score:** Target score refreshed. Actions taken and planned for December are anticipated to reduce risk to a target score of 16 by the end December. The decentralization of services in Q4 may assist to reduce the risk further. A new target for additional reduction of the risk will be considered in January.

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

- Home births are suspended. Reduced the on call requirement for community midwives.
- All midwives are working at the hours they require up to full time.
- A small midwifery bank has been created.
- All midwives are offered additional hours. Enhanced overtime promoted, provided and accepted.
- Band 6 recruitment in training.
- Student midwives on pre-qualifying placement are supporting in the clinical areas within their student capacity.
- 11 new midwives have been employed from September- October 2021. 6 started.
- Risk assessments are currently taking place with OH and H&S leads support for matrons to return staff to clinical front facing roles where possible
- Centralisation of community services to improve staff availability
- NPT Birth Centre temporarily suspended - services relocated to The Bay Birth Centre in Singleton Hospital
- Updated early warning to WG
- Service Group Nurse Director keeping RCM updated
- Daily escalation call with the SG Service Director and Nurse Director to do 24 hour lookback on potential harm events, patient and staff experience, and 3 day look forward of staffing
- Briefings for families via corporate comms & online

Mitigating actions (What more should we do?)

Action	Lead	Deadline
On-boarding new Band 5 recruits (expected all complete by mid November)	Deputy Head of Midwifery	Mid November 2021 (onboarding currently and will require supernumerary period)
14 Band 5 graduates from 2020 – preceptorship completion plan (2 have completed, 9 due by end of December)	Deputy Head of Midwifery	End December 2021 (for majority)
Due to review suspension of the Birth Centre and Home Births	Deputy Head of Midwifery	End October 2021 (status tbc)
Midwifery bank & agency SOP has been developed and will be approved this month (already in use).	Deputy Head of Midwifery	20th October 2021 (status 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?)**
Daily briefings with the senior team are taking place for updated position. Weekly meeting held with staff to update on the situation. No surprise submission to Welsh Government 9/7/2021. CHC informed. Engagement with Clinical Supervisors for midwives for staff support. Engagement with workplace representatives. On call manager for Women and Child Health available 24/7. Datix reports are submitted when appropriate.	

Additional Comments

In addition to controls listed above, additional measures taken include:

• Staff support and well-being information circulated, and presented to the staff
• Where able, block booking agency midwives to improve the baseline numbers in the obstetric unit.
• Enhanced overtime promoted, provided and accepted
• Liaison and working closely with the Local Authorities to utilise Jigso and Flying start midwives where possible
• Cancelled PROMPT training (being reviewed weekly)
• Linking in with Karen re getting an all Wales approach to financing/increasing our part time to full time conversion rates
• Utilising our medical teams to support where possible
• Ensuring the all Wales Midwifery and Neonatal network are aware and linking ensuring SBUHB are represented in with the weekly risk huddle
• Hywel Dda UHB are buddying up to provide support
• Ensuring RCM and RCOG COVID guidance is implemented – esp re vaccinations
• Maintaining a Maternity Helpline to answer any queries, emails received and messages from women who may be worried. We plan to continue with this (utilising staff who may be pregnant themselves)

Risk Score Calculation

For each risk identified, the LIKELIHOOD & CONSEQUENCE mechanism will be utilised. Essentially this examines each of the risks and attempts to assess the likelihood of the event occurring (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