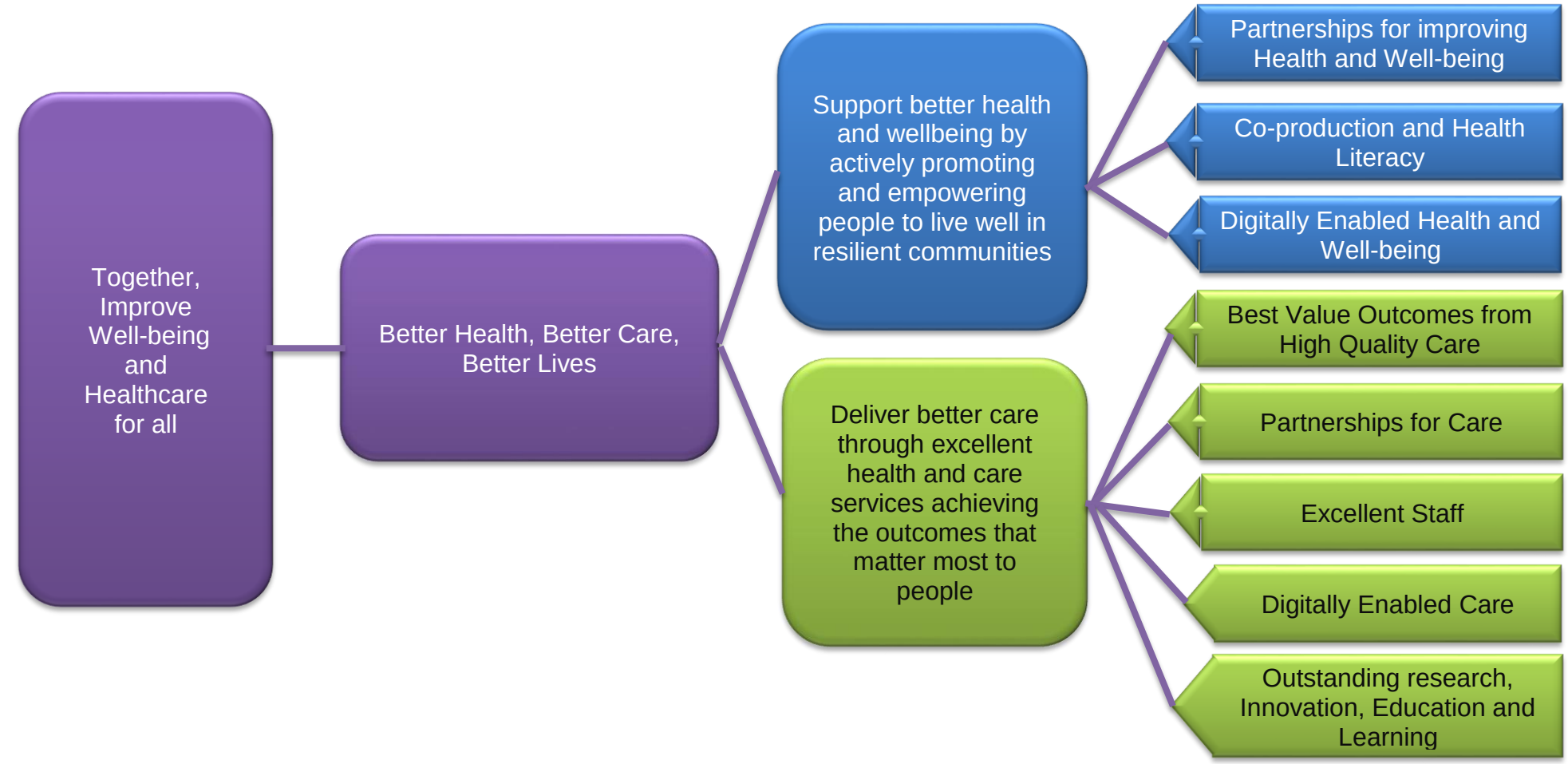
HEALTH BOARD RISK REGISTER
January 2020

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

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



HEALTH BOARD RISK REGISTER
DASHBOARD OF ASSESSED RISKS – January 2020

Impact/Consequences						
	5				**4:** Infection Control **49:** TAVI Service **58:** Ophthalmology Clinic Capacity **16:** Access to Planned Care Services **50:** Access to Cancer Services **63:** Screening for Fetal Growth Assessment in line with Gap-Grow (G&G) **65:** CTG Monitoring in Labour Wards **66:** SACT Treatment **67:** Target breeches to Radical Radiotherapy Treatment	**1:** Access to Unscheduled Care Service
	4				**3:** Workforce Recruitment of Medical and Dental Staff **11:** Healthcare Model for Aging Population **43:** DOLS Authorisation and Compliance with Legislation **45**: Discharge information **48:** Child & Adolescence Mental Health Services **37**: Operational and strategic decisions are not data informed **57:** Non-compliance with Home Office Controlled Drug Licensing requirements **61:** Paediatric Dental GA Service - Parkway	**64:** H&S Infrastructure **39:** IMTP Statutory Responsibility **42:** Financial Plan **62:** Sustainable Corporate Services
	3			**55:** Bridgend Boundary Transition	**13:** Environment of Health Board Premises **36:** Electronic Patient Record **27:** Sustainable Clinical Services for Digital Transformation **41:** Fire Safety Regulation Compliance **52**: Engagement & Impact Assessment Requirements **51:** Compliance with Nurse Staffing Levels (Wales) Act 2016	**15:** Population Health Improvement **54:** No Deal Brexit **53:** Compliance with Welsh Language Standards **60:** Cyber Security
	2					
	1					
C X L		**1**	**2**	**3**	**4**	**5**
		Likelihood				

Risk Register Dashboard

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

39 (1297)	**Approved IMTP – Statutory Compliance** If the Health Board does not have an approved IMTP signed off by Welsh Government, primarily due to the inability to align performance and financial plans it will remain in escalation status, currently "targeted intervention".	16	20	↑	→	January 2020	Performance and Finance Committee
41 (1567)	**Fire Safety Compliance** Fire Safety notice received from the Fire Authority – MH&LD Unit. Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance.re safety regulations.	15	15	→	→	January 2020	Health and Safety Committee
42 (1398)	**Financial Plan** If the Board is unable to successfully deliver a sustainable service and develop a balanced financial plan to support the Statutory Breakeven Financial Duty.	12	20	↑	→	January 2020	Performance and Finance 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	→	→	January 2020	Quality and Safety Committee
48 (1563)	**CAMHS** Failure to sustain Child and Adolescent Mental Health Services (CAHMS).	16	16	→	→	January 2020	Performance and Finance Committee

	49 (922)	**Trans-catheter Aortic Valve Implementation (TAVI)** Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI)	25	20	↓	→	January 2020	Quality and Safety Committee
	63 (1605)	**Screening for Fetal Growth Assessment in line with Gap-Grow** Due to the scanning capacity there are significant challenges in achieving this standard.	20	20	→	→	January 2020	Quality and Safety Committee
	50 (1761)	**Access to Cancer Services** Failure to sustain services as currently configured to meet cancer targets could impact on patient and family experience of care.	20	20	→	→	January 2020	Performance and Finance Committee
	57 (1799)	**Controlled Drugs** Non-compliance with Home Office Controlled Drug Licensing requirements.	20	16	↓	→	January 2020	Audit Committee
	66 (1834)	**Access to Cancer Services** Delays in access to SACT treatment in Chemotherapy Day Unit			→	→	January 2020	Quality and Safety Committee
	67 (89)	**Risk target breeches – Radiotherapy** Clinical risk – Target breeches of radical radiotherapy treatment			→	→	January 2020	Quality and Safety Committee
Excellent Staff	3 (843)	**Workforce Recruitment** Failure to recruit medical & dental staff	20	16	↓	→	January 2020	Workforce and OD Committee

	51 (1759)	**Nurse Staffing (Wales) Act** Risk of Non Compliance with the Nurse Staffing (Wales) Act	16	12	↓	↓	January 2020	Workforce and OD Committee
	62 (2023)	**Sustainable Corporate Services** Health Board's Annual Plan and organisational strategy, and with the skills, capability, behaviours and tools to successfully deliver in support of the whole organisation, and to do so in a way which respects and promotes the health and well-being of our staff and their work-life balance.	20	20	→	→	January 2020	Workforce and OD Committee
Digitally Enabled Care	27 (1035)	**Sustained Clinical Services** Inability to deliver sustainable clinical services due to lack of digital transformation.	16	12	↓	↑	January 2020	Audit Committee
	36 (1043)	**Storage of Paper Records** Failure to provide adequate storage facilities for paper records then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if	20	12	↓	↑	January 2020	Audit Committee
	45 (1565)	**Discharge Information** If patients are discharged from hospital without the necessary discharge information this may have an impact on their care	20	16	↓	→	January 2020	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.	15	15	→	→	January 2020	Audit Committee

	65 (329)	**CTG Monitoring on Labour Wards** Risk associated with misinterpreting abnormal CTG readings in delivery rooms.	20	20	→	→	January 2020	Information Governance Board
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.	20	20	→	→	January 2020	Quality and Safety Committee
	15 (737)	**Population Health Targets** Failure to achieve population health improvement targets leading to an increase in preventable disease amongst the population resulting in increased morbidity impacting on operational and financial pressures.	15	15	→	→	January 2020	Quality and Safety Committee
	61 (1587)	**Paediatric Dental GA Service – Parkway** Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morriston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies.	15	16	↑	→	January 2020	Quality and Safety Committee
Partnerships for Care	52 (1763)	**Statutory Compliance** The Health Board does not have sufficient resource in place to undertake engagement & impact assess in line with Statutory Duties	16	12	↓	↑	January 2020	Performance & Finance Committee
	53 (1762)	**Welsh Language Standards** Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.	15	15	→	→	January 2020	Health Board (Welsh Language Group)

54 (1724)	**Brexit** Failure to maintain services as a result of the potential no deal Brexit	15	15	➔	➔	January 2020	Health Board (Emergency Preparedness Resilience and Response Group)
55 (1764)	**Bridgend Boundary Change** Failure to ensure successful implementation of the Welsh Governments decision to realign the Health Boundary, as it applies to the resident population of the Bridgend County Borough.	20	9	↓	↓	January 2020	Performance and Finance Committee

Risk Schedules

Datix ID Number: 738 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 1**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Quality and Safety Committee
Risk: If we fail to comply with Tier 1 target – **Access to Unscheduled Care** then this will have an impact on patient and family experience. Challenges with capacity /staffing across the Health and Social care sectors.		**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 5 = 20 Target: 3 x 4 =12		**Rationale for current score:** At the end of Quarter performance the Health Board did not achieve performance trajectories. Due to current pressures in MH A&E it was requested by the Q&S Forum that the risk score was upgraded.
Level of Control = 50%		**Rationale for target score:**
Date added to the HB risk register 26.01.16		The service delivery units have been implementing models of care that reflect National priorities and there is evidence that these are starting to impact positively on patient flow, length of stay and demand management. Workforce capacity issues continue to be challenging in some key specialty areas.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Programme management arrangements in place to improve Unscheduled Care performance. • Daily Health Board wide conference calls/ escalation process in place. • Regular reporting to Executive Team, Executive Board and Health Board/Quality and Safety Committee. • Increased reporting as a result of escalation to targeted intervention status. • Targeted unscheduled care investment to support changes to front door service models/ workforce redesign/ patient flow. • Weekly unscheduled care meeting implemented, led by COO and attended by Service Directors	Bed utilisation audit being undertaken to support USC system redesign programme in NPT and Swansea.	Deputy Chief Operating Officer	14th February 2020
	Clinical services plan for USC is being finalised.	Deputy Chief Operating Officer	14th February 2020
	Breaking the Cycle implemented Board-wide for first two weeks of July to help address pressures	Deputy Chief Operating Officer	14th February 2020
	Implement findings of Kendall Bluck report once supported by Executive Team	Chief Operating Officer	14th February 2020

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

Datix ID Number: 739 **Health & Care Standard: 2.4 Infection Prevention & Control & Decontamination**	**HBR Ref Number: 4**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Gareth Howells, Director of Nursing and Patient Experience **Assuring Committee:** Quality and Safety Committee
Risk: Failure to achieve **infection control** targets set by Welsh Government, increase risk to patients and increased costs associated with length of stays.	**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 5 x 4 = 20 Target: 4 x 3 =12	**Rationale for current score:** Currently under targeted intervention for rates of infection, achievement of targets are variable with monthly fluctuations
Level of Control = 40%	**Rationale for target score:**
Date added to the HB risk register January 2016	Once the infection control team is fully recruited to, ICNet is functioning to its full capability the infection control team will be able to support the clinical areas more and drive service improvements. In addition, a negative pressure isolation facility is being built into the new emergency department at Morriston hospital providing another facility to appropriately manage patients at the front door. Review and implementation of a robust clean of patient rooms following an infection will reduce the risk of cross infection.

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
• Regular monitoring on infection rates • Policies, procedures and guidelines in place • Regular reporting through internal processes • ICNet information management system for infections is in place • Infection control team support the clinical teams for issues relating to infection control • A permanent infection control doctor has been recruited • Recruitment is ongoing and the decontamination lead and assistant director of nursing in infection control have been appointed • Bug stop quality improvement programme • Incident reporting	**Action**	**Lead**	**Deadline**
	Recruitment to ensure the team is fully established with the right skills and experience	Assist Dir Nursing Infection Control	31st March 2020
	Ongoing infection control team involvement in site level estates projects to ensure appropriate isolation facilities are factored in from the outset	Senior Infection Control Nurse	14th February 2020
	Review of environmental cleaning and decontamination	Senior Nurse Infection Prevention Control	14th February 2020

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
• Ongoing monitoring of infection control rates and feedback provided to delivery units • Infection Control Committee monitors infection rates and identifies key actions to drive improvement	ICNet provides information linked with PAS relating to patients who have been inpatients since the connection was made therefore additional manual records are maintained by the infection control team creating additional work and some duplication.

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

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

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

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

Datix ID Number: 841 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**	**HBR Ref Number: 13**
Objective: Best Value Outcomes	**Director Lead:** Chris White, Chief Operating Officer **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:** January 2020
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. Lack of accommodation to meet statutory/health and safety requirements could have an adverse impact citizens, staff, financial and operational performance.
Level of Control = 90%	**Rationale for target score:**
Date added to the HB risk register April 2012	Risk assessments of premises.

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

- Key areas where performance linked to health & safety/fire issues flagged through Health & Safety and Quality & Safety Committees and actions agreed to mitigate impacts.
- Issues raised through site meetings held regarding service changes for all 4 acute hospital sites

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Develop a strategy to improve primary & community services estate.	Asst Director Operations	14th February 2020
Develop BJC's to improve the infrastructure of the 3 acute hospital sites (not including NPTH).	Asst Director Operations	14th February 2020

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

- The Cabinet Secretary for Health & Social Services has now set the initial pipeline of health and care centres to be delivered by 2020-21.
- The following projects have been identified for your Health Board including:
  Penclawdd Health Centre - refurbishment/redevelopment proposal (£0.800m at 16-17 prices)
  Murton Community Clinic – refurbishment/redevelopment proposal (£0.400m at 16-17 prices)
  Bridgend Town Centre Primary Care Centre – new build development (£5.000m at 16-17 prices); and Swansea Wellness Centre – new build development (£10.000m at 16-17 prices).
  The figures above represent the funding ceiling identified for the schemes.
  All of the above projects have been identified within the capital pipeline, and we are in the stage of awaiting approval from the Welsh Government for each business cases applicable as soon as possible

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

Current Risk Rating
4 x 3 = 12

Additional Comments

Datix ID Number: 840 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 16**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee
Risk: Access and Planned Care. If we fail to achieve compliance **with waiting times** there is a risk that patients may come to harm. Further, the health board will face financial risk with Welsh Government if the agreed target is not met.		**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 4 = 20 Target: 4 x 2 = 8		**Rationale for current score:** Consequence is high given nature of the risk. Likelihood is being managed through the controls and actions set out.
Level of Control = 90%		**Rationale for target score:**
Date added to the HB risk register January 2013		There is scope to reduce the likelihood score to reduce the Risk to an acceptable level

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Escalation and scrutiny to Performance and finance Committee for off profile specialties	Associate Director Performance	Monthly
Develop sustainability plans for specialties through the emerging Clinical Services Plan	Head of IMPT Development	14th February 2020

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

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

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

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

Datix ID Number: 1217 **Health & Care Standard: Effective Care 3.1 Safer & Clinically Effective Care**	**HBR Ref Number: 37**
Objective: Best Value Outcomes from Quality Care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Audit Committee
Risk: Operational and strategic decisions are not data informed:- • Business intelligence and information already available is not utilized • 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:** January 2020
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 4 = 16 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
Level of Control = 70%	**Rationale for target score:**
Date added to the HB risk register June 2016	C- will remain the same or increase due to increased reliance in information L- Investment in BI will lead to more information be available and used. The higher the use of information at operational level will lead to better quality data.

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Investment and implementation of system to record patient outcome measures	Assist Information Business Manager	31st March 2020
Produce Business Intelligence Strategy and get signed off by the Board	Assist Information Business Manager	14th February 2020
Produce BI strategy implementation plan outlining investment requirements in capacity and capability	Assist Information Business Manager	31st March 2020

• Ensuring that the Health Board has representation on national groups such as the newly formed Advanced Analytics Group (AAG), all Wales Business Intelligence and Data Warehousing Group and Welsh Modelling Collaborative.			
Assurances (How do we know if the things we are doing are having an impact?) More evidence based and proactive decisions being made. Dashboard technology; assist in developing indicators / triangulating information to identify issues	**Gaps in assurance (What additional assurances should we seek?)** Culture of the organisation needs to change to focus on information and Business intelligence for operational rather than reporting purposes. Capability of operational staff to utilise the tools and capacity to act on the intelligence provided.		
Current Risk Rating **4 x 4 = 16**	**Additional Comments** PROMS currently being collected in Lung Cancer (Morriston) August 2019, Cataracts August 2019, Hip & Knee (Morriston) November 2018, and Breast Cancer June 2019 using PKB. Also Heart failure, April 2019, in one Community Clinic.		

Datix ID Number: 1297 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**	**HBR Ref Number: 39**
Objective: Demonstrating Value and Sustainability Risk in Brief: If the Health Board fails to have an approvable IMTP for 2018/19 then we will lose public confidence and breach legislation.	**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee**: Performance and Finance Committee / Strategy, Planning and Commissioning Group Health Board
Risk: Operational and strategic decisions are not data informed:- Health Board does not have an IMTP signed off by WG, primarily due to the inability to align performance and financial plans. WG also advised that the Health Board needed to have a clear strategic direction by developing an Organisational Strategy and refreshing our Clinical Services Plan. In September 2016, the Health Board was escalated to 'targeted intervention' and having an approved IMTP is a key factor in improving our WG monitoring status.	**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 4 = 20 Target: 4 x 2 = 8 **Level of Control** = 70% **Date added to the HB risk register** Q4 2016/17		**Rationale for current score:** Our Organisational Strategy was approved by the Board in November 2018 This Annual Plan includes a balanced financial plan. We have agreed with Welsh Government that we will continue our detailed planning and submit an approvable IMTP when ready. We have continued the work from January onwards on our detailed plans to submit an approvable IMTP when ready. **Rationale for target score:** If the IMTP is approved it is likely our targeted intervention status will be improved when next reviewed and the risk can be closed.

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

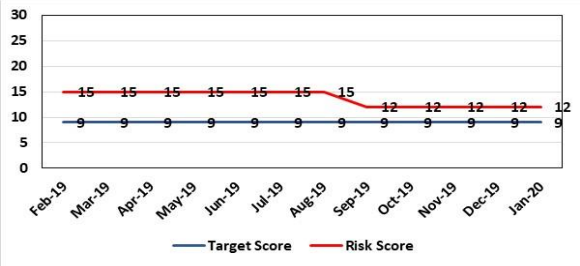
- Organisational Strategy approved by the Board in November 2018
- Clinical Services Plan approved by the Board in January 2019
- Annual Plan submitted to Board and approved in January for submission to Welsh Government, accepted as a draft
- Good feedback received on the document.
- Due to the complexities of the Bridgend transfer, the CEOs of CTM and SB UHBs have formally asked WG for support to resolve the issues and formal arbitration process was initiated by WG.
- The results of the arbitration is now received as is the outcome of the Due Diligence Review.
- The Transformation Programme to deliver the Organisational Strategy and CSP including programme approach was established in April 2019
- Continuous planning through our CSP Programme and IMTP process will work up detailed plans to develop an integrated three year plan in line with the national timescales.
- The new Operating Model and Delivery Support Team will contribute to delivery of the financial plan.
- A decision will be made as to the ability to submit a balanced IMTP in November.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Sign off of Annual Plan 2019/20 by Board – will be submitted in Oct 2019	Director of Strategy	31st December 2020
IMTP development for 2020 -23 to test approvability with Performance Finance Committee.	Director of Strategy and Director of Finance	30th December 2020
Final plan to be submitted to Board for approval for submission to WG.	Director of Strategy	31st December 2020

Additional Comments IMTP Executive Steering Group in place for development of the integrated medium term plan. Integrated	**Gaps in assurance (What additional assurances should we seek?)** EIA in development for PFC assurance

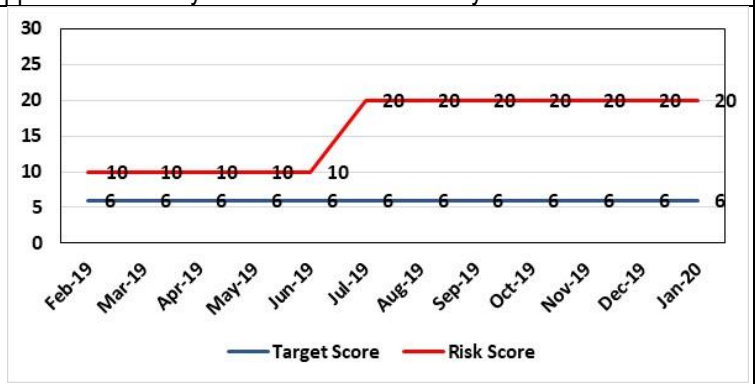
Planning Group in place to co-ordinate Transformation and planning activities and approaches • Performance and Finance Plans are be assured by the P&F Committee before presentation to Board •Through monthly IMTP briefings, TI meetings and bi-annual JET meeting with WG – planning approach and emerging plans discussed and WG fully supportive of the direction of travel.	QIAs in development for joint PFC/Q&S assurance
Current Risk Rating **4 x 5 = 20**	

Datix ID Number: 1567 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**		**HBR Ref Number: 41**
Objective: Best Value Outcomes		**Director Lead:** Gareth Howells, Director of Nursing and Patient Experience **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:** January 2020
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 4 x 3 = 12 Target: 3 x 3 = 9		**Rationale for current score:** Improvement notice in relation 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
Level of Control = 50%		**Rationale for target score:**
Date added to the HB risk register 31/05/2018		Target Score should be lower

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Fire risk assessments. • Evacuation plans (vertical and horizontal). • Fire safety training. • Professional advice sought on compliance of panels. .	**Action**	**Lead**	**Deadline**
	Change in fire evacuation plans and alarm and detection cause and effect	Head of Health & Safety	14th February 2020
	Finalise Business Case for permanent remediation of the external wall cladding to comply with HTM 05-02 and Building Control Regulations Approved Document B	Assistant Director of Strategy & Workforce	20th September 2020
	Replacing the existing cladding and insulation with alternative specifications and inserting 30 minute fire cavity barriers where appropriate	Assistant Director of Strategy & Workforce	31st March 2023

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)** Unclear if additional resources will be available
Current Risk Rating **4 x 3 = 12**	**Additional Comments** Professional assessment of panel compliance being taken forward with NWSSP-SES, building control and WG colleagues. W/c 26/8/19 Cladding being removed from East and West end of main block. Escape route on west end redirected with approval of Fire and Rescue Service. Removal of

	flank cladding completed at end of 2019. Business case being developed for removal of cladding on south side of building. Review of numbers of fire wardens completed by Unit and new wardens being trained.

Datix ID Number: 1398 **Health & Care Standard: Staff Resources 7.1 Workforce**		**HBR Ref Number: 42**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Lynne Hamilton. Director of Finance **Assuring Committee:** Performance and Finance Committee
Risk: Financial Plan - The Board is unable successfully to deliver sustainable services and develop a **balanced financial plan** to support the Statutory Breakeven Financial Duty.		**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 4 = 20 Target: 2 x 3 = 6		**Rationale for current score:** In 19/20 the Health Board has developed a balanced financial plan to support the Statutory Breakeven Financial Duty. However a number of risks have been identified which may result in the breakeven duty not being met in this financial year. Ability to deliver required level of savings; Cost pressures in excess of plan emerge are unable to be managed; Impact of diseconomies of scale following the Bridgend Boundary Change are unable to be mitigated in full during 2019/20; Delivery risks considered too high by Welsh Government and the additional funding support provided in recognition of operational and financial performance improvement is withdrawn; Target set by WG. Improving likelihood due to enhanced controls and mitigating actions and opportunities, led by delivery support team and support by KPMG.
Level of Control = 50%		**Rationale for target score:** Aim to increase confidence levels to deliver set target.
Date added to the HB risk register July 2017		

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
The Health Board has established a multi-professional Delivery Support Team (DST) to focus on: • Grip & control • Driving up confidence in existing savings plan • 2019/20 – Further actions • Financial Sustainability	Monitor risk through Performance and Finance Committee	Director of Finance	Monthly Review
The Health Board has a number of established financial control measures including authorisation hierarchies, QVC panels and vacancy control panel.	Monitor risk and agree action through Financial Management Group	Director of Finance	Monthly Review
These controls are being enhanced through the High Value Opportunity work streams, and Financial Recovery Actions which are monitored and support by the Delivery Support Team.			

From October KPMG external support commission by WG in support of the Health Board's 19/20 Financial Plan delivery and IMTP preparation will be working alongside the DST and the Finance team to support driving up confidence and the development of a strong pipeline of opportunities			
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 : • Unit and cross-system financial recovery meetings (Weekly) • Financial Management Group (chaired by CEO) • Performance and Finance Committee	**Gaps in assurance** **(What additional assurances should we seek?)** Accountability letters to be issued following Annual Plan approved by Board.		
Current Risk Rating **4 x 5 = 20**	**Additional Comments**		

Datix ID Number: 1514 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**	**HBR Ref Number: 43**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Gareth Howells, Director of Nursing & Patient Experience **Assuring Committee:** Quality and Safety Committee
Risk: If the Health Board is unable to complete timely completion of DoLS Authorisation then the Health Board will be in breach of legislation and claims may be received in this respect.	**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 4 x 4 =16 Current: 4 x 4= 16 Target: 3 x 2 = 6 **Level of Control** = 40% **Date added to the HB risk register** July 2017		**Rationale for current score:** Although processes have been planned or implemented, the impact is yet to be measured over a longer term, and the challenges of managing a large backlog of breaches. **Rationale for target score:** Consequences of DoLS breaches for the Health Board will not change. With controls in place, over time likelihood should decrease.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Supervisory body signatories increased from 3 to 7 • BIA rota now implemented • 2 x substantive BIA posts and additional admin post advertised • DoLS database updated and DoLS dashboard devised to enable more accurate monitoring and reporting • Process in place within P&C Unit for management of authorisations and identifications of breaches in timescales. The Corporate Safeguarding Team is monitoring this. • 31.07.19 2 WTE BIA's and a Band 4 Administrator have been appointed since April 2019. These individuals are managed by the Interim Head of Long Term Care, primary & Community Service Delivery Unit	Delivery of DOLS Action plan reviewed monthly	Head of Safeguarding	Monthly Review

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

Datix ID Number: 1563 **Health & Care Standard: Safe Care 5.1 Access**	**HBR Ref Number: 48**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Sian Harrop Griffiths, Director of Strategy **Assuring Committee:** Performance and Finance Committee, Health Board
Risk: Failure to sustain Child and Adolescent Mental Health Services	**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 4 x 2 = 8 **Level of Control** = 50% **Date added to HB the risk register** 31/05/2018	
	Rationale for current score: The specialist CAMHS Network is delivered by Cwm Taf University Health Board on behalf of ABMU. Cwm Taf have confirmed that they will not meet the 28 day target by the end of March 2018. This is as a result of pressures across the entire CAMHS network in relation to demand & capacity and recruitment & retention. **Rationale for target score:**

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

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

Mitigating actions (What more should we do?)

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

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Current Risk Rating **4 x 4 = 16**	**Additional Comments** The service is now in the 2nd cycle of CAPA with new job plans agreed from January, with updated demand & capacity mapping. WLI Clinics initiated at POW Hospital, Bridgend which enabled the 80% target to be achieved by end of end

	March. This was also achieved for NPT area. However Swansea had a significant backlog, which is starting to be addressed with waiting list initiatives from March 2018. Primary & specialist CAMHS services are delivered by Cwm Taf University Health Board on behalf of ABMU (although this will only be for Swansea & NPT from 1/4/19). Cwm Taf achieved the non-urgent 28 day target for specialist CAMHS by the end of March 2019. Their ability to sustain this performance is dependent on consistency and availability of staff which due to the small numbers in the various CAMHS teams can affect achievement of waiting times significantly. Target achieved in March 2019, then missed for a number of months, but achieved from September 2019. However performance is still inconsistent, and will remain so until the existing 3 teams have been integrated into one service across West Glamorgan. New service model being implemented from June 2020 which will stabilise service.

Datix ID Number: 922 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**		**HBR Ref Number: 49**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Richard Evans, Medical Director **Assuring Committee:** Quality and Safety Committee
Risk: Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI)		**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 4 x 5 =20 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 OG meeting. • TAVI has been prioritised in next year's WHSSC ICP for 2020/21. The UHB has commissioned the Royal College of Physicians to undertake a review of the service. Final report awaited, but anticipated that this will indicate that patients have come to serious harm	Commission external review of the service by the Royal College of Physicians (Awaiting report)	Directorate Manager	14th February 2020

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Reduction in waiting times for TAVI. Appointment to key posts (medical & nursing).	
Current Risk Rating **4 x 5 = 20**	**Additional Comments** Business case for WHSSC funding has been agreed. There is considerable reputational risk to the organisation on the outcome of the Royal College of Physicians review. Medical director in receipt of RCP report which will be shared widely in due course. Extensive validation of pathway start dates for cardiothoracic and TAVI patients from external health boards has taken place (in line with recommendations from DU report). Patients are now reported with true reflection of actual wait which has resulted in a reported position of 5 patients waiting >36 weeks. All patients will have TCI date before end of December 2019. As part of external review, we have employed the 2nd TAVI nurse. The service remains challenging due to unscheduled care pressures particularly around cardiac short stay and also DDW has in recent weeks been closed to Norovirus. We are as a service soon to hit a 100 patient

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

Datix ID Number: 1761 **Health & Care Standard: Timely Care 5.1 Access**		**HBR Ref Number: 50**
Objective: Best Value Outcomes from High Quality Care		**Director Lead**: Chris White, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee
Risk: Access to Cancer Services - Failure to sustain services as currently configured to meet cancer targets		**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 = 12		**Rationale for current score:** An overall reducing trend in current risk assessed score. Whilst target not consistently being met, general improvement trajectory which needs to be sustained.
Level of Control = 70%		**Rationale for target score:**
Date added to the HB risk register April 2014		Target score reflects the challenge this area of work present the Board and where small numbers of patients impact on the potential to breach target

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Introduction of revised models for rapid diagnostic review / assessment in cancer pathways being introduced.	Associate Director of Performance	14th February 2020
Continue close monitoring of each patient on the USC pathways to ensure rapid flow of patients through the pathway.	Associate Director of Performance	14th February 2020
Some speciality challenges remain in Lung and Urology - Action plans in place, along with monitoring.	Associate Director of Performance	14th February 2020

Assurances **(How do we know if the things we are doing are having an impact?)** General improvement (sustained) trajectory. Need to continue improvement actions and close monitoring. Early diagnosis pathway launched and impact being closely monitored.	**Gaps in assurance** **(What additional assurances should we seek?)** Clear current funding gap.
Current Risk Rating **4 x 5 = 20**	**Additional Comments** The need to deliver sustained performance.

Datix ID Number: 1799 **Health & Care Standard: Controlled Drug 2.6 Medicines Management**		**HBR Ref Number: 57**
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 Controlled Drug Licensing requirements		**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 2 = 8		**Rationale for current score:** The Health Board has limited assurance regarding whether or not it is compliant with Home Office Controlled Drug Licensing requirements at the present time, nor does it currently have processes in place to ensure any future service change complies. Risk: That the Health Board is operating in breach of the law by managing controlled drugs without an appropriate Home Office Controlled Drug License. Legal advice provided to the Health Board has indicated that failure to comply with the Home Office Controlled Drug licensing requirements could result in criminal and civil action, both against responsible individuals and the Health Board as a public body. Work has commenced to fully understand the licensing situation along with the drafting of a detailed policy that will ensure compliance going forward. Risk: That the Health Board is maintaining unnecessary Home Office Controlled Drug Licenses. Each Home Office Controlled Drug license costs around £3k plus additional administrative set-up and maintenance costs. Health Board wide scrutiny is required to ensure no unnecessary licenses are held (one such example has recently been discovered).
Level of Control = 40%		**Rationale for target score:**
Date added to the HB risk register January 2019		Once the new policy is complete and has been checked for legal compliance to the Home Office regulations there will be a training session held with all clinical areas supported at Executive level. The work currently underway includes checking areas of concern for compliance with the regulations.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**

Legal advice received and principles upon which to decide whether a Home Office Controlled Drug License would be required have been drafted. This forms the basis of a detailed policy that is currently in draft form. This will be sent for legal ratification to ensure compliance to the Home Office regulations. The Home Office have been advised work is currently being completed as a matter of urgency. Areas of specific concern regarding license compliance are being visited to enable an accurate assessment. Additionally work is underway to develop a governance framework to ensure responsibility for management and use of controlled drugs is fully understood within the delivery units. The framework will enable both the Controlled Drug Accountable Officer and the Health Board Medical Director to discharge their individual accountabilities. The Executive Medical Director, the Executive Director of Nursing and the Chief Pharmacist/CDAO are fully involved and supportive of any potential changes for delivery units. .	Training session to be held for all clinical areas. All delivery units will be required to identify a responsible manager and ensure compliance with both the CD Licensing Policy and the new framework for management and use of controlled drugs.	Clinical Director of Medicines Management (Pending internal corporate governance review of controlled drugs governance in new organization)	14th February 2020 (Pending policy development and sign off in conjunction with Home Office)
Assurances **(How do we know if the things we are doing are having an impact?)** • To date the HB has received legal advice. Pending policy development, the principles contained within the legal advice are referred to when issues are raised in order to provide consistency in arrangements.	**Gaps in assurance** **(What additional assurances should we seek?)** The Health Board 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.		
Current Risk Rating **4 x 4 = 16**	**Additional Comments** The Home Office are aware that the Health Board have sought independent legal advice regarding the situations where a Home Office Controlled Drug license is required. Advice received to date from the Home Office regarding particular scenarios of Controlled Drug management by the Health Board has differed from the independent legal advice received. The Home Office are currently awaiting the Health Board policy on this matter so that they can review our position. Once completed the policy outlining the Health Board position on Controlled Drug licensing will be shared with both Welsh government and all other Health Boards in Wales as the Swansea Bay UHB position is likely to be used by the Home Office as a precedent.		

Datix ID Number: 843 **Health & Care Standard: Staff & Resources 7.1 Workforce**	**HBR Ref Number: 3**
Objective: Excellent Staff	**Director Lead:** Hazel Robinson, Director of Workforce and Operational Development **Assuring Committee:** Workforce and OD Committee
Risk: Workforce recruitment of medical & dental staff	**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 =16 Target: 4 x 3 = 12 **Level of Control** = 70% **Date added to the HB risk register** April 2012	
	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.
	Rationale for target score: This remains a challenge and is also a national problem.

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Medical training initiatives pursued in a number of specialties to ease junior doctor recruitment	Director W&OD.	31st December 2020
The Medical Workforce Board continues to monitor recruitment and junior doctor's rotas.	Director W&OD.	17th May 2020
Continue to recruit internationally.	Director W&OD.	17th May 2020

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

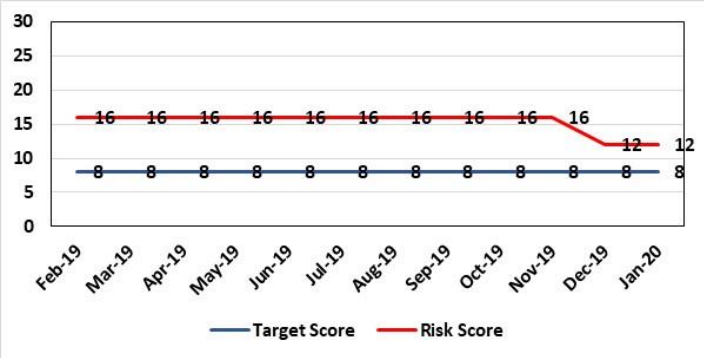
- General situation monitored through W&OD Committee
- Communication with Deanery
- Recruitment campaigns
- Integrated Medicine and Paediatrics short term workforce plans
- Monitoring by Executive Teams and specialty based local workforce boards

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

Current Risk Rating
4 x 4 = 16

Additional Comments

Risk covers all hospitals and multiple specialties. Participated in BAPIO in November, appointed 25 doctors. Working with Medacs to replace long term locums. Developing an Invest to Save Bid for international overseas recruitment for nursing to upscale the activity for 20/21. Workshop planned for end of Feb to look at recruitment for all staff groups. Recruitment remains a challenge but is also a national problem.

Datix ID Number: 1759 **Health & Care Standard: Staff & Resources 7.1 Workforce**	**HBR Ref Number: 51**
Objective: Excellent Staff	**Director Lead:** Gareth Howells, Director of Nursing **Assuring Committee:** Workforce and OD Committee
Risk: Non Compliance with Nurse Staffing Levels Act (2016)	**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 = 16 Target: 4 x 2 = 8 **Level of Control** = 80% **Date added to the HB risk register** November 2018	
	Rationale for current score: • Section 25B places a duty on LHBs and NHS Trusts to calculate and take steps to maintain nurse staffing levels in specified settings, which are currently adult acute medical and surgical inpatient wards timescale. **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.

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

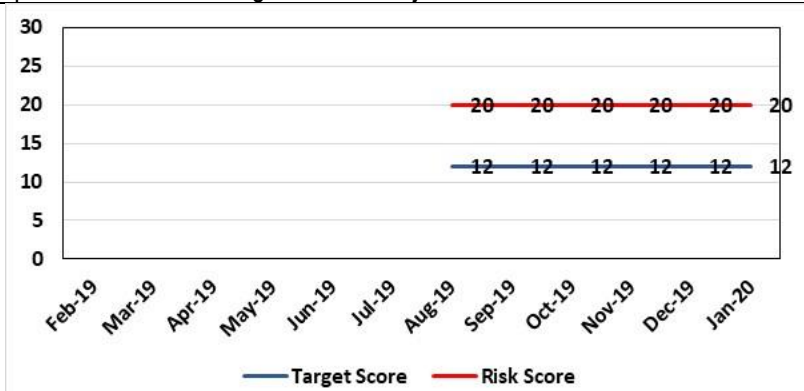
The Health board has put the following controls in place:-

- Confirmed the designated person
- Represented the All-Wales Nurse Staffing Group and its sub groups
- Contributed with the work undertaken at an all-Wales level on Acuity levels of care.
- Undertaken a formal review across all acute Service Delivery Units for calculating and reporting nurse staffing requirements to ensure a Health Board wide consistent approach is adopted.
- Presented a Health Board position status paper to both Board & Executive team outlining the preparedness for the Nurse Staffing Act (Wales).
- Conducted a review of workforce planning procedures, for 2018 to 2021, which includes; Health Board recruitment events, retention, workforce Planning & redesign, training and development.
- Developed a monthly Health Board Multidisciplinary Nurse Staffing Act Task & Finish Group, chaired by the Interim Deputy Director of Nursing & Patient Experience, which reports to Nursing and Midwifery Board and Workforce & Organisational Development Committee.
- Provided acuity feedback sessions to all Service Delivery Units included in the June audit.
- Formally launched the Nurse Staffing (Wales) Act Guidance.
- Raised the issue regarding Information Technology barriers around the capture of data required for the Act on an All- Wales and Health Board basis.
- Circulated the Welsh Levels of Care and Operational Handbook to Service Delivery Unit Leads.
- Confirmed the 32 acute medical & surgical clinical areas that fall within the Act. These areas have been agreed using the criteria set out in the Operational Handbook.
- A Rigorous data approval process has been put in place to ensure accuracy of the 6 monthly

Mitigating actions (What more should we do?)

Action	Lead	Deadline
The Ward Sister / Charge Nurse and Senior Nurse should continuously assess the situation and keep the designated person formally appraised.	Director of Nursing & Patient Experience	30th November 2020 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.	Director of Nursing & Patient Experience	4th February 2020
The responsibility for decisions relating to the maintenance of the nurse staffing level rests with the Health Board should be based on evidence provided by and the professional opinions of the Executive Directors with the portfolios of Nursing, Finance, Workforce, and Operations.	Director of Nursing & Patient Experience	1st May 2020
Health Board should agree the operating framework for these decisions to include actions to be taken, and by whom.	Director of Nursing & Patient Experience	30th March 2020

acuity data prior to sign off. There has also been a number of workshops organised across the organisation to ensure a consistent approach to data collection and there is national work on solutions for electronic capture of acuity data. • The NSA Steering group continues to meet on a monthly basis. • Risks are presented at each meeting • 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.			
Assurances (How do we know if the things we are doing are having an impact?) • Ongoing robust recruitment and retention plans in place to reduce vacancies in key clinical areas, which is in line with the Health Board recruitment plan. • Accurate reporting of Acuity data and governance around sign off. • Implement mobile devises to be used within adult acute medical and surgical wards included within the Act in readiness for the June Adult Acuity Audit. • Agreed establishments to funded. • Implementation of E-Rostering to enable accurate reporting of Compliance • Implement all Wales Templates, which are visible and signed within the agreed 32 ward areas, informing patients of planned roster. • At least Yearly Board reports outlining compliance and any key risks. August 2019 update In line with the Boundary changes there are now 29 reportable wards which excludes POW. E-rostering has been rolled out in Singleton and Morriston is in the process of being rolled out. Scrutiny panels are in place. Following the investment already provided to the funded establishments. The overall risks have reduced as outlined above. The quality and accuracy of the Acuity data has improved.	**Gaps in assurance** **(What additional assurances should we seek?)**		
Current Risk Rating **4 x 3 = 12**	Non Compliance with Nurse Staffing Levels (Wales) Act (2016) The Nurse Staffing Levels (Wales) Act, which received Royal Assent on 21st March 2016, places an overarching duty on Local Health Boards and NHS Trusts in Wales to ensure that nurses have time to care sensitively for their patients and codifies current best practice for determining nurse-staffing levels. It requires Local Health Boards and NHS Trusts in Wales to calculate and maintain staffing levels in specific clinical areas, which are Adult acute Medical & Surgical wards. In accordance with the Act, Health Boards/Trusts must submit annual reports to their board and three-yearly reports to Welsh Government in relation to their compliance with the staffing levels, the impact upon the quality of care where the nurse staffing level was not maintained and the actions required in response to this. The Act currently requires the reporting of adult acute medical and surgical inpatient wards, 32 wards in total across the Health Board. In preparation for the Act Service delivery Units have all produced detailed risk assessments in preparation for the Act: Morriston 20 Singleton 16 NPT 6 POW 16 Current Status Singleton 15 Morriston 15 NPT 6. Operating Framework in place.		

Datix ID Number: 2023 **Health & Care Standard: Staff Resources 7.1 Workforce**	**HBR Ref Number: 62**
Objective: Excellent Staff **Risk:** Sustainable Corporate Services aligned to the Health Board's Annual Plan and organisational strategy, and with the skills, capability, behaviours and tools to successfully deliver in support of the whole organisation, and to do so in a way which respects and promotes the health and well-being of our staff and their work-life balance.	**Director Lead:** Tracy Myhill, CEO **Assuring Committee:** Workforce and OD Committee
Risk: Failure to deliver corporate services and organisational objectives due to insufficient staff.	**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 = 12 **Level of Control** = 50% **Date added to the HB risk register** August 2019		**Rationale for current score:** Constraints, stress and resourcing of corporate services post Bridgend Boundary Change and in light of the change agenda in the Health Board. Current resourcing levels have been benchmarked with other Health Boards, in some areas. The Finance department has been under considerable pressure due to the work required to support the Health Board's Targeted Intervention status and the Bridgend boundary change. **Rationale for target score:** Sustainable services will always encounter turnover and need to develop skill set and capabilities. Target score reflects requirement to resource to be able to meet the operational and Strategic priorities of the Health Board. Failure to do this will negatively impact of financial, service, performance and quality outcomes. Failure to do this will negatively impact of financial, service, performance and quality outcomes.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Designing and Developing new Operating model for the Health Board • Designing and Developing HB HQ and Corporate structures • Reviewing Directorate requirements • Vacancy Panel to support prioritisation.	To conclude the recruitment process for the critical corporate posts including the Workforce and OD function	Chief Executive	27th March 2020

Assurances **(How do we know if the things we are doing are having an impact?)** • Decisions late summer / early autumn on corporate services structures, operating model and resourcing.	**Gaps in assurance** **(What additional assurances should we seek?)**
Current Risk Rating **4 x 5 = 20**	**Additional Comments** Utilise temporary funded capacity to meet immediate areas of risk. Continue to raise resourcing issue at corporate level and through committee governance arrangements. Review of corporate 'critical' posts have been undertaken including resourcing required for investment in the Workforce and OD Function. These posts will be recruited to on a phased basis.

Datix ID Number: 1035 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**HBR Ref Number: 27**
Objective: Digitally enabled care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Audit Committee
Risk: Digital Transformation Inability to deliver sustainable clinical services due to lack of Digital Transformation. There are insufficient resources to: • invest in the delivery of the ABMU Digital strategy, • support the growth in utilisation of existing and new digital solutions • replace existing technology infrastructure and the end of its useful life.	**Date last reviewed:** January 2020
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 current score:** C – reliance on digital ways of working has increased. Loss of IT service has a greater impact on ability to provide clinical care. Lack of investment in new digital solutions to make services more effective will mean clinical service provision will become unsustainable. L- There has been an increase in the number of devices in circulation by 3000 (39%) over the last 4 years (2015-2018) without an increase in IT support capacity. HB are currently only able to replace devices that are over 7 years old. Call volumes and wait times have increased over the last 4 years. Key IT maintenance work is not being completed in a timely fashion. Investment required in Informatics to deliver the Digital strategy is greater than the funding currently available. Informatics budget is estimated to be 0.73% of the HB budget - well below the recommended 4%. Resources available to provide digital services could be reduced because of the boundary change. **Rationale for target score:** C – of failure will increase as the reliance and proliferation of the use of digital solutions increases. L – investment will mean the support mechanisms, rate of failure and ability to deliver solutions that meet the needs of users will improve sustainable digital services. There will however always be an inherent risk of failure of IT solutions.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Digital strategy has been approved by the Health Board • Capital priority group for the HB considers digital risks for replacement technology which is fed into the annual discretionary capital plan • IBG process allows for investment requests in projects to be submitted to the HB for consideration and provides scrutiny to ensure Digital resources required are considered for all projects	Develop a new Strategic Outline Plan setting out the requirement to deliver the first phase of the Digital strategy. Three year plan to be developed in line with the Health Boards IMTP Planning process.	Assistant Informatics Business Manager	14th February 2020
	Work with finance and the Health Board leadership team to identify additional revenue	Assistant Informatics	31st March 2020

• Informatics prioritisation process has been introduced to ensure requests for digital solutions are considered in terms of alignment to the strategy objective, technical solutions and financial implications • HB has invested £900k recurrently in the project staffing resources to facilitate the delivery of the Informatics Strategic Outline Plan • Working closely with WG to identify funding streams to support investment in digital including the approval of the Informatics Strategic Outline Plan	streams. 2019/ 2020 Capital plan approved. 200K revenue increase agreed to reflect growth in IT service provision	Business Manager	
	Ensure informatics prioritisation process is embedded into the ways of working so that resource implications of digital solutions are transparent and agreed at outset of projects.	Assistant Informatics Business Manager	31st March 2020
	Ensure business cases requiring digital services include appropriate implementation and support costs.	Assistant Informatics Business Manager	31st March 2020
Assurances **(How do we know if the things we are doing are having an impact?)** • Progress has been made in securing capital investment both internally and externally for new developments • IBG and CPG processes are in place and ensuring highest technology replacement risks are being addressed • There are 22 active projects in place and being delivered • Digital enablement is a cornerstone of the organization strategy. Two of the strategies, 8 areas, of focus are digital enablement. • WG have announced (Oct 19) £50m investment into Digital Transformation in 19/20. The HB are awaiting final confirmation of its allocation which is indicated to be £1,390k capital and £1,060k revenue. Whilst this is under what was requested it will be utilised against priority requirements for the HB.	**Gaps in assurance** **(What additional assurances should we seek?)** Lack of certainty over future funding streams makes planning and implementation difficult/less effective Revenue model for support unclear given the financial pressures of the organisation.		
Current Risk Rating **4 x 3 = 12**	**Additional Comments** This is further impacted by the boundary change which could have significant impact on resources and capability to deliver digital services going forward. Internal processes have been established to ensure that all informatics costs are included in Business cases developed by Informatics. Representation from Informatics at IBG and the Scrutiny Panel. Strategic Outline Plan based on the three year IMTP will be presented to the Health Board on the 30th January 2020. Three year plan to be developed in line with the Health boards IMTP Planning process The Strategic Outline Plan will be based on the Three Year Plan which will be developed in line with the Health Boards IMTP Planning process.		

Datix ID Number: 1043 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**HBR Ref Number: 36**
Objective: Digitally enabled care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Audit Committee
Risk: Paper Record Storage: Lack of a single electronic record means there is greater reliance on the provision of the paper record. If we fail to provide adequate storage facilities for paper records then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if there is poor records management in some wards.	**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 3= 12 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 L - we know this happens from incidents raised
Level of Control = 70%	**Rationale for target score:**
Date added to the HB risk register June 2016	C - Inability to find records for patients could delay care/increase length of stay over 15 days. Could also mean patients receive incorrect treatment L – RFID and digitalisation of the health record will reduce the constraints of the current filing methodology and reduce the volume of paper being added to the record. Further digitalisation of the paper record will reduce the reliance of clinicians on the paper record.

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
Temporary retention and destruction plans are in place. Alternative storage arrangements are being identified and utilised where appropriate. Ward protocols and audits have been rolled out across sites. RFID project now approved. Implementation process has started and will change the way records are filed and release storage capacity. Roll out plan for WCP is in place and being enacted as outlined in the SOP All records must be documented and risk assessed in the Information Asset Register (IAR) Develop a case for improved storage solution both for paper and digitally.	Continue with the roll out of WCP	Interim Chief Information Officer	30th April 2020
	Continue with roll out of digitisation of health record with a focus on Outpatients and Nursing documentation	Interim Chief Information Officer	28th February 2020
	Develop case for improved storage solution for acute paper record.	Head of Health Records & Clinical Coding	14th February 2020

Assurances **(How do we know if the things we are doing are having an impact?)** • RFID has been implemented for the acute record improving the management of records • Health Records performance reports to be 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 • Monitoring complaints and incident reporting Gaps in Assurance Investment required	**Gaps in assurance** **(What additional assurances should we seek?)** 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.

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 is increasing the pressure on storage capacity and negating some of the mitigating actions that are being put in place	
Current Risk Rating **4 x 3 = 12**	**Additional Comments** All records must be documented and risk assessed in the Information Asset Register (IAR). This will mean that the risk can be quantified and understood. **Action - All SDU and corporate leads** Health Records Department will work with HB colleagues to develop a case for improved storage solution both for paper and digitally. In regard to the plans for the HB wide storage work, given the delay with the implementation of RFID, the timescales have been moved back slightly. Timescales for this work is as followed (based on current allocation of resources / no additional support. A dedicated project resource would get this done quicker) o Scoping and requirements gathering exercise by October 19 o Options developed – Q4 2019-20 o Business case - Q1 2020-21 o Implementation Q3/4 2020-21 Discussions are ongoing with Welsh Health Supplies and Welsh Government on the availability of All Wales Records solution, the outcome of this scoping work will inform the options of the Business Case.

Datix ID Number: 1565 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**HBR Ref Number: 45**
Objective: Digitally enabled care	**Director Lead**: Richard Evans, Medical Director **Assuring Committee**: Audit Committee
Risk: If patients are discharged from hospital without the necessary discharge information this may have an impact on their care	**Date last reviewed:** January 2020

Risk Rating (consequence x likelihood):
Initial: 5 x 4 = 20
Current: 4 x 4 = 16
Target: 3 x 3 = 9

Level of Control = 50%

Date added to the HB risk register May 2018

Rationale for current score:

- Despite the provision of an electronic discharge summary available across the Health Board to support the processing of discharge summaries within agreed targets, compliance with the targets, on average, remains low. GPs are therefore not always provided with the information required to provide continued care on discharge of the patient.
- The implementation of MTED across surgical wards has been delayed by NWIS due to a delay in the release of WCP probably until April 2020.

Rationale for target score:

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Implementation of WCP will include the MTED module which will allow extra project support to facilitate improved compliance	Medical Director	24th December 2020

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

- All SDUs to focus on improved performance - actions plans required from each SDU to demonstrate how compliance will be achieved
- Implementation of WCP will include the MTED module which will allow extra project support to facilitate improved compliance.

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

Current Risk Rating
4 x 4 = 16

Additional Comments
The most recent HB "completed & sent" performance was 60% (August 2017) compared with 48% a year ago.• In August 2017 the best performing hospital is NPTH (83%), this is reduced by the poor performance on wards not directly managed by NPT. Medical Wards regularly achieve 99%• August 2016 v August

	2017 Delivery Unit comparisons demonstrate substantial improvement in Morriston, POW & Singleton• Morriston is coming to the end of a 6-month improvement programme which is bearing fruit, performance was 46% in March when it started. MTeD went live on 10 wards (medicine) at Morriston Hospital on 20 May 2019. The delivery unit have also mandated that alongside MTeD, they are implementing a no discharge summary, no discharge policy with an escalation procedure for when patients are discharged without one. Implementation across remaining wards is scheduled for later in the year when we are able to send surgical data with the discharge summary/operation note directly to GPs.

Datix ID Number: 146 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**CRR Ref Number: 58**
Objective: Excellent Patient Outcomes	**Director Lead**: Chris White. Chief Operating Officer **Assuring Committee**: Quality and Safety Committee
Risk: There is a failure to provide adequate clinic capacity to support follow-up patients within the **Ophthalmology** specialty. The consequence of this failure is a delay in patients with chronic eye conditions accessing ongoing secondary care monitoring of diagnosed conditions with the potential risk of permanently impairing eyesight.	**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 4 x 5 = 20 Target: 4 x 1 = 4	
Level of Control = 40%	**Rationale for current score:** Sustainable plans underway - short term measures in process of being implemented. Serious incidents being reported to WG. Gold Command exec-led oversight established November 2018. Risk rating increased to 25 January 2019 as instructed by Gold Command. LJ advised change risk score to 16, 03/04/2019 as Probable x Major.
Date added to the HB risk register December 2014	**Rationale for target score:**

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• All patients are categorised by condition in order to quantify issue. Second glaucoma consultant appointed November 2018. • Additional accommodation secured to increase capacity; implementation plan under development. Welsh government funding secured for 2019/20 to employ additional activity and deliver some services in a community setting. Virtual clinics established. • Service Manager for Ophthalmology providing regular updates via Planned Care Programme.	Strawberry Place ODTC clinics planned to commence in April 2019	Service Group Manager Surgical Specialties	31st January 2020
	Further additional Glaucoma practitioner and Visual Field Technician posts are to be advertised and recruited to in increase Glaucoma capacity further as part of an OPDTC Outreach Community Clinic in Strawberry Place GP Surgery	Service Group Manager Surgical Specialties	31st January 2020
	Vacant Orthoptist post within AMD filled, start date TBC.	Service Group Manager Surgical Specialties	31st January 2020
	Several posts out for recruitment	Service Group Manager Surgical Specialties	31st January 2020
	An overall Sustainability Plan to be delivered	Service Group Manager Surgical Specialties	1st April 2020

Assurances **(How do we know if the things we are doing are having an impact?)**	Gaps in assurance **(What additional assurances should we seek?)**
• A Welsh Government pilot programme was implemented in June 2014. The purpose of the HES project is to use clinic capacity to assess, review and treat patients within clinical priority rather than prioritising new patients based on their waiting time. A Project Management Lead was in post to deliver on the HES objectives.	Extended waiting times for patients requiring routine clinical intervention, but these are still listed as per RTT guidance.
Current Risk Rating **4 x 5 = 20**	**Additional Comments** Additional Glaucoma practitioner (temporary for 12 months) commenced in post 11/06/2018. 2nd Glaucoma Consultant started 05/11/2018. Accommodation in Corridor 3 reconfigured 08/02/2019. Further work needed on accommodation and additional rooms required. Ongoing discussions continue with Singleton Unit so that space can be created to house a co-located Ophthalmology Department Middle grade doctor to commence in post April 2019. Monthly tracker of glaucoma backlog patients indicates reduction of over 800 patients to end of January 2019. Diabetic Retinopathy Virtual Review clinics are to be increased via a WG funded successful bid. Reviewed by AD& PT Sustainable plans are under way and are on target against follow up trajectory backlog. 20/21 sustainable plans are currently being drafted. Risk score reviewed to maintain at 20.

Datix ID Number: 737 **Health & Care Standard: Staying Healthy 1.1 Health Promotion**	**HBR Ref Number: 15**
Objective: Partnerships for Improving Health and Wellbeing	**Director Lead:** Keith Reid, Director of Public Health **Assuring Committee:** Quality and Safety Committee
Risk: If we fail to achieve **population health improvement targets** leading to an increase in preventable disease amongst the population resulting in increased morbidity impacting on operational and financial pressures.	**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 3 = 15 Target: 3 x 3 = 9 **Level of Control** = 60% **Date added to the HB risk register** 26.01.16		**Rationale for current score:** If we fail to prevent a serious outbreak by effectively achieving herd immunity in the population through immunisation and vaccination programmes, or to effectively manage an outbreak by disrupting the spread, this will result in serious harm to individual, maybe death, and pressure on health services, disruption to flow, business continuity and reputational damage to the health board and public health team. **Rationale for target score:** Manage preventable disease

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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Deliver immunisation awareness training for pre-school settings to promote key vaccination messages	Consultant Public Health Medicine	30th April 2020
Contribute to the implementation of recommendations made in the "MMR Immunisation: process mapping of the child's journey" report.	Consultant Public Health Medicine	30th April 2020
Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins	Consultant Public Health Medicine	30th April 2020

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

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

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

Current Risk Rating
5 x 3 = 15

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

Datix ID Number: 1763 **Health & Care Standard: Staff & Resources 7.1 Workforce**	**HBR Ref Number: 52**
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:** January 2020
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 = 12 Target: 4 x 2 = 8	**Rationale for current score:** •
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?)

- Engagement – a temporary post was created for a Head of Engagement for 6 months. The impact of this post was evaluated and will be used to inform the structures change (Operating model). In the meantime the Band 5 has been backfilled to support engagement activities. Robust processes are, however, in place as agreed with the CHC and based on best practice guidance.
- Impact Assessment - A JD has been drafted. The post has now been put forward as part of the CSP support package. Will be taken forward as part of the review of Executive portfolios regarding Equalities.
- Commissioning - two temporary posts are in place until the end of 2019/20 to support the disaggregation programme relating to Bridgend. Will be considered by the Joint Executive Group as part of the resource assessment for the ongoing legacy of the Bridgend transfer.
- Planning - 2 temporary unfunded posts in place (Partnerships Manager and Older people's Programme Manager). Executive Team agreed to fund these, as well as appoint an Acute Care Planning Manager. Core department resources have been aligned to the needs of the CSP and a range of additional posts have been put forward in the resource assessment for the Transformation Portfolio.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Agreement of dedicated resource to support Engagement activity – through structure reviews	Director of Transformation	14th February 2020
Conclude work on Exec Equalities portfolios	WoD	14th February 2020
Appoint to agreed Planning posts	Director of Strategy	14th February 2020

Assurances (How do we know if the things we are doing are having an impact?)
Temporary backfill resource for engagement.

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

Current Risk Rating
4 x 3 = 12

Additional Comments

Datix ID Number: 1762 **Health & Care Standard: Staff & Resources 7.1 Workforce**	**HBR Ref Number: 53**
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:** January 2020
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.
Level of Control = 60%	**Rationale for target score:** Working through its related improvement plan the likelihood of noncompliance will reduce as awareness and staff training in response to the Standards, is raised.
Date added to the HB risk register November 2018	

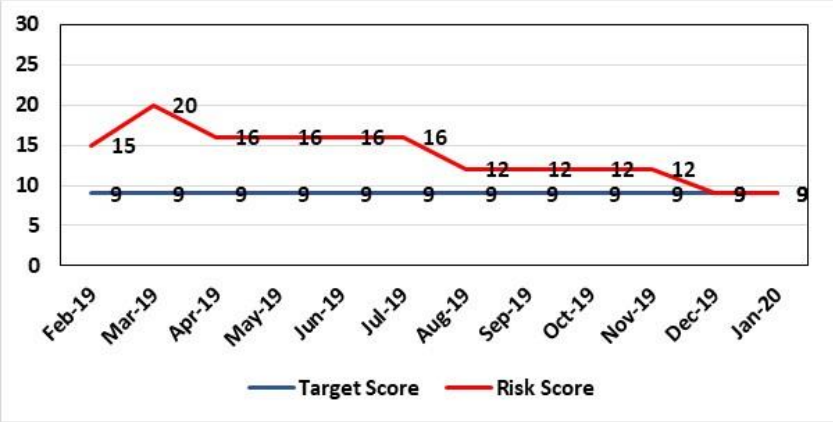
Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• A self-assessment of the requirements of the Standards and how they apply to the Health Board. • Close constructive working relationships are in place with the Welsh Language Commissioner's Office • Strong networks are in place amongst Welsh Language Officers across NHS Wales to inform learning and development of responses to the Standards. • The Welsh Language Delivery group has been set to integrate Welsh language into the business and share responsibility for compliance and learning – first meeting 14 May 2019. • Proactive communication and marketing activity is being undertaken across the Health Board to raise awareness of Welsh language compliance, customer service standards and training opportunities. Working with NHS Wales Shared Services (NWSSP) to achieve compliance for workforce and recruitment standards.	To Welsh Language Delivery Group meet quarterly and ensure the group comprises of appropriate representation from across all sectors of the organisation.	Director of Corporate Governance	27th March 2020
	Ensure the Board is fully sighted on the UHB's position through regular reporting to the Health Board. Update reports issued to the Executive Team and Board	Director of Corporate Governance	27th March 2020

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. Monitoring through the WLD group 3. Meetings with the Welsh Language Commissioner.	**Gaps in assurance** **(What additional assurances should we seek?)** ESR Welsh language competency information needs to be improved and targeted actions are being undertaken to increase compliance.
Current Risk Rating **5 x 3 = 15**	**Additional Comments** The self-assessment has confirmed that the Health Board is not able to fully comply with all the Standards by May 2019 and that the Health Board will need to take a risk management approach to the delivery of the standards. Current gap in the team following the retirement of the Welsh Language Manager. Plans in place to recruit by the end of March 2020.

Datix ID Number: 1724 **Health & Care Standard: Safe Care 2.1 Managing Risk & Health & Safety**		**HBR Ref Number: 54**
Objective: Partnerships for Care		**Director Lead:** Sian Harrop Griffiths, Director of Strategy **Assuring Committee:** Health Board (Emergency Preparedness Resilience and Response Group)
Risk: Failure to maintain services as a result of the potential no deal Brexit		**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 5 x 3 = 15 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 services as business as usual
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 in light of a no deal Brexit.
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**
• All services to identify high risks related to Brexit on risk register Engagement in health national groups • Welsh Government is working with NWSSP procurement to commission a review of devices and consumables supply chain in Wales to complement the work already completed at UK level. • Welsh Government has put in place national communication and co-ordination arrangements, including: o A Brexit Ministerial Stakeholder Advisory Forum made up of senior leaders from across the sector, and led by the Cabinet Secretary for Health and Social Services and the Minister for Children, Older People and Social Care; o An EU Transition Leadership Group, chaired by WG focusing on ensuring operational readiness arrangements for both health and social services in Wales (terms of reference attached); o Regular meetings of NHS emergency planners, chaired by Welsh Government, as part of established resilience arrangements; o A 4 Nations public health group addressing public health associated risks and health security concerns, and a joint Welsh Government – Public Health Wales working group considering specific Welsh issues; o Working in partnership with the Welsh NHS Confederation to ensure ongoing flexible and effective communication and engagement between us and other stakeholders in the health and care system; and Regular updates on Brexit to the monthly NHS Wales Executive Board meetings. o Assessing command and control requirements o Work programme monitored via EPRR Strategy Group o All services to complete business continuity plans o all services to identify high risks related to Brexit on risk register o Engagement in health national groups	To review and rehearse promptly the existing business continuity and resilience/contingency arrangements, and to do so working with your local and regional partners, including through your local resilience forums.	Head of Emergency Preparedness, Resilience & Response	Ongoing Monthly meetings
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 to complete business continuity plans	To understand from the review what arrangements need to be in place to minimise the risks in relation to a potential no deal Brexit.
Current Risk Rating **3 x 5 = 15**	**Additional Comments** There is an obligation to maintain critical services and business as usual in an emergency and this includes Brexit and consequently there is the potential for disruption in commercial and public services and therefore supplies, services, transport, fuel, border issues, EU national issues, immigration, critical infrastructure, energy and command resilience etc.

Datix ID Number: 1764 **Health & Care Standard: Safe Care 2.1 Managing Risk & Health & Safety**		**HBR Ref Number: 55**
Objective: Partnerships for Care		**Director Lead:** Sian Harrop Griffiths, Director of Strategy **Assuring Committee:** Joint Transition Board, Health Board
Risk: Failure to manage the residual risks arising from the Welsh Governments decision to realign the Health Boundary, as it applies to the resident population of the Bridgend County Borough.		**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 3 x 3 = 9 Target: 3 x 3 = 9		**Rationale for current score:** • The risk score has reduced from red 20 to red 16 which reflects that the Bridgend Boundary change took effect 1 April 2019 and that there are ongoing arrangements being put in place to manage the residual risks arising from the transfer. • The score has reduced to red 16, however it is important to recognise that financial discussions are ongoing with Welsh Government. • Outcome from arbitration and due diligence still unknown
Level of Control = 70%		**Rationale for target score:** • The Bridgend Boundary change took effect 1 April 2019 and there are ongoing arrangements being put in place to manage Service Level Agreement's (SLA's) and Long Term Agreements (LTA's) for service delivery.
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**
• Responsibility for the provision of health and care services for the Bridgend County Borough Council (BCBC) area transferred to Cwm Taf Morgannwg UHB on the 1 April 2019, this included the transfer of assets, services and resources. • A Joint Handover statement was approved by the Joint Transition Board on the 23 April 2019 and captures the business of the University Health Boards (UHBs), identifying key achievements, developments and investments, as well as highlighting any outstanding areas of work, risks and considerations which will need to be taken into account by Cwm Taf Morgannwg UHB and Swansea Bay UHB going forward. • A Memorandum of Understanding (MOU) has been devised which outlines joint agreements and stipulates what Service Level Agreements (SLAs) and Long Term Agreements (LTAs) are in place for cross border working. • A Quality and Patient Safety legacy document has been devised outlining the outstanding risks and the residual work required post April 2019. (can be accessed from the Joint Handover statement) • The cost pressures of the transfer are being discussed with Welsh Government	**Phase 2 – Service Transformation Plan** **Finance** Further discussion to take place with Welsh Government around to cost neutrality and financial stability. **Commissioning –** joint meeting set up to monitor memorandums of understanding and SLAs	Director of Transformation	14th February 2020

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance** **(What additional assurances should we seek?)**
• Performance is reviewed at monthly meetings with Cwm Taf Morgannwg UHB and progress is monitored by the Director of Transformation. • Executive leadership for boundary change will be transferring to director of strategy that the	

relationship with CTMHB is largely a service planning and commissioning one.	
Current Risk Rating **3 x 3 = 9**	**Additional Comments** The last Joint Transition Programme group meeting was held in April 2019, all supporting work streams will disband thereafter. The ongoing work to manage the residual issues will need to be included on top of routine duties and responsibilities

Datix ID Number: 2003 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**		**HBR Ref Number: 60**
Objective: **Digitally Enabled Care**		**Director Lead:** Chris White, Chief Operating Officer **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 has increased digital services (users, devices and systems) and therefore the impact of a cyber security attack is much higher than in previous years. The introduction of the Network and Information Systems Directive (NISD) in May 2018 means that large fines can be issued to organisations that are not compliant with the Directive. A report from the department of health following the Wannacry incident in May 2017 stated that attack cost the NHS (England) £92m as 19,000 appointments were cancelled and this was before the NISD came into effect. The largest risk to the organisation is on user awareness and unsupported software (old versions which are no longer patched for security vulnerabilities) and devices not managed by the ICT department e.g. medical devices.		**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 3 = 15 Target: 5 x 3 = 15		**Rationale for current score: C and L** The level of cyber security incidents is at an unprecedented level and health is a known target. The health board has increased digital services (users, devices and systems) and therefore the impact of a cyber security attack is much higher than in previous years.
Level of Control		**Rationale for target score:**
Date added to the HB risk register July 2019		C- will remain the same or increase due to increased reliance in information L- The overall likelihood score would increase to (20) if the funding of the 8A and 2 x Band 6 are not recruited .

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
The ICT department only has one ICT security manager and agreement is in place to recruit a Band 8A Cyber Security manager to provide strategic direction and develop action plans to address the risks highlighted in the Stratia Report as well as ensuring the Health Board complies with NISD. There are also 2 x band 6 WTE positions agreed pending release of funding to build the team which are required to act on information provided by the national security tools. The national security tools will highlight vulnerabilities and provide warnings when potential attacks are occurring. Swansea Bay will adopt these tools in financial year 2019/20.	Recruit Band 6 operational cyber security staff x 2	Head of ICT Systems	14th February 2020
	Implement National Cyber Security Tools	Cyber Security Manager	31st March 2020

The NHS in Wales is protected by a firewall by NHS Wales Informatics Service (NWIS). Swansea Bay UHB has advanced firewall protection to protect the network from potential cyber- attacks. All emails coming into NHS Wales are scanned using the national email filter. Whilst malicious emails come into the health board on a daily basis, the number are vastly reduced using the email filter and NWIS issue warnings to users affected when the contents are discovered (same day). Users are warned to delete emails and if opened, contact ICT service desk for investigation. A patching regime has been in place around 18 months which ensures desktops, laptops and servers are protected against any known security vulnerabilities. Anti-virus is in place to protect against known viruses with intelligent scanning on potential viruses not yet discovered. Access to the internet is controlled through a smart filtering solution which restricts access to potentially vulnerable content. Work is ongoing in order to replace out of date systems, this is a huge task given the number of clinical and administrative systems in place across the health board. The creation of the service management board will help in terms of getting stakeholder agreement and engagement. Capital funding has also been available to address this. A Cyber Security training module has been developed and available in the Electronic Staff Record training to ensure staff are fully aware of the risk of cyber security and are vigilant in recognising malicious activity e.g. malicious email. This needs to be adopted as mandatory training.			
Assurances (How do we know if the things we are doing are having an impact?) This will be developed following the appointment of the Cyber Security Manager. In the meantime, the follow up Stratia report has confirmed a major improvement in terms of Microsoft Security patching and SBU are compliant with standards agreed. The Cyber Assurance Framework (compliance with NISD) has been submitted to the Operational Security Service Management Board and plan will be developed nationally to address areas of non-compliance.	**Gaps in assurance (What additional assurances should we seek?)**		
Current Risk Rating **5 x 3 = 15**	**Additional Comments** Band 8a Cyber Security Manager appointed October 2019. Interviews scheduled for January 2020 to appoint to additional Band 6 staff within the team. Microsoft patching is compliant. NISD CAF completed and submitted to OSSMB.		

Datix ID Number: 1587 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**	**HBR Ref Number: 61**
Objective: Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morriston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies.	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Strategy Planning and Commissioning Committee
Risk: Paediatric dental GA/Sedation services provided under contract from Parkway Clinic, Swansea. Risk to patient safety with no immediate access to crash team/ICU facilities in Parkway Clinic. Sustainability issue within Parkway Clinic due to reduced commissioning. Financial risk to Parkway in reduction of remuneration received.	**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 4 x 4 = 16 Target: 4 x 2 = 8	**Rationale for current score:** There is no immediate access to crash team/ICU facilities in in Parkway Clinic – the client group are undergoing G/A/sedation. Paediatric GA/Sedation services provided under contract from Parkway Clinic, Swansea continue due to lack of capacity for these patients to be accommodated in Secondary Care
Level of Control = 60%	**Rationale for target score:**
Date added to the HB risk register 4th July 2018	Relocation of the paediatric GA service [provided by Parkway Clinic] to a hospital site being treated as a priority

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

- 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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Transfer of services from Parkway.	Interim Head of Primary Care	1st April 2020

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

- RMC collate referral and treatment outcome data for review by Paediatric Specialist
- Regular clinical meeting arranged with Parkway to discuss individual cases/concerns
- Regular clinical/ management meeting for CDS/primary care management team to discuss service pathway /concerns/issues arising
- Roll out of new pathway to encompass urgent referrals

Gaps in assurance
(What additional assurances should we seek?)
ToR for the task and finish group should continue to include consideration of the pressures on the POW special care dental GA list and this service is considered alongside any plans for the Parkway contract.

Current Risk Rating
4 X 4 = 16

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

Datix ID Number: 1605 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**	**HBR Ref Number: 63**
Objective: Screening for Fetal Growth Assessment in line with Gap-Grow (G&G)	**Director Lead**: Gareth Howells, Director of Nursing and Patient Experience **Assuring Committee:** Quality and Safety Committee
Risk: There is evidence a growth restricted/small for gestational age fetus (SGA), has an increased risk of intra-uterine death before or during the intrapartum period. Identification and appropriate management for SGA in pregnancy should lead to improved outcomes. GAP & Grow standards were implemented to contribute to the reduction of stillbirth rates in wales. Obstetric USS scan appointments are at capacity leading to delays in obtaining required appointments. In addition the guidance from Gap & Grow is for women requiring serial scanning with a risk factor for a growth restricted baby must have 3 weekly scans from 28 to 40 week gestation. Due to the scanning capacity there are significant challenges in achieving this standard.	**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 5 = 20 Target: 3 x 4 = 12 **Level of Control** = 60% **Date added to the HB risk register** 1st August 2018		**Rationale for current score:** CSFM's leading on audit reviewing records of all women where SGA not identified in antenatal period. Scanning capacity under increasing pressure. Meeting arranged with radiology management to discuss introduction of midwife sonographer third trimester scanning. Staff to be informed to submit Datix incident where scan not available in line with standards. **Rationale for target score:** Compliance with Gap & Grow requirements.

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

Assurances **(How do we know if the things we are doing are having an impact?)** Audit of compliance with guidance being undertaken, detection rates of babies born below the 10th centile is being monitored via datix and audited by the service. Ultrasound are assisting with finding capacity wherever possible in order to meet standards for screening and complying with Gap & grow recommendations.	**Gaps in assurance** **(What additional assurances should we seek?)**
Current Risk Rating **4 X 5 = 20**	**Additional Comments** Meeting took place with Deputy Head of Therapies for the HB. Arrangement to meet in January 2020 to review radiology capacity and plan future service needs. This will form part of the antenatal clinic review. Audit of missed cases themes and trends to be presented to the MDT in February 2020

Datix ID Number: 2159
Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety

HBR Ref Number: 64

Objective: Best Value Outcomes

Director Lead: Gareth Howells, Director of Nursing and Patient Experience
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.
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Date last reviewed: January 2020

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

Rationale for current score:
The Health Board are in receipt of 10 Health & Safety Executive (HSE) improvement notices concerning health and safety management, violence and aggression and manual handling, limited assurance internal audit reports for water safety management and COSHH, and a fire enforcement notice for one of our sites. Fire risk assessment frequencies are not being kept up to date. Statutory/mandatory training provision and recording will not be sustainable. Unable to support units sufficiently for H&S, case management (V&A), fire and training or to conduct audits/inspections. Potential for litigation, with implications of financial and reputational consequences for not meeting legislative requirements.

Level of Control
= 70%

Rationale for target score:

Date added to the HB risk register
September 2019

Additional resources and updated/refreshed/new systems will enable the Health Board to 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. Risk assessments are being undertaken within required frequencies and periodic audits are taking place to support the various units and departments.

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

- HSE Improvement working group set up to address the HSE recommendations and meets fortnightly to monitor the improvement action plan.
- Interim posts of Assistant Director of Health and Safety and Interim Head of Compliance employed on secondment to support strengthening and developing the H&S function
- Health and Safety Operational Group meets quarterly and reports to the Health and Safety Committee
- Water safety management action plan in place
- COSHH procedure reviewed and updated
- Fire risk assessments are being undertaken at priority sites (patient areas) to address recommendations of the MAWWFRS
- Fire training in place and fire wardens in place

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Health and safety department structure to be reviewed and produce proposals, business case	Assistant Director of H&S	31st March 2020
Health and safety structure review to be presented to the H&S Committee	Assistant Director of H&S	30th June 2020

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

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

• Monitoring through the H&S committee to receive assurance and or identify gaps for key compliance and adherence to applicable legislation. • HSE focus group monitor compliance against the 10 improvement notices and report to the H&S operational group and H&S committee. • Site visits/tours to identify compliance and gaps in compliances.	
Current Risk Rating **4 X 5 = 20**	**Additional Comments** The re-inspections took place w/c 16 September 2019, visiting NPTH on 16th, Singleton & Morriston Hospital on 17th, Tonna Hospital and NPTH on 18th and NPTH on 20th. All visits went well overall with a number seven of the ten notices closed and three extended to 6th December 2019. A further visit was arranged for 5th December (Theatres at Singleton) where it was confirmed that two more notices were complied with and the other one extended to 31 January 2020. Confirmation via email was received on 7th February that all improvement notices have been complied with. Business case to be written by 31st March 2020. Re-structure review to be presented to H&S committee during 1st quarter 2020/21. Long term plans to be developed to understand the Health and Safety resource requirements for the Health Board.

Datix ID Number: 329 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**	**HBR Ref Number: 65**
Objective: Digitally enabled Care	**Director Lead**: Gareth Howells, Director of Nursing and Patient Experience **Assuring Committee:** Quality & Safety Committee
Risk: Risk associated with misinterpreting abnormal cardiotocography readings in the delivery room. A central monitoring station would enable multi-disciplinary viewing and discussion of the readings to take place, and reduce the risk of a concerning CTG trace going unidentified. Provisionally scored C4 (irrecoverable injury) x L3= 12. The central monitoring system has a facility to archive the CTG recordings: currently these tracings are only available as a paper copy, which can be lost from the maternity records. There is also a concern that the paper tracings fade over time which makes defending claims very difficult.	**Date last reviewed:** January 2020 **Rationale for current score:** Meeting with K2, IT, finance, procurement and midwifery team on 30/09/2019. System viewed and IT needs identified. Final costing to be assessed prior to resubmission to IBG in Oct or November 2019.
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 5 = 20 Target: 4 x 2 = 8 **Level of Control** = 50% **Date added to the HB risk register** 31st December 2011	
Rationale for target score:	
Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**

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.

Action	Lead	Deadline
Business case prepared for Central monitoring system to store CTG recordings of fetal heart rate in electronic format.	Deputy Head of Midwifery	3rd April 2020
Identified need for midwife for fetal surveillance training and support to improve knowledge through increased support and training in the clinical areas as well as support for the formal training programme within SBUHB.	Deputy Head of Midwifery	14th February 2020

Assurances **(How do we know if the things we are doing are having an impact?)** All Wales Fetal Surveillance Standards for 6hrs Fetal Surveillance Training per year	**Gaps in assurance** **(What additional assurances should we seek?)**
Current Risk Rating **4 X 5 = 20**	**Additional Comments** Submission to IGB in January 2019. CTG envelopes placed in every set of records for safe storage of CTG. Business case completed by maternity service and multi-professional team. Remaining issue outstanding is the financial detail from IT. To ensure submission of case in January 2020

Datix ID Number: 1834 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 66**
Objective: Best values outcomes from high quality care		**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee:** Quality and Safety Committee
Risk: Unacceptable delays in access to SACT treatment in Chemotherapy Day Unit		**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 5 = 25 Target: 2 x 2 = 4		**Rationale for current score:** Increased risk to 25 as waiting times starting to re-increase for Long chair regimes, discussed at oncology business meeting
Level of Control =		
Date added to the HB risk register 30/11/2019		**Rationale for target score:**

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	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. Options appraisal to be completed for SSDU senior management team by service group	Options appraisal paper to be produced for SSDU senior team by service group	Service Manager Surgical Services	20th March 2020
Assurances **(How do we know if the things we are doing are having an impact?)** Extra nurse in place reliant on agency Senior team meeting to review findings of service review paper. Additional funding agreed to support increase in nurse establish to appropriately run the unit during their main opening hours	**Gaps in assurance** **(What additional assurances should we seek?)**		
Current Risk Rating **5 X 5 = 25**	**Additional Comments** Additional staffing in place from Dec 19 to allow full use of chairs but capacity gap remains. Looking at options around use of additional SACT capacity via Tenovus. Also working with MSD/GE around potential partnership agreement to look at C&D mapping and best practice elsewhere with visit to Leeds being arranged by MSD colleagues.		

Datix ID Number: 89 **Health & Care Standard: 5.1 Timely Care**	**HBR Ref Number: 67**
Objective: Best values outcomes from high quality care	**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee:** Quality and Safety Committee
Risk: Clinical risk-target breeches in the provision of radical radiotherapy treatment. Due to capacity and demand issues the department is experiencing target breeches in the provision of radical radiotherapy treatment to patients.	**Date last reviewed:** January 2020
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 5 = 25 Target: 2 x 2 = 4 **Level of Control** = **Date added to the HB risk register** 30/11/2019		**Rationale for current score:** Waiting times deteriorating for elective delays patients, particularly prostates discussed in Oncology business meeting. **Rationale for target score:**

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
Requests for treatment and treatment dates monitored by senior management team.	**Action**	**Lead**	**Deadline**
	Additional risk capacity	Service Manager Surgical Services	6th March 2020

Assurances **(How do we know if the things we are doing are having an impact?)** Performance and activity data is being monitored and monthly data shared with radiotherapy management meeting and cancer board. It is also now included in scorecard.	**Gaps in assurance** **(What additional assurances should we seek?)**
Current Risk Rating **5 X 5 = 25**	**Additional Comments** Radiotherapy waiting times continue to cause concerns, new COSC guidelines launched this year mean we now reporting Rx waiting times to WG. Sept Performance has been added to this risk. Options to increase our capacity and include in PBC for SWWCC which is being developed and internal efficiency work with QI colleagues is also being reviewed. Rx Performance is discussed in Radiotherapy management meeting and papers are chased in Cancer Board. Agreement has been reached around outsourcing 12 prostate radiotherapy cases per month for 6 months to Rutherford. Commencing in January 2020. While case for extended day is further reviewed.

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