HEALTH BOARD RISK REGISTER
March 2022

RISKS ASSIGNED TO THE QUALITY & SAFETY COMMITTEE

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

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

- Programme management office in place to improve Unscheduled Care.
- Daily Health Board wide conference calls/ escalation process in place.
- Regular reporting to Executive and Health Board/Quality and Safety Committee.
- Increased reporting as a result of escalation to targeted intervention status.
- Targeted unscheduled care investment of £8.5m in the annual plan, including a new Acute Medical Model focused on increasing ambulatory care.
- Development of a Phone First for ED model in conjunction with 111 to reduce demand.
- 24/7 ambulance triage nurse in place

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Re-establish short stay unit on ward D at Morriston	SGD (Morriston)	31/03/2022
Increase SDEC working hours and throughput of patients.	SGD (Morriston)	31/03/2022
Third phase of procurement to be undertaken to commission additional care home beds.	SGD (PCT)	31/03/2022

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

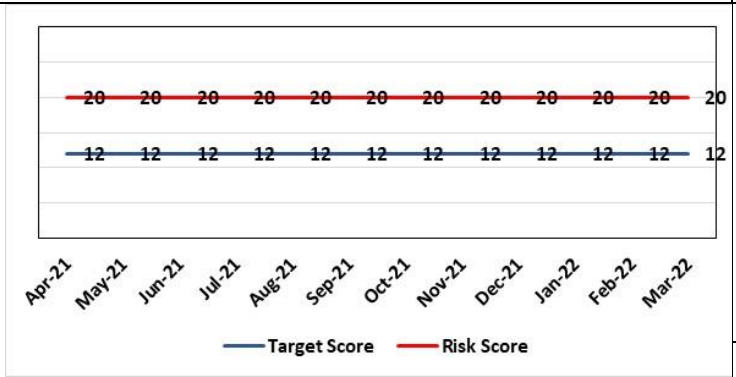
- New Urgent & Emergency Care Board to meet monthly

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

The need to deliver sustained service.

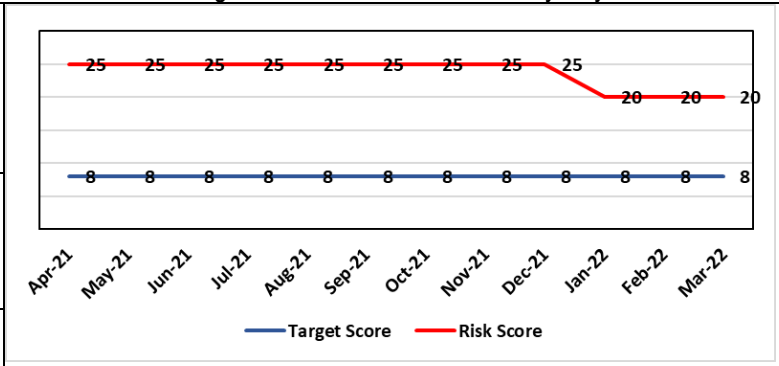
Additional Comments

Zero tolerance target of 4 hours agreed. SOP in place. Currently not achieving due to Omicron surge and increased pressures at Morriston.
Patient pathways that can bypass ED have been identified, but the EMD is working with WAST and SBU clinicians to maximise the number of patients receiving SDEC (Same Day Emergency Care).
Acute hub relocated to TAWE as planned in December. Estates works have commenced in Enfys ward.
Update 11.02.22 Action closed: Business case to take virtual wards up to 8 have been submitted to Management Board.

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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Policies, procedures, protocols and guidelines supplement the National Infection Control Manual. • Seven-day infection prevention & control service provides advice and support HB staff. • Medical microbiology & infectious diseases team provides expertise and support. • Infection Prevention & Control related training provided programmes. • Surveillance of infections, with early identification of increased incidence, and instigation of controls. • Provision of cleaning service to meet National Standards of Cleanliness. • Engineering controls for water safety, ventilation, and decontamination.	Drive improvements in prudent antimicrobial prescribing	Cons. Antimicrobial Pharmacist	31/03/22
	Develop ward to board Dashboard on key Tier 1 infections	HoN IP&C & Digital Intelligence	31/03/22
	Achieve compliance with IPC mandatory training	Service Group Triumvirates	31/03/22
Assurances **(How do we know if the things we are doing are having an impact?)** • Clear Corporate and Service Group IPC Assurance Framework in place.	**Gaps in assurance** **(What additional assurances should we seek?)** Review single room capacity. Poor condition of hospital estate requires investment. High		

• Ongoing monitoring of infection control rates, with weekly feedback corporately & to Service Groups. • Infection Control Committee and Quality Priority Sub-groups receive assurance reports, monitor infection rates, and identify key actions to drive improvement. Quality Priority Sub-groups of ICC review progress of improvement actions. • Training compliance. • IPC, antimicrobial, decontamination and cleaning audit programmes. • Compliance and validation systems for water safety, ventilation systems and decontamination.	activity limits access for planned preventative maintenance and necessary HTM validation/compliance checks. Seek improved Corporate and Service Group oversight of compliance with ventilation, water safety, decontamination & cleaning checks. Challenge to sustain cleaning workforce to achieve National Minimum Standards of Cleanliness. Review plans to reduce bed occupancy rates and patient multi-ward moves. Investment in ESR Self-service to provide data on IPC-related training compliance. Investment in digital intelligence systems to provide Board to Ward oversight of infection, antimicrobial, cleanliness, and training data.
Additional Comments Update February 2022 - Three actions closed – 1. Define governance structures to support the HCAI Quality Priority. 2. Recruitment to support strengthening governance of decontamination processes. 3. Recruitment of key personnel to support improvements in antimicrobial prescribing. 21/03/22 - IPC Improvement Plan approved in principle by Management Board on 9th March 2022, with amendments to be incorporated in next iteration. The aim is to create a guiding coalition of responsible clinical leaders (not just nursing staff) at all levels in the organisation who see the intrinsic benefits and reduction in harm from infection. Management Board IPC Improvement Plan Paper and actions attached in Documents on Datix. This will be presented at the next Infection Control Committee on 30/03/22 and is for adoption by all Service Groups.	

Datix ID Number: 840 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 16** **Target Date: 31st March 2022**	**Current Risk Rating** **5 x 4 = 20**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Inese Robotham, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee **For information:** Quality & Safety Committee	
Risk: Access and Planned Care. There is a risk of harm to patients if we fail to diagnose and treat them in a timely way.		**Date last reviewed:** March 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 4 = 20 Target: 4 x 2 = 8		**Rationale for current score:** All non-urgent activity was cancelled due to response to the Covid-19 pandemic and has increased the backlog of planned care cases across the organisation. Whilst mitigating measures such as virtual clinics have been put in place new referrals are still being accepted which is adding to the outpatient backlog particularly in Ophthalmology and Orthopaedics. The significant reduction in theatre activity during the pandemic increased the number of patients now breaching 36 and 52 week thresholds.	
Level of Control = 90%		**Rationale for target score:** There is scope to reduce the likelihood score to reduce the overall risk to an acceptable level	
Date added to the HB risk register January 2013			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Post Covid 19 the focus is on minimising harm by ensuring that the patients with the high clinical priority are treatment first. The Health Board is following the Royal College of Surgeons guidance for all surgical procedures and patients on the waiting list have been categorised accordingly. • There is a bi-weekly recovery meeting for assurance on the recovery of our elective programme. • Specialty level capacity and demand models set out the baseline capacity and identify solutions to bridge the gap. Non-recurring pump – prime funding is available to support initial recovery measures. Fortnightly performance reviews track progress against delivery. • A focused intervention is in train to support to the 10 specialties with the longest waits. • Long waiting patients are being outsourced to the Independent Sector • Additional internal activity is being delivered on weekends (via insourcing)	Implement demand management initiatives between primary and secondary care to reduce the number of new patients awaiting outpatient appointments.	Service Group Directors	31/03/2022
	Implement a full range of interventions to support patients to be kept active and well whilst on a waiting list. The focus will be on cancer patients awaiting surgery and long waiting orthopaedic patients.	Service Group Directors	31/03/2022
	Develop robust demand and capacity plans for delivery in 2022/23	Service Group Directors/ Deputy COO	31/03/2022

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

Additional Comments

27/01/22: An additional ophthalmology day case theatre in Singleton will also be operational early in 2022/23.
23/02/22 – Work has commenced in cardiology, ENT, dermatology and colorectal surgery. Other areas are being developed.

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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Additional supervisory body signatories in place BIA rota now implemented but limited uptake due to inability to release staff. BIA Training undertaken for 9 nursing staff (7 within the Long Term Care Team). Able to undertake assessments utilising additional monies from WG. 1 x substantive BIA in post and additional admin post in place. DoLS database updated and DoLS dashboard in place, monitoring applications and breaches via dedicated BIAs and Admin. Delivery of DOLS Action plan reviewed monthly Regular reporting to Mental Health and Legislative Committee (MHLC) Health Board presence at National and regional meetings relating to DoLS / LPS Increased IMCA services to support increased BIA resource Additional funding received from WG to manage the backlog of DoLS assessments and implementation of LPS. Current MCA practice reviewed to support MCA DoLS issues in practice Use of WG funding to support changes to service model.	Business case for revised service model	GND Primary and Community	31/03/2022
	Agency commissioned to support backlog of assessments	GND Primary and Community	31/03/2022
	Overtime agreed to fund sign off from nurse assessor team to process the backlog assessments	GND Primary and Community	31/03/2022

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

Additional Comments

24.03.2022 update

Agency Best Interest Assessor's (BIA) commissioned utilising welsh government funding.
Four experienced competent BIA's will begin undertaking assessments from 28th March 2022.
Weekly allocation meetings set up to track and monitor action on the backlog.
The current backlog today 24/03/22 stands at 97 referrals. It is anticipated that approximately 12 plus assessments will be completed per week.
The Dols Team Leader has arranged regular weekly coordination and allocation/peers support for each Monday morning at 10am with Liquid Personnel BIA's and will support with overseeing the Quality Assurance process required as the Supervisory Body (SB) function.
There are 6 signatories based within the Long Term Care Team that will be supporting the signatory SB functions, in focusing on clearing the Dols backlog over the subsequent months.

Additional information received from Head LPS
New legislation changes regarding Liberty Protection Safeguards (LPS) were expected in April 2022. Confirmation received from UK government December 2021 that this is to be delayed.
WG Draft code of Practice launched 17th March – 16 week consultation concludes 7th July. Health Board and regional response to be developed with LPS Head of Nursing.
Additional funding received from WG to manage the backlog of DoLS assessments and implementation of LPS have been utilised to support training and IMCA services to address the backlog. Options for a new service model have been presented and terms of reference have been drafted for a senior working group to support this work.

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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Performance Scrutiny - is undertaken at monthly commissioning meetings between Swansea Bay & Cwm Taf Morgannwg University Health Boards. Improved governance -ensures that issues and concerns are discussed by all interested parties including local authorities to support the network identify local solutions. • New Service Model was established by Summer 2019 which gave further stability to service. • Staffing of service is being strengthened & supplemented by agency staff	Improvement plan has been shared by CTM and is monitored monthly. Action to mitigate the risk to young people waiting is being taken including utilisation of the third sector for support. Update is scheduled to the performance & finance committee in March	Assistant Director of Strategy	31/03/2022

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

Additional Comments

28/01/22: Risk reviewed – no change to score.
17/02/22: New action added.
Update 22.02.2022 - Potential for repatriation of CAMHS service from Cwm Taf Morgannwg HB being considered through commissioning additional external support to review.

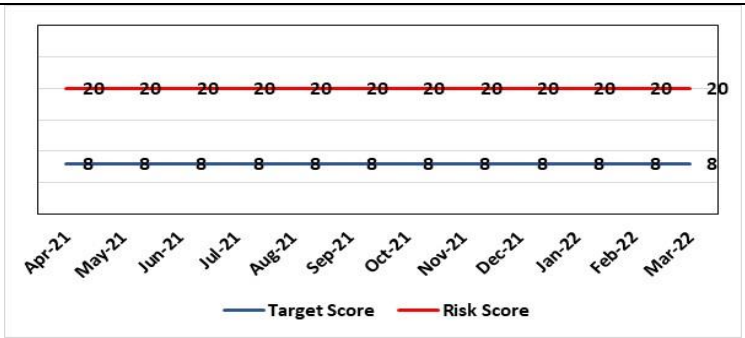
Datix ID Number: 1761 **Health & Care Standard: Timely Care 5.1 Access**		**HBR Ref Number: 50** **Target Date: 31st March 2022**	**Current Risk Rating** **5 x 5 = 25**
Objective: Best Value Outcomes from High Quality Care		**Director Lead**: Inese Robotham, Chief Operating Officer **Assuring Committee:**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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Tight management processes to manage each individual case on the Urgent Suspected Cancer Pathway. Enhanced monitoring & weekly monitoring of action plans for top 6 tumour sites. • Initiatives to protect surgical capacity to support USC pathways have been put in place • Additional investment in MDT coordinators, with cancer trackers appointed in April 2021. • Prioritised pathway in place to fast track USC patients. • Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. This will form part of the remit of the Cancer Performance Group. • Weekly cancer performance meetings are held for both NPTS and Morriston Service Groups by specialty. • The top 6 tumour sites of concern have developed cancer improvement plans. • Additional work being undertaken as part of diagnostic recovery and theatre recovery workstreams. • Endoscopy contract has been extended for insourcing.	Phased and sustainable solution for the required uplift in endoscopy capacity that will be key to supporting both the Urgent Suspected Cancer backlog and future cancer diagnostic demand on Endoscopy Services.	Service Group Manager	31/03/2022
	Implement a process for clinical harm review (Waiting on all Wales decision of patient pathway reviews & framework).	Cancer Quality & Standards Manager	31/03/2022
	Cancer Programme Board to be established	Cancer Quality & Standards Manager	31/03/2022

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Backlog trajectory accepted at Management Board on 15th September and trajectory will be monitored in weekly enhanced monitoring meetings. Cancer Performance Group being established to support execution of the services delivery plans for improvements.	Performance and activity data monitored, but delays to treatment continue while sustainable solutions found.

Additional Comments

07.02.22 - A health board Cancer Performance Group has been established in November 2021. A work programme for the group has been established.
01.03.22 – CEO has requested zero waits over 100days by end of March 2022. Deputy COO meeting with teams with longest waits.

Datix ID Number: 146 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**		**HBR Ref Number: 58** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Excellent Patient Outcomes		**Director Lead**: Inese Robotham, Chief Operating Officer **Assuring Committee**: Quality and Safety Committee	
Risk: Failure to provide adequate clinic capacity for follow-up patients **Ophthalmology** results in a delay in treatment and potential risk of sight loss.		**Date last reviewed:** March 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 5 = 20 Target: 4 x 2 = 8		**Rationale for current score:** Risk rating increased to 20 in July 2020 due to Covid-19 pandemic backlog has continued to grow.	
Level of Control = 40%		**Rationale for target score:** Mitigation plan via outsourcing will reduce the backlog to pre-covid levels.	
Date added to the HB risk register December 2014			

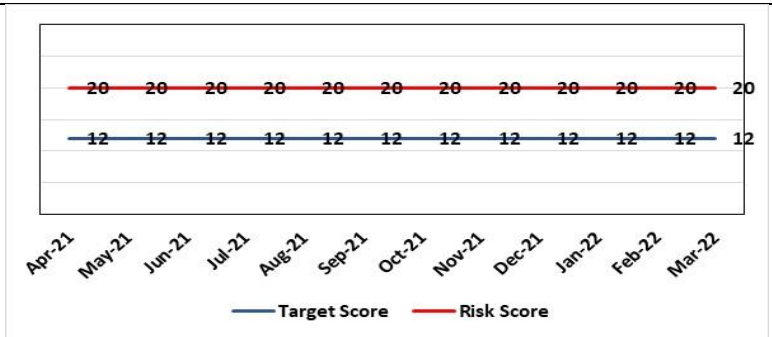
Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• All patients are categorised by condition in order to quantify issue. • Community optometry scheme successfully implemented to reduce number of diabetic retinopathy patients on follow up list. • Scheme developed for assessment of glaucoma patients by community optometrists for virtual review by consultant ophthalmologists to reduce follow up backlog. • Outsourcing of cataract activity to reduce overall service pressures.	An overall Regional Sustainability Plan to be delivered	Service Group Manager Surgical Specialties	31/03/2022 (Bi-weekly ongoing)
Assurances **(How do we know if the things we are doing are having an impact?)** • Deputy COO holds Gold Command meetings on a monthly basis to monitor progress.	**Gaps in assurance** **(What additional assurances should we seek?)** Regular liaison with patients on extended waiting list/times and validation.		
Additional Comments			

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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Consultant Anaesthetist present for every General Anaesthetic clinic. • Assurance Documentation supplied by Parkway Clinic including confirmation of arrangements in place with WAST and Morriston Hospital for transfer and treatment of patients • New care pathway implemented - no direct referrals to provider for GA. • Multi-drug sedation ceased from Sep 2018 in line with WHC 2018 009 • Revised SLA/Service Specification • HIW Inspection Visit Documentation provided to HB • All extended GA cases require approval from paediatric specialist prior to treatment	**Action**	**Lead**	**Deadline**
	Transfer of services from Parkway.	Interim Head of Primary Care	31/05/2022

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

Additional Comments

Datix ID Number: 1605 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**	**HBR Ref Number: 63** **Target Date: 31st March 2022**	**Current Risk Rating** **4 X 5 = 20**
Objective: Screening for Fetal Growth Assessment in line with Gap-Grow (G&G)	**Director Lead**: Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality and Safety Committee	
Risk: There is evidence a growth restricted/small for gestational age fetus (SGA), has an increased risk of intra-uterine death before or during the intrapartum period. Identification and appropriate management for SGA in pregnancy should lead to improved outcomes. GAP & Grow standards were implemented to contribute to the reduction of stillbirth rates in wales. Obstetric USS scan appointments are at capacity leading to delays in obtaining required appointments. In addition, the guidance from Gap & Grow is for women requiring serial scanning with a risk factor for a growth restricted baby must have 3 weekly scans from 28 to 40 week gestation. Due to the scanning capacity there are significant challenges in achieving this standard.	**Date last reviewed:** March 2022	
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 2019		**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	30/03/2022
Assurances (How do we know if the things we are doing are having an impact?) Audit of compliance with guidance being undertaken, detection rates of babies born below the 10th centile is being monitored via Datix and audited by the service. Ultrasound are assisting with finding capacity wherever possible in order to meet standards for screening and complying with Gap & grow recommendations.	**Gaps in assurance (What additional assurances should we seek?)**		

Additional Comments

UWE course now anticipated to be completed for 2 midwifes by early 2022. Business case for 2nd cohort to be completed.
28.10.21 This risk additionally going to be added to the Radiology Risk Register to acknowledge the issues identified. ML to email AS for an update as to whether we can return to pre-covid scanning.
19.11.21 Expressions of interest requested from midwives to attend January 2022 sonographer training at UWE. Training places funded by HEIW. Business case required to backfill for trainees. Further capacity issues identified due to the introduction of 30 minute fetal anomaly scans in line with ASW standards. Increased capacity gap assessed to be 20 scans per week.
14.01.22: Two midwives have commenced ultrasound training at UWE. Two midwives currently on preceptor program with an aim to achieve service delivery lists in April 2022. Resignation received from midwife sonographer trainer. Options being explored for covering 15 hours training.

20.01.2022: Meeting with USS lead trainer and lead obstetric consultant. Concern raised of the impact of one USS machine on bot service development and training. Suggestion for all issues to be set out using a risk assessment form which will be passed to divisional manager and cc Chair of HB ultrasound group convened for development of midwife sonographer third trimester screening clinics 08.03.2022 – U/S machine on order for delivery before 31.3.22. Two midwife sonographers will provide service from the first week of April 2022.

Datix ID Number: 329 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 65** **Target Date: 31st March 2022**	**Current Risk Rating** **4 X 5 = 20**
Objective: Digitally enabled Care		**Director Lead**: Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality & Safety Committee	
Risk: Risk associated with misinterpreting abnormal cardiotocography readings in the delivery room. A central monitoring station would enable multi-disciplinary viewing and discussion of the readings to take place, and reduce the risk of a concerning CTG trace going unidentified. Provisionally scored C4 (irrecoverable injury) x L3= 12. The central monitoring system has a facility to archive the CTG recordings: currently these tracings are only available as a paper copy, which can be lost from the maternity records. There is also a concern that the paper tracings fade over time which makes defending claims very difficult.		**Date last reviewed:** March 2022 **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:** Funding for central monitoring approved for 2021/22 Meeting to be arranged with provider and key stakeholders in SBU to commence the project toward installation and training.	
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**: Business case prepared for Central monitoring system to store CTG recordings of fetal heart rate in electronic format. **Lead**: Deputy Head of Midwifery **Deadline**: 31/03/2022	
Assurances (How do we know if the things we are doing are having an impact?) All Wales Fetal Surveillance Standards for 6hrs Fetal Surveillance Training per year		**Gaps in assurance (What additional assurances should we seek?)**	
Additional Comments 25.10.21 – Update – Business case completed. Awaiting update from K2 regarding when the monitoring system can be delivered as funds available through slippage funding. Update 05.11.21 – Meeting to agree costings - On completion and agreement of the action a project Board Steering Group will be set up to manage installation and training on the system 14.01.22 - Central monitoring system approved at BCAG - project board being developed. 08.03.22 - Procurement process completed. Order placed. Project board to be set up.			

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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Review of CDU by improvement science practitioner was completed in 2020. Resulted in change to booking processes to streamline booking process and deferral. Review of scheduling by staff to ensure all chairs used appropriately. Business case endorsed by CEO for shift of capacity to home care to be considered by the Management Board A Daily scrutinizing process in progress to micro manage individual cases, deferrals etc	Business Case for phase 2 home care expansion based on moving further treatments to community service. Paper with CEO for comments, prior to going to BCAG	Associate Service Group Director – Cancer Division	30/04/2022
	Paper to support extended day working every Saturday	Service Director Lead for Cancer	30/04/2022
	Relocation of SACT linked to AMSR programme and phase 2 of home care expansion case brought forward	Service Director Lead for Cancer	January 2023 (dependant on AMSR moving Sept 2022)

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

Management Board and internally via governance arrangements with NPTSSG where Oncology services sit.	

Additional Comments

11.03.21 – New QI SACT practitioner post appointed to in March 2022 awaiting start date. will support monitoring of our performance and as the Quality Improvement, lead the post holder will identify and implement innovative ways to improve the timely and equitable access of patients to SACT treatment in the South West Wales Cancer Centre.
15.03.22- Phase 2 case for home care expansion based on moving further treatments to community service. Paper with CEO for comments, prior to going to BCAG and Paper to support extended day working every Saturday rather than alternate Saturday Paper with CEO for comments.
15.03.22 We now appointed a dedicated SACT QI practitioner to work with team. The post holder will be responsible for establishing efficient, effective and equitable pathways for SACT treatment with a focus on quality improvement to improve patient access for SACT treatments and compliance with performance metrics. Awaiting Start date provisional looking at June 22.
2 Actions closed - Business case endorsed by CEO for shift of capacity to home care to be considered by the Management Board (Phase 1 complete). A second business case is being developed to propose relocation of CDU to a vacant ward area, which would increase chair capacity.

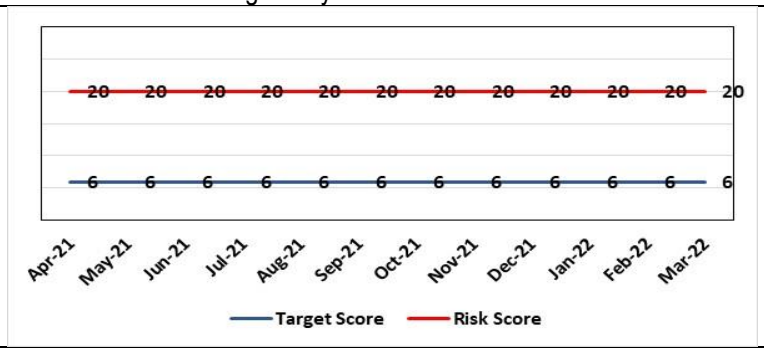
Datix ID Number: 89 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 67** **Target Date: 31st March 2022**	**Current Risk Rating** **5 X 3 = 15**
Objective: Best values outcomes from high quality care		**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee:**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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Implementation of revised radiotherapy regimes for specific tumour sites, designed to enhance patient experience and increase capacity. Breast hypo fractionation in place. Requests for treatment and treatment dates monitored by senior management team. Protected capacity rate set as part of 2020/21 Operational Plan. Outsourcing of appropriate radiotherapy cases. Additional outsourcing for Prostate RT commenced June 2021.	Hypofractionated Prostate - Business plan submitted for additional resources required to implement hypofractionated technique.	Service Manager Cancer Services	31/05/2022
	New Linac required – Linac case agreed with WG	Service Manager Cancer Services	01/07/2022

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Performance and activity data is being monitored and monthly data shared with radiotherapy management meeting and cancer board. It is also now included in scorecard.	Performance and activity data monitored, but delays to treatment continue while sustainable solutions found.

Additional Comments

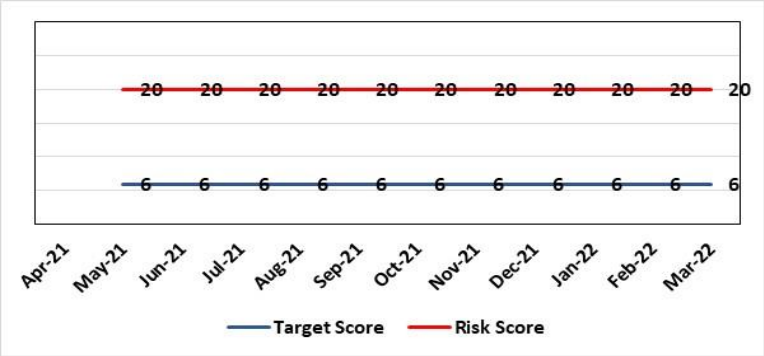
15.03.22 -new linac replacement work remains on track to be clinically operational end of June 22
Still waiting on update from Hywel Dda around supporting prostate Hypo fractionation case. Visit planned by Hywel Dda planning execs 23.03.22
Action Complete - Explore the possibility of undertaking SABR treatment for lung cancer patients at SWWCC.

Datix ID Number: 1418 **Health & Care Standard: 5.1 Timely Access**		**HBR Ref Number: 69** **Target Date: 31st March 2022**	**Current Risk Rating** **5 X 4 = 20**
Objective: Best values outcomes from high quality care		**Director Lead**: Inese Robotham, Chief Operating Officer / Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality & Safety Committee	
Risk: Risk issues related to **adolescent patients being admitted to Adult MH inpatient wards**- Inappropriate settings resulting in 'Safeguarding Issues' The WG has requested that HBs identify Secondary Care in -patient facilities for the care of adolescents- in Swansea Bay University Health Board Ward F NPT hospital is the dedicated receiving facility with one bed identified.		**Date last reviewed:** March 2022	
Risk Rating (consequence x likelihood): Initial: 2 x 3 = 6 Current:5 x 4 = 20 Target: 2 x 3 = 6		**Rationale for current score:** Every health board is required to have an admission facility for adolescent MH patients. Whilst ward F has been identified as the single point of access in SBU and a dedicated bed is ring-fenced for adolescent admissions it is a mixed sex adult ward. Therefore the facilities are less than ideal for young patients in crisis.	
Level of Control =			
Date added to the HB risk register 27/02/2020		**Rationale for target score:**	

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

Additional Comments

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

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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Diary is maintained for booking of IOL with agreed numbers of IOL per day. Daily obstetric consultant ward round to review all women undergoing IOL. Ongoing/regular monitoring by cardiotocograph for fetal wellbeing. Labour ward coordinator and labour ward obstetric lead ensure women on ward 19 for IOL are factored into daily planning of workload on labour ward. If IOL's/ Augmentation of labour are put on hold/delayed the women are reviewed by the MDT to assess for any potential risk to mother or baby. The MDT (Obstetric, Neonatal and Midwifery) discuss and consider the impact of delay for each woman. Escalation to the appropriate senior staff takes place and the Escalation Policy is implemented. Daily acuity is gathered and sent to the senior midwifery management team who can anticipate potential problems and support the clinical team. The matron of the unit is contacted in office hours and the senior midwife manager on call is contacted out of hours. The senior midwife will review staffing across all areas and deploy staff if possible including the specialist midwives and the community midwifery on call team. Neighbouring maternity units are contacted to ask if they are able to support by accepting the transfer of women.	Ongoing review of risk	Head of Midwifery	30/03/2022
Assurances (How do we know if the things we are doing are having an impact?) Review of midwifery staffing on ward 19 (antenatal ward), during recent birthrate plus assessment. This will ensure women receive effective midwifery support and reassurance of fetal wellbeing.	**Gaps in assurance (What additional assurances should we seek?)**		

Additional Comments

28.10.21 Update - This was reviewed on 27.10.21 with NT & CW. If any delays for transfer to LW this is incident reported and reviewed. 19.11.21 Critical midwifery staffing levels have had a severe impact on the ability of the team to transfer women to labour ward in a timely manner. See Critical Staffing Risk (ID 2788) for mitigation. 14.01.22 No change.
08.03.22 - To continue to monitor all IOL delays to identify any harm caused. Recruitment of Band 6 midwives underway. Introducing NICE guidelines for IOL (being managed by AN Forum). Working with NN to ensure capacity issues for maternity & NN services are managed appropriately.

Datix ID Number: 2521 (& COV_Strategic_017) **Health & Care Standard: 2.4 Infection Prevention and Control (IPC) and Decontamination**		**HBR Ref Number: 78** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Richard Evans, Executive Medical Director **Assuring Committee:** Quality & Safety Committee	
Risk: Nosocomial transmission Nosocomial transmission in hospitals could cause patient harm; increase staff absence and create wider system pressures (and potential for further harm) due to measures that will be required to control outbreaks.		**Date last reviewed:** March 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 5 = 20 Target: 3 x 4 = 12		**Rationale for current score:** Outbreak remains in Morriston Service Group and evidence has shown that sustainability of IPC processes are challenging. EMD and Director of Public Health considers this should be increased again to 16 – reflecting less effective track-and-trace measures and indications that testing is not as effective on staff who have been fully vaccinated.	
Level of Control = 40%		**Rationale for target score:** Measures in place will require regular review and scrutiny to ensure compliance. Levels of community incidence or transmission may change and the HB will need to respond. Vaccination programme on going but not complete.	
Date added to the HB risk register May 2021			

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

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

Additional Comments

Update 16.03.2022 – Advise retain score of 20 given planned communication to families regarding learning from nosocomial COVID - EMD.

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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Clinically optimised numbers are monitored and reviewed weekly by the MDU. Delays are reported and escalated to try to ensure timely progress along a patient's pathway. • Review on a patient by patient basis – with explicit action agreed in order to progress transfer to appropriate clinical setting. • Critical constricts in relation to access/time delays for social workers and assessment for package of care and social placement – lead times in excess of 5 weeks. • Patient COVID-19 status has added an additional level of complexity to decision making. • The health board has procured 63 additional care home beds to provide additional discharge capacity.	**Action**	**Lead**	**Deadline**
	Undertake another procurement round with the aim of increasing additional care home beds to 100.	Service Group Director (PCT)	31/03/2022

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

Additional Comments

Update 18.03.22 – The health board has procured 63 additional care home beds to provide additional discharge capacity

Phase 1 – Original bids received: 55 (Beds not utilised:31 St. Martin's Court-10; Plas Cwm Carw-12; Peniel Green-4; Hollins-5)

Phase 2 – Original bids received: 4

Phase 3 – Original bids received: 7. Undertake another procurement round with the aim of increasing additional care home beds to 100- Procurement aim to publish another expression of interest to join the framework by end of March

Datix ID Number: 2788 **Health Care Standards: 7.1 Workforce**		**HBR Ref Number: 81** **Target Date: 31/03/2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Best value outcomes		**Director Lead:** Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality & Safety Committee **For Information:** Workforce & OD Committee	
Risk: Critical staffing levels – Midwifery: Unplanned absence resulting from Covid-19 related sickness, shielding and isolation, alongside other current absences, has resulted in critical staffing levels, further reductions in which could result in unsafe service provision, poor patient outcomes and/or experience. In turn, poor service quality or reduction in services could impact on organisational reputation.		**Date last reviewed:** March 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 4 = 16		**Rationale for current score:** Centralisation of community services has broken down continuity of carer which means women will see many midwives through pregnancy. There is evidence that shows the outcome for women is better with lower interventions when continuity of carer is maintained. This is particularly relevant for women with perinatal mental health issues and for safeguarding. Singleton Hospital working with on average 10 /11 midwives w/c 22/08/2021. The lowest staffing number being 8 instead of 13 midwives.	
Level of Control = %		**Rationale for target score:** Target score refreshed. Actions taken and planned for December are anticipated to reduce risk to a target score of 16 by the end December. The decentralization of services in Q4 may assist to reduce the risk further. A new target for additional reduction of the risk will be considered in January.	
Date added to the risk register 12/10/2021			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Home births are suspended. Reduced the on call requirement for community midwives. • All midwives are working at the hours they require up to full time. • A small midwifery bank has been created. • All midwives are offered additional hours. Enhanced overtime promoted, provided and accepted. • Band 6 recruitment in training. • Student midwives on pre-qualifying placement are supporting in the clinical areas within their student capacity. • 11 new midwives have been employed from September- October 2021. 6 started. • Risk assessments are currently taking place with OH and H&S leads support for matrons to return staff to clinical front facing roles where possible • Centralisation of community services to improve staff availability • NPT Birth Centre temporarily suspended - services relocated to The Bay Birth Centre in Singleton Hospital • Updated early warning to WG • Service Group Nurse Director keeping RCM updated • Daily escalation call with the SG Service Director and Nurse Director to do 24 hour lookback on potential harm events, patient and staff experience, and 3 day look forward of staffing • Briefings for families via corporate comms & online	On-boarding new Band 5 recruits (expected all complete by mid November)	Deputy Head of Midwifery	Mid November 2021 (onboarding complete - will require supernumerary period)
	14 Band 5 graduates from 2020 – preceptorship completion plan (2 have completed, 9 due by end of December). All remaining active 2020 graduates to complete preceptorship *(3 of 4 graduates – the exception being on maternity leave)*.	Deputy Head of Midwifery	Majority Complete Remainder March 2022
	Due to review suspension of the Birth Centre and Home Births	Deputy Head of Midwifery	1st February 2022 (next review)
	Midwifery bank & agency SOP has been developed and will be approved this month (already in use).	Deputy Head of Midwifery	20th October 2021 *See Additional Notes*

Assurances **(How do we know if the things we are doing are having an impact?)**	Gaps in assurance **(What additional assurances should we seek?)**
Daily briefings with the senior team are taking place for updated position. Weekly meeting held with staff to update on the situation. No surprise submission to Welsh Government 9/7/2021. CHC informed. Engagement with Clinical Supervisors for midwives for staff support. Engagement with workplace representatives. On call manager for Women and Child Health available 24/7. Datix reports are submitted when appropriate.	

Additional Comments

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

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

19.11.21 Update: Recruitment of band 6 midwives completed. Employment checks underway. Working with 2020 band 5 midwives to support achievement of their preceptor passport for transition to band 6. 2021 graduates in post (1 outstanding). All band 5 midwives on temporary increase to full time hours. Workforce paper in preparation. Consider there are enough vacancies to offer 2020 graduates substantive full time hours. Awaiting sign off with finance. Obstetric unit stabilised. Community midwifery service continue to carry significant shortfalls due to staff unavailability. Centralised community midwifery service continues.

09.01.2022 Update: - 2021 Graduate midwives (Band 5) are all in post and are working full time to support during the current midwifery critical staffing levels related to Covid pandemic. Good feedback from midwives via Clinical Supervisors for Midwives (CSfM) that they have settled into the role and are well supported by the team.

- The preceptorship programmes for the 2020 graduate midwives are completing in line with expectation. 4 midwives continue with Individualised action plans and rotation to the required clinical areas for completion of the programmes. All 2020 graduate midwives will complete the preceptorship programme by March 2022 with one exception (delay due to maternity leave).
- Suspension of homebirth and NPT birth centre are ongoing. The midwifery critical staffing levels continue and are risk rated at 25 The Executive Nurse Director is updated of the position. The next review date for the recommencement of service is the 1st February 2022.
- The Bank and agency SOP is in place and working effectively. Bank and a limited number of agency midwives have been employed as appropriate to maintain safe staffing levels within the Obstetric Unit and Community Services.

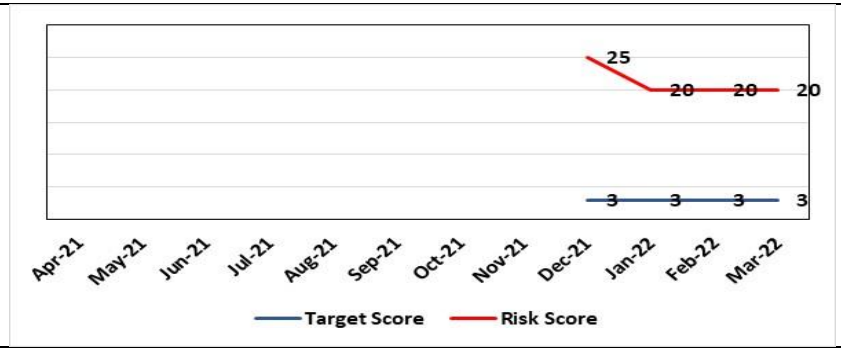
14.01.22: All band 6 midwives due to commence by February 2022. Workforce planning is being progressed. Management trainee allocated to maternity services to support this work.

23.01.22: Daily acuity meeting on 19/01/2022 midwifery unavailability 28.66%

As the unavailability has remained below 30% for previous three days risk rating reduced to 20. Monitoring will continue. Plan in development for re-introduction of midwifery led intrapartum services at 1/2/2022 if unavailability remains below 30%.

08.03.22 - WG request for briefing paper in relation to suspension of services at NPT Birth Centre. Recruitment for Band 6 midwives intrain. Suspended training study days with view of

complete training year in May 2022 (with the exception of PROMPT). Review with bank for block booking agency midwives continue to request bank shifts as required. All staff currently working at the hours they want.

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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• The general ITU consultants to support the Burns service on a temporary basis, supporting the remaining burns anaesthetic colleagues to provide critical care input for burns patients • The agreement reached is that they will cover the current Burns Unit on Tempest ward at Morriston hospital for 6-9 months while capital work is underway on general ITU to enable co-location of the service • The capital works will be in two phases (1) to co-locate in a smaller footprint in GITU, followed by (2) larger-scale capital work to accommodate complete co-location by mid-2023. • WHSSC as commissioners of the service have been kept fully informed, as has the South West (UK) Regional Burns Network • Other UK burns units have ICU co-located with Burns ICU, removing the need for dual certified consultants	Securing the agreement of GITU consultants to cover pending completion of capital work	CEO & EMD	Completed
	Submit bid for capital funding to Welsh Government for both phases of work required	Morriston Service Group	30/04/2022

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Effect on patients of the temporary closure of the burns service in Swansea is mitigated by maintaining an	

urgent assessment/stabilisation service for patients in Wales with severe burns, with onward transfer for inpatient care to another unit in the UK following the initial assessment. The service reopened fully on 14/02/2022.	
Additional Comments Ongoing staff burnout combined with two substantive consultants resigning means there is no foreseeable mechanism to open the burns unit as it previously operated. Have recurrently advertised with no applicants and initial efforts for oversea recruitment not successful. November 2021: Burns service currently closed to P3 patients; P2 patients located in Wales will be assessed before transfer to another unit or downgrade to ward based patient; WG notified via NSA – November 2021. 31.03.22: The service reopened fully on 14/02/2022.	

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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Invited Service Review by Royal College of Surgeons to advise on outcomes, good practice and areas for improvement; • Implementation of local action plan to address areas of concern; widespread engagement among clinicians in the department. • All surgery is now only undertaken by consultants and mitral valve repair surgery is undertaken by two mitral valve specialists; a third consultant undertakes mitral valve replacements as agreed with WHSSC. • Complex heart valve MDT established to make decisions on appropriate surgery including MV repair and MV replacement and to direct to the appropriate consultant. • Internal review of deaths following mitral valve surgery. • High Risk MDT implemented, outcome decision documented on Solus. • Dual surgeon operating mandated for complex cases (determined by the MDT) to improve outcomes. • MDT discussion to be undertaken for all patients who develop deep sternal wound infections. • Quality & Outcomes database established capture case outcome metrics in real time.	Implementation of local improvement plan targeting areas of concern and implementing actions to reduce variation	Executive Medical Director	30/04/2022
	Commission an Invited Review of Service with support from Royal College of Surgeons	Executive Medical Director	31/03/2022

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
• An improvement plan has been developed in conjunction with WHSSC and agreed. Progress is monitored by Gold Command arrangements. • Quality & Outcomes database established capture case outcome metrics..	Assurance sought via RCS Invited Review on outcomes and governance in the department

Additional Comments
The Royal College of Surgeons have confirmed the they will undertake a review of the service in 28 – 30th March 2022. WHSSC have de-escalated the service to Stage 3 following an agreed pathway for aorta-vascular cases.

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