Meeting Date	**28 June 2022**	**Agenda Item**	**5.1**
Report Title	**Risk Management Report – Quality & Safety Risks**		
Report Author	Neil Thomas, Assistant Head of Risk & Assurance		
Report Sponsor	Hazel Lloyd, Interim Director of Corporate Governance		
Presented by	Hazel Lloyd, Interim Director of Corporate Governance		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to inform the Quality & Safety Committee of the risks from the Health Board Risk Register (HBRR) assigned to the Quality & Safety Committee.		
Key Issues	• The Health Board Risk Register for May 2022 was received and endorsed by the Management Board in June 2022. • During April, an additional meeting of the Risk Scrutiny Panel attended by the Executive Medical Director reviewed risks scored 20 and above. Advisory notes were shared with Executive leads following the meeting for consideration during the update process in April. • The May HBRR currently contains 40 risks. Fifteen of these risks are assigned to the Quality & Safety Committee for oversight, 10 of which are at or above the Health Board's current risk appetite score of 20. Five further risks are included in the register extract for information, but overseen by other committees. • The delivery of risk management training workshops for managers in service groups is continuing. They have completed in two service groups (NPTS and PCT); commenced in the remaining two (MH&LD and Morriston). • At the final meeting of the Covid-19 Gold Command arrangements for the ongoing oversight of the remaining risks on the Covid-19 Gold risk log were agreed. Proposals for the ownership and management of risk information in the Datix risk register have been circulated. • There is a national programme to migrate concerns management from the legacy DatixWeb system to a new Once4Wales system – Datix Cymru. Modules for managing incidents, complaints, patient experience feedback and claims are now live. However, there is a need to close down records remaining open within the legacy system by the end of August 2022 (when the legacy system becomes read-only) or transfer them into the new system. A risk-based approach to this task has been agreed at Management Board in June.		

Specific Action Required *(please choose one only)*	Information	Discussion	Assurance	Approval
	☐	☐	☒	☐
Recommendations	Members are asked to: • **NOTE** the updates to the Health Board Risk Register (HBRR) relating to risks assigned to the Quality & Safety Committee. • **NOTE** the decisions taken to support the closure of incident, complaint and feedback modules within the legacy DatixWeb system. • **DISCUSS** the risks assigned to the Quality & Safety Committee and endorse the mitigating action being taken to manage the risks.			

RISK MANAGEMENT REPORT – QUALITY & SAFETY RISKS

1. INTRODUCTION

The purpose of this report is to inform the Quality & Safety Committee of the risks from the Health Board Risk Register (HBRR) assigned to the Quality & Safety Committee for scrutiny.

2. BACKGROUND

2.1 Risk Management Framework

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

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

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

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

2.2 Risk Appetite

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

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

Following the onset of the Covid-19 pandemic, members of the Board agreed that the risk appetite score would increase to 20 and above for an initial period of 3 months. The risk appetite level of 20 and above has remained in place since the start of the

pandemic. These arrangements are reviewed regularly by the Executive Team, Audit Committee and the Board. In accordance with Board wishes, a more nuanced approach to the expression of risk appetite is being developed.

2.3 Health Board Risk Register (HBRR)

The Health Board Risk Register (HBRR) is intended to summarise the greatest organisational risks facing the Health Board and the actions being taken to mitigate them.

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

2.4 Covid-19 Risk Register

In recognition that Covid-19 is an issue which the Health Board is managing, a separate risk register was established to capture the key risks associated with managing the response to the Pandemic. The final meeting of the Covid-19 Gold Command took place in April 2022. At that meeting, arrangements for the ongoing oversight of the remaining risks on the Covid-19 Gold risk log were identified. Proposals for the capture and management of risk information in Datix have been circulated and will be reviewed by Risk Scrutiny Panel.

3. MANAGEMENT OF QUALITY & SAFETY RISKS

3.1 Action to Update the HBRR

Health Board risk register entries were circulated to lead Executive Directors during May for review and update where required.

Comments received from Directors and their senior management leads have been reflected within the extract of the revised May 2022 HBRR attached at **Appendix 1**. Key recent changes are highlighted in red font.

3.2 HBRR Quality & Safety Risks

The HBRR currently contains 40 risks. Fifteen of these are assigned to the Quality & Safety Committee for oversight, 10 of which are at or above the Health Board's current risk appetite score of 20. Five further risks are included in the register extract for information, but overseen by other committees.

Table 1 below highlights where there have been key changes of note (as captured at the cut off point for the March HBRR) since the last meeting of the Committee. Where there are changes in risk status or score these are highlighted in bold:

Table 1 – HBRR Risks Assigned to the Quality & Safety Committee

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
4 (739)	**Infection Control** This risk description has been refreshed: Failure to achieve Welsh Government infection reduction goals, and a higher incidence of Tier 1 infections than average for NHS Wales. Risk of nosocomial transmission of infection.	20	Executive Director of Nursing	The risk score remains unchanged currently. Update: The Infection Prevention & Control Improvement Plan approved in principle by Management Board in March 2022 was amended to incorporate discussions from members at the meeting. The amended version was resubmitted to the Management Board in April 2022. Each Service Group will develop their action plans to support the Health Board's infection improvement goals.
43 (1514)	**Deprivation of Liberty Safeguards (DoLS)** Due to a lack of Best Interest Assessor resource, there is a risk of failure to complete and authorise the assessments associated with Deprivation of Liberty/Liberty Protection Safeguards within the legally required timescales, exposing the health board to potential legal challenge and reputational damage.	16	Executive Director of Nursing	The risk score remains unchanged currently. Update: Experienced Best Interest Assessors sourced externally continue to complete 5-7 assessments per week. The backlog was 55 assessments at the end of May.
58 (146)	**Ophthalmology - Excellent Patient Outcomes** Risk of failure to provide adequate clinic capacity for follow-up patients in Ophthalmology results in a delay in treatment and potential risk of sight loss.	20	Chief Operating Officer	The risk level is subject to review currently following progress made in the department to reduce the number of delayed followed appointments.
61 (1587)	**Paediatric Dental GA Service – Parkway** Identify alternative arrangements to Parkway Clinic for the	16	Chief Operating Officer	This risk score remains unchanged currently. Update: Current position reviewed at Senior

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
	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.			Management Board April 2022. Extension agreed until 31st May 2023 due to current theatre challenges. Repatriation remains a priority and it is to be included in theatre planning. Deputy Chief Operating Officer to re-establish a task & finish group.
63 (1605)	**Screening for Fetal Growth Assessment in line with Gap-Grow** There is not enough Ultrasound capacity within Swansea Bay UHB to offer all women serial ultrasound scan screening in the third trimester in line with the UK perinatal Institute Growth Assessment Programme (GAP). Welsh Government mandate fetal growth screening in line with the GAP programme. There is significant evidence of the increased risk for stillbirth or neonatal mortality/morbidity (hypoxic ischaemic encephalopathy (HIE)), where a fetus is growth restricted (IUGR) and/or small for gestational age fetus (SGA). Identification and appropriate management for IUGR/SGA in pregnancy will lead to improved outcomes for babies.	16 (was 20)	Executive Director of Nursing	Risk re-articulated and register entries refreshed. The risk score has reduced from 20 to 16. Update: Due to the trained midwife sonographer role there is improved capacity for ultrasound scan (USS) referral within requisite timeframes with reduced incidents for non-completion of USS. A joint radiology/maternity operational governance group has been convened which will report into the health board radiology governance group and maternity Q&S group. USS scan schedules have returned to pre-Covid pandemic schedules in line with local policy. A business case is to be prepared for service in NPT on completion of current trainee midwife sonographers programme (December 2022). This will ensure equity of service across the health board and ensure women receive care close to their home.
65 (329)	**CTG Monitoring on Labour Wards** Misinterpretation of cardiotocograph and failure to take appropriate action is a	20	Executive Director of Nursing	This risk has been re-articulated and register entries refreshed. The score remains unchanged currently.

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
	leading cause for poor outcomes in obstetric care leading to high value claims. The requirement to retain maternity records and CTG traces for 25 years leads to the fading/degradation of the paper trace and in some instances traces have been lost from records which makes defence of claims difficult.			The K2 central monitoring system has been purchased by the health board however is not yet installed. A project team is being established to ensure oversight of installation and training. Full use of the system will be available from December 2022 when it is anticipated the risk will reduce as appropriate. Update: Project group have held first meeting. Development of sub groups to follow – training of sub groups essential to ensure all staff are able to transition to new way of working. This has been highlighted as a key action.
66 (1834)	**Access to Cancer Services** Delays in access to SACT (Systemic Anti-Cancer Therapy) treatment in Chemotherapy Day Unit	20	Executive Medical Director	This risk score remains unchanged currently. Update: Recruitment to Phase 1 of the service change remains one pharmacy post short – this has been out to advert twice, and re-advertised again. In the meantime, the team have been asked to confirm how much of workload can be moved into home care with current resources in post and whether this shift which was planned to commence in Qtr 2 is now locked down. Phase 2 of the change is under full review as new Deputy Head of Nursing who commenced in post end of April has identified some internal efficiency gains linked to our booking process and our pre-assessment pathway. Both changes are being implemented:

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
				Pre-assessment changes planned for end of May 2022 (May HBRR update position). New booking system implemented to avoid block booking treatment for dates in advance. Each treatment cycle will be booked one at a time to release capacity in the treatment diary.
67 (89)	**Risk target breaches – Radiotherapy** 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.	15	Executive Medical Director	This risk score remains unchanged currently. Update: Decision by partners enables health board to proceed with prostate hypofraction case. Meeting set up with Surgical colleagues across Hywel Dda and SBU to plan the implementation of the revised pathway and for workforce to be appointed to. Plan to have first patient hypo-fractionated by Sept 2022.
69 (1418)	**Safeguarding** Adolescents being admitted to adult MH wards resulting in potential safeguarding issues	20	Chief Operating Officer / Executive Director of Nursing	This risk score remains unchanged currently. Update: The Nurse Director, Director of Strategy and Service Director have met with WHSCC colleagues to review recent admissions and identify lessons learned to include review and publication of admission criteria for Tier 4 CAMHS Unit.
74 (2595)	**Delay in Induction of Labour (IOL)** Delays in IOL can introduce avoidable risk and unnecessary intervention which can lead to poor clinical outcome for mother and/or baby. Delays in IOL lead to increased complaints and	20	Executive Director of Nursing	This risk has been re-articulated and register entries refreshed. The score remains unchanged currently. Update: Recruitment drive for Band 6 midwives commenced reported in March was unsuccessful. Post was re-

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
	decreased patient satisfaction.			advertised and interviews pending. Eleven graduate midwives have accepted the offer of a preceptorship programme in SBU. A midwifery workforce paper is being prepared to present recommendation for future staffing levels in the obstetric unit to ensure adequate staffing each shift. A Birthrate+ Cymru assessment will be completed for future workforce needs.
78 (2521)	**Nosocomial Transmission** Nosocomial transmission in hospitals could cause patient harm; increase staff absence and create wider system pressures (and potential for further harm) due to measures that will be required to control outbreaks	20	Executive Medical Director	The risk score remains unchanged currently, pending communication to families regarding learning from Covid-19. Update: Following dissolution of Gold and Silver COVID command structures, the function of monitoring nosocomial spread and implementing preventative actions will be taken on by the Infection Prevention & Control Committee.
80 (1832)	**Discharge of Clinically Optimised Patients** If the health board is unable to discharge clinically optimised patients there is a risk of harm to those patients as they will decompensate, and to those patients waiting for admission.	20	Chief Operating Officer	This risk score remains unchanged currently. Update: The Board has approved the extension of the transitional bed scheme to November 2022. The health board will engage with Welsh Government in the social care taskforce to look for alternative ways to provide out of hospital care.
81 (2788)	**Critical staffing levels – Midwifery:** Midwifery absence rates are outside of 26.9% uplift leading to difficulty in	20	Executive Director of Nursing	This risk has been re-articulated and the register entries refreshed. The score remains unchanged currently.

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
	maintaining midwifery rotas in the hospital and community setting.			Update: National Midwifery Workforce summit being held 30th May 2022 led by CMO due to national midwifery staffing position and models of care. Staff unavailability in SBU remains over 30%. Recruitment undertaken and 3.2 whole time equivalent (WTE) staff appointed. Further appointment to infant feeding coordinator role will release seconded midwife back to service. Recent recruitment round unsuccessful. Band 5 graduate midwives remain on uplift hours up to full time. Staff escalation meeting now three times weekly. The Birth Centre in Neath Port Talbot is suspended with a view to reopen in the autumn following the employment of our graduate midwives.
84 (2561)	**Cardiac Surgery – A Getting It Right First Time (GIRFT)** The GIRFT 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.	16	Executive Medical Director	This risk score remains unchanged currently. Update: The Royal College of Surgeons undertook a review of the service in March 2022. Interim letter received with positive feedback. A formal report is anticipated in 6-8 weeks' time, following which consideration will be given to the level of risk remaining.

Risk Reference	Description of risk identified (Summary)	Current Score	Exec Lead	Key Update
85	**Non-Compliance with ALNET (Additional Learning Needs & Education Tribunal) Act** There are risks to the Health Board's ability to meet its statutory duties and establish the effective collaborative arrangements required by the ALNET Act, which is being implemented through a phased approach.	20 New	Director of Therapies & Health Sciences	This risk is a new addition to the health board risk register. Current actions being taken: Under the governance of the ALN Steering Group, an ALN Operational Group will be formed. Its first task will be development of an ALN work plan for 2022/23. Work with Local Authority partners is to be progressed to establish a prudent, longer-term operational model through which statutory referrals / requests to the Health Board will be made. Management to develop, based on updated Welsh Government implementation guidance and current data, the additional staffing resource required to meet the requirements of the ALN Act for the next period and develop an initial business case.

The Committee is requested to ensure that its agenda provides for the scrutiny and challenge of actions being taken to address the risks, and supports the reporting of assurance to the Board accordingly.

3.3 Risks Assigned to Other Committees

There are five risks which are assigned to other Committees in terms of overseeing actions to mitigate the risks, as outlined in table 2 below, noted here for information. As noted earlier, the detailed HBRR entries are also included in Appendix 1 for information. In view of the consequence to patients if the risks materialise, the Committees have requested that the Quality & Safety Committee be made aware of these risks as well.

Table 2 - Risks Assigned to Other Committees with Referral to Q&S Committee for Information

Ref	Description of Risk Identified (Summarised)	Exec Lead	Committee	Current Score
1 (738)	**Access to Unscheduled Care Service** If we fail to provide timely access to Unscheduled Care then this will have an impact on quality & safety of patient care as well as patient and family experience and achievement of targets. There are	Chief Operating Officer	P&F Committee	25

Ref	Description of Risk Identified (Summarised)	Exec Lead	Committee	Current Score
	challenges with capacity/staffing across the Health and Social care sectors.[1]			
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.	Chief Operating Officer	P&F Committee	20
48 (1563)	**CAMHS** Failure to sustain Child and Adolescent Mental Health Services (CAHMS).	Director of Strategy	P&F Committee	16
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.	Chief Operating Officer	P&F Committee	25
82 (2554)	**Risk of Closure of Burns Service** ***(Risk score reduced)*** There is a risk that adequate Burns Consultant Anaesthetist cover will not be sustained, potentially resulting in closure to this regional service and the associated reputational damage.	Executive Medical Director	P&F Committee	16

3.4 Operational Quality & Safety Risks

Each Service Group and Directorate hold their own risk registers, which outline the operational risks facing each Service Group/directorate.

Operational risks relating to quality and safety that may need to be escalated for inclusion on the HBRR are brought to the attention of the Risk Management Group and/or Risk Scrutiny Panel for review and where appropriate added to, or linked to existing risks in, the Health Board Risk Register.

3.5 Covid-19 Risk Register – Transfer of Risks

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

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

Gold Ref	Risk Title & Description	Risk Score	Executive Owner (in Gold log)	Gold Command Agreed Oversight to Transfer to:
COV 004	**Covid related sick absence** Number of staff who are absent from work through self-isolation or family illness will impact on ability to deliver safe care for patients; and will	15	Director of Workforce	Workforce & OD Committee Monitored via Workforce Directorate and reported to

[1] Risk has been re-articulated by the Chief Operating Officer.

Gold Ref	Risk Title & Description	Risk Score	Executive Owner (in Gold log)	Gold Command Agreed Oversight to Transfer to:
	impact on ability to keep capacity open and to staff surge and super surge capacity. Note: This risk only captures the total of staff absence as reported weekly to Welsh Government. Risk score reflects the position in comparison with wave one position which peaked at 1700 staff absent.			W&OD Committee as appropriate.
COV 005	**Care Homes** Potential failure in local care home sector to manage staff absences could result in emergency closure of care home which will place undue pressure and therefore on community health and social services to support and/or lead to an increase in patient admission to hospital. Risk of patient harm if care homes are not adequately covered.	16	Director of Nursing	Transformation Board The Chief Operating Officer will oversee this following transfer.
COV 009a	**Workforce Shortages** Measures the risk to service provision, deployment plans and health board strategic workforce related developments ie surge capacity, field hospital / immunisation programme in the context of the number of available staff. Factors impacting cover Covid and general sick absence, deployment restrictions relating to staff Covid risk assessment, general turnover, and outbreaks. Key risk areas where specific workforce shortages impact is the greatest (eg ITU, A&E, Covid wards) are reflected in the overall score.	15	Director of Workforce	Workforce & OD Committee Monitored via Workforce Directorate and reported to W&OD Committee as appropriate.
COV 009b	**Workforce Recruitment** Despite efforts to recruit staff into substantive, agency, bank and other roles the health board fails to meet the expanding requirement to replace staff where Covid related, or increase staff resource as a consequence of new staff resource needs. The workforce staff recruitment/supply risk has been assessed not just against the existing health board plans which had already highlighted the difficulties with staffing super surge. The risk score reflects the risks with meeting every and all existing confirmed requirements. The risk includes the internal risk given the pressures on relatively small	12	Director of Workforce	Workforce & OD Committee Monitored via Workforce Directorate and reported to W&OD Committee as appropriate.

Gold Ref	Risk Title & Description	Risk Score	Executive Owner (in Gold log)	Gold Command Agreed Oversight to Transfer to:
	departments who need to support recruitment. There is significant pressure on the pool of non-registered staff in the south west of Wales with health boards and local authorities all recruiting from the same pool. This impacts not only on the availability but quality of candidates.			
COV 015	**Mass Vaccination** The health board has operationalised its Mass Vaccination Programme in line with the strategic plan submitted to Welsh Government in 2020. Risks that are being managed in the programme are: - delivery of booster vaccine supply to enable the Board to meet the milestones set out in the National Vaccination Strategy for the first phase of the programme from September 2021 - Delivery of a safe and effective programme that is being rolled out at pace and with significant and ensuring effective and timely communication to the public and key stakeholders - changes to guidance that necessitate frequent adaption of delivery models in line with JCVI and/or Welsh Government policy decisions.	12	Director of Public Health	Immunisation Silver Group
COV 017	**Nosocomial Transmission** Nosocomial transmission in hospitals due to the unavailability of single rooms and the inadequacy of ventilation systems (natural & mechanical) could cause patient harm, increase staff absence, and create wider system pressures (and potential for further harm) due to measures that will be required to control outbreaks.	20	Executive Medical Director	Infection Prevention & Control Committee Nosocomial deaths review will continue, but the Nosocomial group will stand down and this risk will be transferred for IPCC oversight. Additionally, it was agreed clinical oversight at Executive level will continue and small group meetings may be convened if issues arise. NB This risk scoring 20 has previously been escalated and is already captured within the HBRR.
COV 019a	**Opening of Field Hospital (revised model - December 2020)** Risk of patient harm if the field	16	Director of Finance	Field Hospital Decommissioning Group

Gold Ref	Risk Title & Description	Risk Score	Executive Owner (in Gold log)	Gold Command Agreed Oversight to Transfer to:
	hospital is opened without adequate assurance that the clinical and workforce models are robust and that appropriate policies and procedures are in place.			The management of the Field Hospital will transfer to the Field Hospital Establishment Group, but there will be a name change to the "Decommissioning Group" and it will report to Management Board. All actions/risks related to the Field Hospital will be owned in the new Governance stream. Since the Gold meeting, the Director of Finance has approved closure of this risk following formally agreement at Board to close the field hospital.
COV 024	**Fragility of External Domiciliary Care Market** Significant reduced staffing levels in domiciliary care agencies due to staff exiting the care home sector for employment in alternative business such as hospitality and retail has resulted in a number of providers being unable to fulfil contracts with attendant handbacks of packages of care. This high level of additional demand has impacted flow from hospital, from bedded reablement and out of domiciliary reablement services where there is any recourse to long term care resulting in delays across all of the discharge pathways and many of the admission avoidance support routes for those in crisis in the community.	25	Community Silver (now stood down also)	Transformation Board The Chief Operating Officer will oversee this following transfer.

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

3.6 Migration from DatixWeb to Datix Cymru – Concerns Management Modules

The health board uses modules within the Datix Web system for the management of concerns. During 2021/22, the national Once4Wales Concerns Management System Programme has been managing the transition of all NHS Wales Organisations from

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

The number of open records remaining in legacy modules requiring management action to close or transfer is significant and discussion with Datix user leads in services indicated concern in respect of the ability to close down all remaining cases fully. Additionally, the re-entry of large volumes of records would potentially require a significant amount of staff time. Following discussion with services at the former Quality & Safety Governance Group, it was agreed to explore a risk-based approach to the review & closure of records. A paper was prepared and shared with Datix user leads, Service Group Directors and Executive Quality & Safety leads. A final paper was considered by the Management Board on Wednesday 15th June. The paper is presented at **Appendix 2**.

The paper presented the position in respect of open records within the legacy DatixWeb system modules relating to incidents primarily, but also complaints and compliments, for which management responsibility sits within service groups in addition to corporate teams:

Record Type (high level)	Date figure reported	Number of records open
Incidents	15/04/2022	4733
Complaints	05/04/2022	278
Feedback & Compliments	20/04/2022	5793

The paper presented a risk-based approach to closing open records that recognised the numbers of records open, the potential workload pressures within services to close all with the timescale, and balanced the minimisation of records requiring transfer to the new system (a manual process) with the demonstration of quality in the process of investigation and learning of lessons. In summary the Management Board agreed the following:

INCIDENTS MODULE
Close without further investigation: • Incidents referred to other organisations (their responsibility to investigate) • No harm incidents • Near misses • Low harm incidents • Pressure damage incidents, where damage is reported as developing prior to admission with no prior healthcare involvement.
Require full investigation in order to close: • Redress incidents • Incidents reported to the health board by GPs via a local 'short form' • Incidents categorized 'blank' by Type

• All Obstetric, Gynaecology & Neonatal incidents • Moderate & higher harm incidents (and those not categorized)
COMPLAINTS MODULE
Close in DatixWeb and export detail for management outside of the system (eg using spreadsheets) as Datix Cymru does not support yet: • GMC & NMC Referrals • Professional Concerns & Safeguarding
Require full investigation to closure, or transfer into the new system of: • Court of Protection cases (Patient Experience team to transfer to new system) • Formal Putting Things Right, Out of Time Complaints, Redress & Re-opened Complaints
COMPLIMENTS MODULE
Batch-close the following corporately: • All records other than "Concerns" • All Concerns relating to 2020 or earlier
Services to review & close: • Records classed as Concerns and recorded in 2021.

In addition, it was agreed that documentation embedded in the legacy system relating to records requiring transfer into the new Datix Cymru system, would not require transfer, provided an appropriate audit trail can be made available to allow users to access them in the legacy system.

Following discussion, it was agreed to proceed with the above and it was agreed that the Quality & Safety Committee be apprised of the approach being taken. Full details of the considerations and modelling undertaken to support the decisions are provided in the paper at **Appendix 2**.

4. GOVERNANCE AND RISK

4.1 Risk Appetite & Tolerance Levels

As noted earlier, members of the Board agreed that the risk appetite, whilst dealing with Covid-19, would increase to 20 and above for an initial period of 3 months. These arrangements have been reviewed regularly by the Executive Team, Audit Committee and the Board, but the appetite has not changed since and remains at 20 currently. Further consideration is being given to adopting a revised, more nuanced approach to appetite.

5. FINANCIAL IMPLICATIONS

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

6. RECOMMENDATION

Members are asked to:

- **NOTE** the updates to the Health Board Risk Register (HBRR) relating to risks assigned to the Quality & Safety Committee.

- **NOTE** the decisions taken to support the closure of incident, complaint and feedback modules within the legacy DatixWeb system.

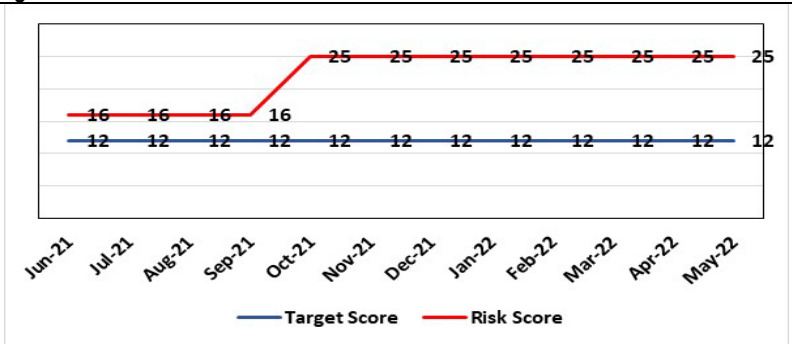
- **DISCUSS** the risks assigned to the Quality & Safety Committee and endorse the mitigating action being taken to manage the risks.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
Quality, Safety and Patient Experience		
Ensuring the organisation has robust risk management arrangements in place that ensure organisational risks are captured, assessed and mitigating actions are taken, is a key requisite to ensuring the quality, safety & experience of patients receiving care and staff working in the UHB.		
Financial Implications		
The risks outlined within this report have resource implications which are being addressed by the respective Executive Director leads and taken into consideration as part of the Board's IMTP processes.		
Legal Implications (including equality and diversity assessment)		
It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks faced by the organisation, as failure to do so could have legal implications for the UHB.		
Staffing Implications		
All staff have a responsibility for promoting risk management, adhering to SBUHB policies and have a personal responsibility for patients' safety as well as their own and colleague's health and safety. Executive Directors/Unit Directors are requested to review their existing operational risks on Datix Risk Module to ensure SBUHB has an accurate and up to date risk profile.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
The HBRR and the Covid 19 risk register sets out the framework for how SBUHB will make an assessment of existing and future emerging risks, and how it will plan to manage and prepare for those risks.		
Report History	• This report provides an update on the risk profile reported to QSC in April 2022.	
Appendices	• Appendix 1 – Health Board Risk Register (HBRR) Risks Assigned to the Quality & Safety Committee • Appendix 2 – Closure of DatixWeb Modules	

HEALTH BOARD RISK REGISTER
May 2022

RISKS ASSIGNED TO THE QUALITY & SAFETY COMMITTEE

Risk Schedules

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

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

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

Additional Comments / Progress Notes

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

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

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

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

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

Additional Comments / Progress Notes

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

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

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

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

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

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

Additional Comments / Progress Notes

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

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

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

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

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

Additional Comments / Progress Notes

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

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

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

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

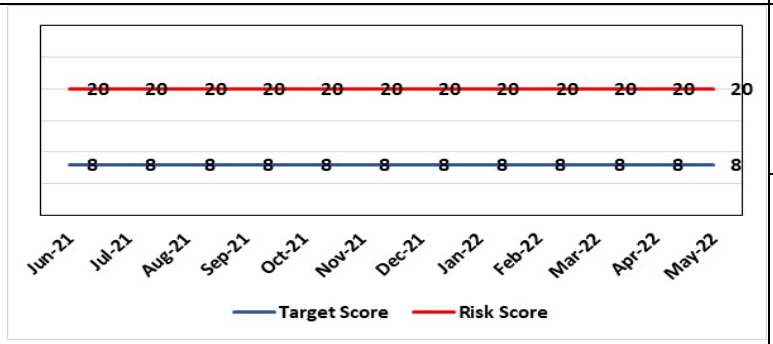
Additional Comments / Progress Notes

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

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

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

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

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

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

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

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

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

Additional Comments / Progress Notes

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

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

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

Assurances (How do we know if the things we are doing are having an impact?) The third trimester ultrasound capacity will increase by a minimum 2200 scans per annum in year one increasing to 4400 in year 2. The detection rate of IUGR/SGA will increase leading to improved	**Gaps in assurance (What additional assurances should we seek?)** Assurance of maintaining a sustainable third trimester ultrasound service.

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

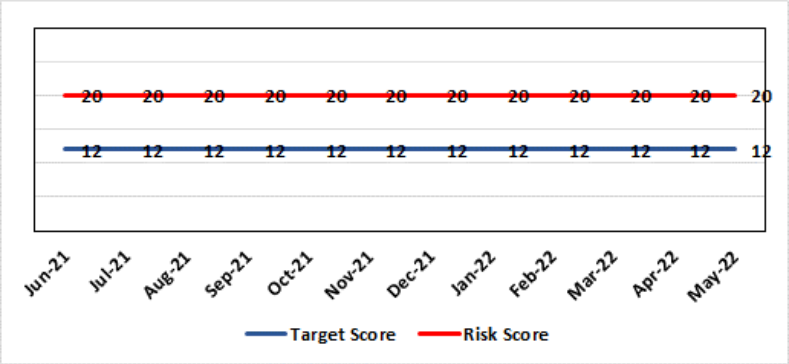
Additional Comments / Progress Notes

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

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

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

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

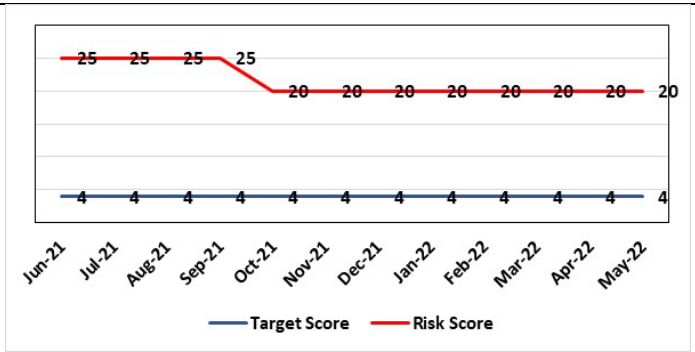
Datix ID Number: 329 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 65** **Target Date: 31st October 2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Digitally enabled Care		**Director Lead**: Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality & Safety Committee	
Risk: Misinterpretation of cardiotocograph and failure to take appropriate action is a leading cause for poor outcomes in obstetric care leading to high value claims. The requirement to retain maternity records and CTG traces for 25 years leads to the fading/degradation of the paper trace and in some instances traces have been lost from records which makes defence of claims difficult.		**Date last reviewed:** May 2022 **Rationale for current score:** The K2 central monitoring system has been purchased by the health board however is not yet installed. A project team is being established to ensure oversight of installation and training. Full use of the system will be available from December 2022 when the risk will reduce as appropriate.	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 5 = 20 Target: 4 x 2 = 8		**Rationale for target score:** A central monitoring station will enable senior clinicians to support decision making across the service, and from home, leading to senior involvement in management decisions toward improved outcomes. All CTG traces will be stored electronically and therefore will not fade and cannot be lost.	
Level of Control = 50%			
Date added to the HB risk register 31st December 2011			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
All staff receive annual training in fetal surveillance as mandated by Welsh Government. SBU have appointed a midwife and obstetric lead for training and development of staff Compliance with training is reported annually in 2021/2022 the training year has been extended due to the service ability to release staff for training A "fresh eyes" protocol in place requiring intrapartum CTG classification hourly by two clinicians which is monitored via audit of records A "jump call" policy is available to request additional support where there is disagreement over CTG classification CTG prompt labels in use to support staff with CTG categorisation.	Fetal surveillance leads to set up training team for transition to use of electronic labour record. TNA analysis to be completed for all staff	Fetal surveillance leads	31/12/2022
	For the project Board to complete a risk assessment to manage the changeover from paper based to electronic monitoring to ensure all risks are captured	Project Board	31/07/2022

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
All Wales Fetal Surveillance Standards for 6hrs Fetal Surveillance Training per year	Assurance all staff are able to transition to a new way of working

Additional Comments / Progress Notes

27/05/2022 - Project board has held first meeting. Projected installation date December 2022- January 2023. SIGNAL installation to coincide in January 2023.
7/06/2022 – Project group have held first meeting, development of sub groups. Training sub group essential to ensure all staff are able to transition to new way of working. Highlighted as a key action.

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

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

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

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

Additional Comments / Progress Notes

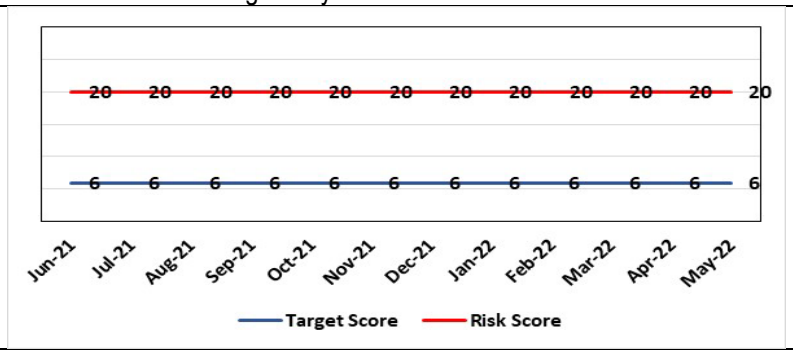
15.03.22 We now appointed a dedicated SACT QI practitioner to work with team. The post holder will be responsible for establishing efficient, effective and equitable pathways for SACT treatment with a focus on quality improvement to improve patient access for SACT treatments and compliance with performance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

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

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

Additional Comments / Progress Notes

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

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

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

Additional Comments / Progress Notes

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

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

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

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

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

Additional Comments / Progress Notes

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

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

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

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

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

Additional Comments / Progress Notes

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

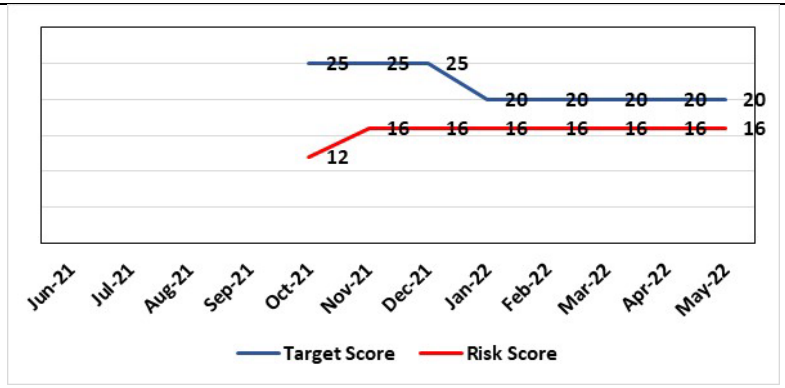
Datix ID Number: 1832 **Health & Care Standard: : 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 80** **Target Date: 31/07/2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Inese Robotham, Chief Operating Officer **Assuring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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• 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**
	We will engage with WG in the social care taskforce to look for alternative ways to provide out of hospital care.	COO/EMD	31/07/22

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

Additional Comments / Progress Notes

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

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

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

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

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

Additional Comments / Progress Notes

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

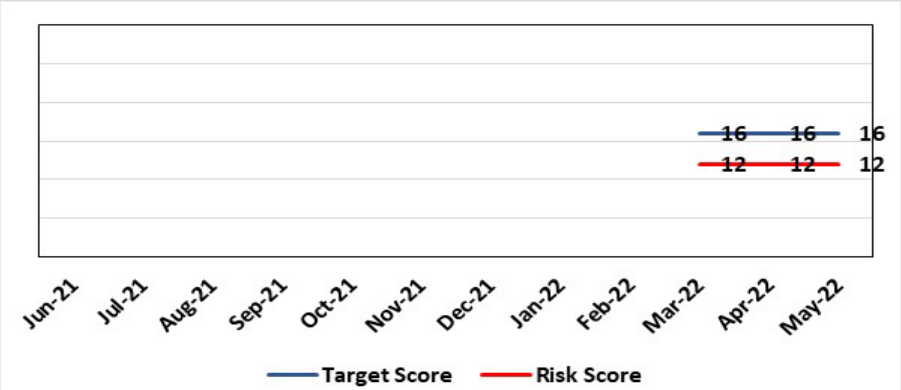
Update 03.05.2022 - staff unavailability remains over 30%. Recruitment undertaken 3.2wte appointed with a further 1.0wte interview to be undertaken w/c 3/05/2022. further appointment to Infant feeding coordinator role will release seconded midwife back to service. Recruitment in progress with regular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

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

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	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	Submit bid for capital funding to Welsh Government for both phases of work required	Morriston Service Group	31st May 2022

Assurances (How do we know if the things we are doing are having an impact?)	**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 / Progress Notes 31.03.22: The service reopened fully on 14/02/2022. Action completed - Securing the agreement of GITU consultants to cover pending completion of capital work. 13/05/22: Scoping document submitted to WG; meeting 17/05/22 to agree timescale for submission of business case. Risk score reviewed – interim arrangements working well; no concerns raised. Propose reduce risk to 16 now and reduce to 12 when funding confirmed by WG.	

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

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

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

Datix ID Number: 2561 New Risk **Health & Care Standard: Effective Care 3.1 Safe & Clinically Effective Care**		**HBR Ref Number: 85** **Target Date: 30th September 2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Best value outcomes		**Director Lead:** Director of Therapies & Health Sciences **Assuring Committee**: Quality & Safety Committee	
Risk: Non-Compliance with ALNET Act There are risks to the Health Board's ability to meet its statutory duties and establish the effective collaborative arrangements required by the ALN Act, which is being implemented through a phased approach. This risk is caused by: • Lack of staff resource needed to carry out the additional work needed to comply with the ALN Act for operational services, especially those in the PCST Service Group, though the size of the gap in terms of staff resource is currently unclear. • Gaps in the structure and processes needed to meet the requirements of the ALN Act leading to slippage against a previous ALN work plan. There is a need to identify and progress the work needed for 2022/23, and without adequate planning capacity, existing staff will not be able to make the progress what is needed. • Issues around multi-agency working which may impact on levels of demand on operational services, and on existing SLAs through which the Health Board delivers some services to partner LAs. • Aspects of the requirements on Health Boards which are currently ambiguous and uncertainty regarding the implementation timetable. Potential consequences of this risk are: parent / carer and young peoples' dissatisfaction leading to complaints, Educational Tribunals and Judicial Reviews (this is new legislation with many points of ambiguity and is highly likely to be legally 'tested'); reputational impact; and children failing to access the multi-agency support that they need with their learning needs, leading to poor outcomes.		**Date last reviewed:** May 2022 **Rationale for current score:** Risk score reflects that while controls are in place, there are multiple areas of risks (relating to compliance with legislation; governance and assurance; workforce and OD; and sustainable services); and high probability (especially given multiple risk areas) of at least one of these areas of risk being realised. Caused by implementation timetable for the ALN Act, slippage against plan and need for strengthened governance (as described in 'Risk' section). **Rationale for target score:** As the ALN Act is new legislation, there remains some ongoing likelihood of risk events during the initial phases of implementation, though with lessened consequences as a result of mitigating actions.	
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 4 x 5 = 20 Target: 2 x 3 = 6			
Level of Control =			
Date added to the HB risk register 14/05/2022			

<table>
<tr><th colspan="2">Controls (What are we currently doing about the risk?)</th><th colspan="3">Mitigating actions (What more should we do?)</th></tr>
<tr><td rowspan="4">Progressing the necessary work within an appropriate structure (see under ‘ACTIONS’) are constrained by financial and/or service delivery pressures.
DECLO (Designated Educational Clinical Lead Officer) is in post - this is a statutory requirement.
Health Board ALN Steering Group has been established, with structure agreed for Operational Group working under the governance of this
Work is being progressed with Local Authority partners to ensure that activity relating to the ALN Act is grounded in a shared vision and principles to support collaborative working.
Initial operational processes relating to statutory processes (through which Local Authorities access Health Board involvement) have been established and are in effect and work is being progressed with partners to refine this approach.
Advice has been received from WG regarding some areas of particular ambiguity relating to Health Board duties under the Act, and dialogue is ongoing to resolve other areas of uncertainty.
Regarding demand / capacity and staffing resource challenges, WG has a phased implementation timetable for the Act which offers short-term, partial mitigation of risks. An update is expected imminently regarding the implementation timetable post-September 2022.
Awareness has been raised at Board level through Development session and an update is being provided to the Quality and Safety Committee.</td><td>Action</td><td>Lead</td><td>Deadline</td></tr>
<tr><td>Under the governance of the ALN Steering Group, an ALN Operational Group will be formed. Its first task will be development of an ALN work plan for 2022/23.</td><td>DECLO</td><td>31/5/2022</td></tr>
<tr><td>Work with LA partners to be progressed to establish a prudent, longer-term operational model through which statutory referrals / requests to the Health Board will be made</td><td>DECLO</td><td>30/5/2022</td></tr>
<tr><td>Development, based on updated WG implementation guidance and current data, of the additional staffing resource required to meet the requirements of the ALN Act for the next period and develop an initial business case.</td><td>DECLO</td><td>31/6/2022</td></tr>
<tr><td colspan="3">Assurances (How do we know if the things we are doing are having an impact?)
There is regular reporting in respect of the ALN Act through the Quality and Safety Committee.
ALN Steering Board has been established, ensuring oversight at a senior level within all impacted operational and corporate areas
DECLO meets regularly with ADOTHS / DoTHS of the 3 health boards of South-West and Mid Wales for update and assurance.</td><td colspan="3">Gaps in assurance (What additional assurances should we seek?
Extent of gap in staffing resource (gap between work required and capacity available) has not been quantified yet. Actions above aim to address this.</td></tr>
<tr><td colspan="5">Additional Comments / Progress Notes</td></tr>
</table>

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

1. INTRODUCTION & PURPOSE

Following go live of the Incident module of Datix Cymru in April 2022 and the earlier Feedback modules in July 2021, there is a need to maximise the close down of all remaining open cases within Datix Web ahead of the date by which the system will become read-only, preventing further input to records in that system. We have been informed that we will have access to the incidents module until August 2022 (last working day available for input would be Friday 29th July).

This paper presents the position in respect of open records within the legacy DatixWeb system modules relating to incidents primarily, but also complaints and compliments, for which management responsibility sits within service groups in addition to corporate teams.

The claims module is not considered in this paper (management of claims sits within the corporate team and arrangements are being made for closure & transfer of records with that team). Risk Registers and Safety Alerts modules are also excluded as these will remain functional pending the next phase of development of the new Datix Cymru system.

2. BACKGROUND

The Datix Web system has been used to record incidents, complaints, compliments, claims, redress and inquests. Following go live of the last of the modules within the Datix Cymru system to capture the above, the Datix Web system will be made read-only by the supplier allowing access to historical data, but with no further input allowed. Steps have been taken by the SBU Datix Team to prevent the input of new incidents.

Staff still have access to incidents that are open and already recorded on the system prior to 1st April 2022, to input investigation details and enable closure. We are informed that this level of access will be available to the health board until 31st July 2022, following which the system will be made read-only.

The Welsh Risk Pool Head of Safety & Learning, and Project Owner for the Once4Wales Concerns Management System, has indicated the following:

"The programme board has already made the decision regarding incidents that there will be no automated migration. Discussion of this will only cause delays and difficulties and I cannot support it.

"In relation to your incidents in SBUHB, you have access to the legacy system until August 2022 and there is a quality issue if large volumes of incidents remain open past this date, even though SBUHB have delayed go-live of Datix Cymru until April for obvious reasons. You really need to focus on getting incidents closed and completed. For the small number that remain open after this date, much like claims and redress, you can manually migrate a manageable number. To plan for anything else would be appearing to suggest poor quality in my view."

An approach is required to maximise the number of open records in Datix Web that are closed by the deadline of 31st July 2022, in order to minimise the numbers requiring manual transfer. Manual transfer of data would:

- Require additional staff time re-entering data already input with associated opportunity (or real) costs.
- Potentially require additional data not previously required in old system as the fields in incident reporting forms in the systems differ (with the associated burden on staff).

- Transferred cases may add complexity to the subsequent monitoring/reporting (the nature of this has not been worked through yet).

Consideration needs to be given to a risk-based approach to closing open records that balances the minimisation of records requiring transfer with the demonstration of quality in the process of investigation and learning of lessons.

3. ASSESSMENT

The following table indicates the numbers of records open in each of the three modules considered here:

TOTAL RECORDS OPEN

Record Type (high level)	Date figure reported	Number of records open
Incidents	15/04/2022	4733
Complaints	05/04/2022	278
Feedback & Compliments	20/04/2022	5793

At the Datix User Group in April 2022, services indicated concern in respect of the resource required to close records within timescales alongside the need to actively manage new incidents and other cases in the new Datix Cymru system as they are input.

An earlier draft of this paper suggested an internal target of the end of June for closure, with July as contingency to close/transfer all cases. This has been revised in this paper to use the full period of DatixWeb full-function availability for closure (up to end of July), and the subsequent read-only period (from August) for transfer of open cases (records can be transferred before this time also). There is no external timescale for the transfer of remaining open cases, but the ability to report effectively on all open cases remaining will require data to be captured within a single system to do it effectively, so a swift transfer will be required.

From 1st May, there are 62 working days (excludes Bank Holidays) in May, June & July for closure of cases.

To maximise closure and minimise transfer of records, consideration should be given to options to close some records outside of normal process where this balances the need to manage the risk of failing to close/transfer all cases by the deadline date, against the risk of closure without following the full process. The following sections provide a breakdown of open cases and possible options to consider:

3.1 INCIDENTS MODULE

3.1.1 OUTCOME OF INVESTIGATION

At the end of incident investigation, three fields should be completed:
- Outcome of Investigation
- Action Taken
- Lessons Learned

The following table indicates the number of open incidents with complete/incomplete *Outcome* fields, and their distribution across services:

Service / Directorate	No Outcome	Outcome Recorded	Grand Total
Corporate Governance	100	3	103
Corporate Medical Director (Including IT,Health Records)	12		12
EMRTS	3		3
Finance	2	6	8
Mental Health and Learning Disabilities Delivery Unit	492	65	557
Morriston Hospital Service Delivery Unit	1745	549	2294
Neath Port Talbot Hospital Service Delivery Unit	192	39	231
Nursing & Patient Experience	22	3	25
Operations (previously Planning)	42	23	65
Primary and Community Services	243	51	294
Princess of Wales Hospital Service Delivery Unit	1		1
Singleton Hospital Service Delivery Unit	948	136	1084
Strategy	2		2
Transformation	2		2
Workforce & Organisational Development	31	14	45
(blank)	5	2	7
Grand Total	**3842**	**891**	**4733**

Of those 891 with *Outcome* recorded:
- Only one has blank fields for *Action Taken* & *Lesson learned* (Morriston #134668 – initial result & severity was 'actual harm' and 'severe')
- Of the 890 with *Action* field complete, 98 have *Outcome* indicating possible learning, but *Learning* field blank.

Service Group feedback indicates that for incidents where there is a requirement within the system to complete an additional investigation tool, that completion of the tool requires the pulling of a hard copy health record. This reason has contributed to the circa 800 incidents with an outcome recorded but which have not been closed. We are informed that there are many incidents that are in limbo like this where the investigation has reached a point but cannot proceed until the form is completed – mainly pressure ulcers and falls but there are lesser issues with medical device and medication incidents. It has been indicated that these outstanding cases align with known peaks in COVID-19 where staff ability to do detailed work was limited and where the health record has now been moved on.

Following this feedback from services, no proposal is suggested for thematic closure of incidents on the basis of outcome field completion alone.

3.1.2 CASES REFERRED TO OTHER ORGANISATIONS

Some incidents are reported within SBU but they relate to events for which it is not the responsibility of the SBU to investigate and act. These are identified to the Datix Team, referred onwards to responsible organisations and then categorized as such within the system. Investigating organisations do not always report back on the outcome of incidents and once referred on the

closure of incidents by other organisations is not a responsibility of SBU. However, some of these incidents remain open in the system.

Row Labels	Cases Referred to Other HB/Trust	Incident	Redress Incident	Reported via the GP form	(blank)	Grand Total
Corporate Governance		86	17			103
Corporate Medical Director (Including IT,Health Records)		11		1		12
EMRTS	3					3
Finance		8				8
Mental Health and Learning Disabilities Delivery Unit	4	547			*	551
Morriston Hospital Service Delivery Unit	48	2226	10	10		2294
Neath Port Talbot Hospital Service Delivery Unit	6	225				231
Nursing & Patient Experience		25				25
Operations (previously Planning)	2	63				65
Primary and Community Services	7	280		7		294
Princess of Wales Hospital Service Delivery Unit		1				1
Singleton Hospital Service Delivery Unit	8	1073	1	2		1084
Strategy		2				2
Transformation		2				2
Workforce & Organisational Development		45				45
(blank)		7				7
Grand Total	**78**	**4601**	**28**	**20**	*****	**4727**

* An additional MH&LD 6 records (making up the 4733 total in earlier table) have no entry in the Type field.

While general support expressed at Datix User Group for closure of incidents referred onwards to other organisations for investigation, comment was made that some clinicians would wish to retain these records (eg Cancer service clinicians cited as examples).

Proposal 1
a) Decide to close all 78 records referred to other organisation without further action within Datix in respect of Outcomes.
b) Noting read only access to DatixWeb will be available, devolve decision to local services in respect of whether additional tracking is required for those open incidents referred onwards and allow for local monitoring of closure outside of the system (eg via spreadsheet or other mechanism – not within Datix).
c) Require full investigation and closure (or transfer) of 54 records:
- Redress incidents (28)
- GP Form incidents (20)
- Blanks (6)

This leaves 4601 Incidents for further analysis and consideration.

3.1.3 HARM ("Incident Result")

Reporters can classify the *Result* of an incident as resulting in harm / no harm and assign an initial *Severity* rating to it. Incidents within Datix Web can be reviewed by Approvers and adjusted where required if the reporter's initial assessment is not correct. All incidents have the potential to provide learning for the future – however, it should be a priority that the health board demonstrates that it learns from those events that are known to have caused harm, particularly where the severity of harm is high, and has taken action to avoid recurrence. The following sections present the data recorded in these fields for consideration.

Caveat: It is understood that within maternity services is it custom and practice to record all incidents as 'no harm' and severity as 'low' until investigated. There are 162 incidents remaining recorded against Gynaecology, Neonatal and Obstetrics.

Proposal 2a
Require review of all 162 remaining incidents relating to Gynaecology, Neonatal and Obstetrics.

This leaves 4439 remaining for further analysis according to Harm categorization as follows:

RESULT (HARM)

Row Labels	Actual harm caused to person or organisation	Near Miss	No harm caused to a person or the organisation	(blank)	Grand Total
Corporate Governance	1	3	82		86
Corporate Medical Director (Including IT,Health Records)	2	3	6		11
Finance	3	2	3		8
Mental Health and Learning Disabilities Delivery Unit	268	27	252		547
Morriston Hospital Service Delivery Unit	858	193	1175		2226
Neath Port Talbot Hospital Service Delivery Unit	76	25	124		225
Nursing & Patient Experience		2	23		25
Operations (previously Planning)	32	5	26		63
Primary and Community Services	74	13	193		280
Princess of Wales Hospital Service Delivery Unit	1				1
Singleton Hospital Service Delivery Unit	352	69	490		911
Strategy	2				2
Transformation			2		2
Workforce & Organisational Development	5	10	30		45
(blank)			2	5	7
Grand Total	**1674**	**352**	**2408**	**5**	**4439**

Where choices other than "Actual Harm" have been chosen for *Result* field, the Datix *Severity of Incident* field records "No Harm (1)" (2760) or is blank (5).

Proposal 2b
Close all 1674 "no harm" incidents, without further investigation, leaving 2031 for further review.

Proposal 2c
Close a further 352 near misses without further investigation, leaving 1679 for further review.

Two further approaches may be considered for focusing investigations further:
- Prioritisation of incident review according to severity
- Prioritisation of incidents review according to age

The figures associated with these are considered separately below and then modelled together.

3.1.4 SEVERITY (Initial) of those for which HARM has been recorded

Of the 1679 remaining open incidents, initial *Severity* field is populated as follows:

SEVERITY

Row Labels	Death Â (5)	Severe (4)	Moderate (3)	Low (2)	(blank)	Grand Total
Corporate Governance				1		1
Corporate Medical Director (Including IT,Health Records)				2		2
Finance			1	2		3
Mental Health and Learning Disabilities Delivery Unit	162	5	16	85		268
Morriston Hospital Service Delivery Unit	39	11	239	569		858
Neath Port Talbot Hospital Service Delivery Unit	12	5	30	28	1	76
Operations (previously Planning)		1	8	23		32
Primary and Community Services	7		14	53		74
Princess of Wales Hospital Service Delivery Unit	1					1
Singleton Hospital Service Delivery Unit	5	17	134	196		352
Strategy			1	1		2
Workforce & Organisational Development		1	1	3		5
(blank)					5	5
Grand Total	**226**	**40**	**444**	**963**	**6**	**1679**

If a *Severity* threshold is set above which investigation is expected, but below which the incident can be closed without further action, this would reduce the volume of incidents requiring investigation, focusing effort on those where more severe harm is known to have occurred in the past. The following table indicates the number of incidents that would require investigation, dependent upon the *Severity* field threshold chosen:

Severity Field Entries	Numbers of incidents requiring investigation
Death + blank	232
Death + blank + Severe	272
Death + blank + Severe + Moderate	716
Death + blank + Severe + Moderate + Low	1679

Annex A lists the definitions of Severity levels.

3.1.5 TIME ELAPSED

If instead of *Severity*, we analyse the 1697 remaining open harm incidents according to the days elapsed since reported, we note the following:

TIME ELAPSED

	Age of incidents report in days (to 31/3/22)				
Row Labels	**90**	**180**	**365**	**Over 365**	**Grand Total**
Corporate Governance	1				1
Corporate Medical Director (Including IT,Health Records)	1			1	2
Finance	2	1			3
Mental Health and Learning Disabilities Delivery Unit	120	39	50	59	268
Morriston Hospital Service Delivery Unit	219	181	274	184	858
Neath Port Talbot Hospital Service Delivery Unit	34	5	11	26	76
Operations (previously Planning)	7	2	13	10	32
Primary and Community Services	38	13	18	5	74
Princess of Wales Hospital Service Delivery Unit				1	1
Singleton Hospital Service Delivery Unit	110	71	130	41	352
Strategy	1	1			2
Workforce & Organisational Development			1	4	5
(blank)	5				5
Grand Total	**538**	**313**	**497**	**331**	**1679**

If a decision is taken to set a time elapsed threshold outside of which investigation of incidents is not required, with a focus on ensuring the more recent incidents are prioritised, then numbers requiring full investigation would be may be reduced as follows:

Days Elapsed (Incident → 31/03/2022)	Numbers of incidents requiring investigation
<=90 days	534
<=180 days	851
<=365 days	1348
All incidents	1679

3.1.6 MODELLING SEVERITY (3.1.4) & TIME ELAPSED (3.1.5) ABOVE TOGETHER

There are 62 working days in May, June & July (excl Bank Holidays). To investigate & close all 1679 harm incidents fully would require rate of just over 27 a day.

The impact of further decisions using *Severity* and *Time* criteria can be modelled as follows (This excludes Gynaecology, Obstetrics, and Neonates incidents):

Severity Options	Cases	Per Day
Death + blank	232	3.7
Death + blank + Severe	272	4.4
Death + blank + Severe + Moderate	716	11.5
Death + blank + Severe + Moderate + Low	1679	27.1

Time Elapsed Options	Cases	Per Day
<=90 days	538	8.7
<=180 days	851	13.7
<=365 days	1348	21.7
All incidents	1697	27.1

Combining Severity with Time indicates that choice made would result in the below numbers of incidents requiring full investigation before closure:

	Cases			
Severity Days	<=90	<=180	<=365	ALL
Death + blank	45	70	121	232
Death + blank + Severe	63	92	149	272
Death + blank + Severe + Moderate	179	279	493	716
Death + blank + Severe + Moderate + Low	538	851	1348	1679

The equivalent daily rate (During May, June and July) looks as follows:

	Per Day			
Severity Days	<=90	<=180	<=365	ALL
Death + blank	0.7	1.1	2.0	3.7
Death + blank + Severe	1.0	1.5	2.4	4.4
Death + blank + Severe + Moderate	2.9	4.5	8.0	11.5
Death + blank + Severe + Moderate + Low	8.7	13.7	21.7	27.1

Proposal 3a (Severity)
Require all incidents with severity of Moderate and above to be investigated, and for the investigation to prioritise those of higher severity first. Consider agreeing closure of 'low harm' incidents, or de-prioritise the review of those graded as such, with a view to allowing closure with no further investigation at a later point prior to the closure of DatixWeb.
There is risk associated with this proposal as a 'low harm' incident could be subject to a complaint or claim – but the level of risk can be expected to be lower than that for an incident with a greater harm level.
If the decision were taken to allow closure of 'low harm' incidents without further work, this would reduce the number open by 963 records, leaving 716 for investigation (in addition to those identified earlier as requiring investigation).

Proposal 3b (Time)
Figures have been provided to illustrate the impact of prioritising recent incidents over older incidents. However, the benefit of allowing closure of the records over a year old appears smaller in terms of impact on incident numbers, so no proposal is being made here to reduce numbers using this criterion.

Service Group Feedback: Service feedback has included doubts about the ability to close open records in the period remaining, identifying as noted earlier the likely requirement to retrieve patient case notes as a constraint. Consideration should be given to this when (i) agreeing an acceptable approach/threshold to prioritisation of records for closure, and/or (ii) consideration of any flexibility that can be afforded to services on other quality & safety performance targets to free resource for this work.

The cumulative effect of proposals made above in respect of incidents is presented in the below table:

Action	Type of record proposed (& proposal ref)	Number	Cumulative
INCIDENTS			
Close	1a) Incidents referred to other organisations	78	78
	2b) No harm incidents	1674	1752
	2c) Near misses	352	2104
	3a) 'Low harm' incidents	963	**3067**
Investigate/Transfer	1bi) (Known) Redress incidents	28	28
	1bii) GP Form incidents	20	48
	1biii) Incidents categorized 'blank' by Type	6	54
	2a) All Obs, Gynae & Neonatal incidents	162	216
	3a) Moderate harm & above (or blank)	716	**932**

Adopting **ALL** of the proposals in this paper in respect of incidents reduced the number of records requiring investigation & closure from **4733** to **932**.

(If all except proposal 3b (closing low harm incidents) are adopted, an additional 963 records would require investigation and the total number remaining would be **1895**.)

3.1.7 ADDITIONAL CONSIDERATION: PRESSURE DAMAGE

Following review of pressure damage incidents, services have highlighted the distinction between issues of pressure damage that have been reported as developing prior to admission with no prior healthcare involvement, and those that have developed or worsened while the health board has been responsible for care. There is arguably more to learn from cases within our care – however both are captured within the Datix system.

The impact of a decision to focus on only the latter of these has not been modelled yet, but may enable further prioritisation of resources in a risk-based way, and is presented for consideration.

Proposal 4:
Close open incidents relating to pressure damage, where the damage is reported as developing prior to admission with no prior healthcare involvement.

3.2 COMPLAINTS MODULE

Open records within the Complaints module are classified as the following types:

Type of Concern	Records
Court of Protection	43
Formal - PTR	12
GMC Referrals	26
NMC Referrals	30
Out of Time	2
Professional Concerns (code for use by safeguarding adults team only)	39
Redress	99

Type of Concern	Records
Re-Opened Complaint	7
Safeguarding (code for use by safeguarding adults team only)	20
Total	**278**

Proposal 5

a) Court of Protection

It is proposed that the corporate Patient Experience Team transfer all Court of Protection Cases from Datix Web into Datix Cymru.

b) Formal – PTR, Out of Time Complaints, Redress, Re—Opened Complaints (120)

It is suggested that Service Groups affected (Morriston, NPTS and PCT) review these open cases for likely closure, but transfer into the new system if unlikely to close by end of July.

c) GMC & NMC Referrals

The Datix Web system has provided a mechanism for recording these referrals in the past. This is not available within the same module in Datix Cymru. A dedicated module is in development nationally, but not available currently.

It is proposed that the current data is exported for monitoring via local spreadsheets and the records closed within DatixWeb.

d) Professional Concerns, Safeguarding

The complaints module has been used to capture these cases, with additional layers of security regarding access. This is not available in the new system. The new Datix Cymru system will provide a dedicated module for capture of safeguarding referrals.

It is proposed that the current data is exported for monitoring via local spreadsheets and the records closed within DatixWeb.

The effect of the above proposals is as follows:

Action	Type of record proposed (& proposal ref)	Number	Cumulative
COMPLAINTS			
Close in Datix	4c) GMC & NMC Referrals	56	56
	4d) Professional Concerns & Safeguarding	59	**115**
Investigate/Transfer	4a) Court of Protection (transfer)	43	43
	4b) Formal PTR, Out of Time Complaints, Redress & Re-opened Complaints	120	**163**

Adopting **ALL** of the proposals in this paper in respect of complaints module records reduces the number of records requiring investigation & closure, or transfer, from **278** to **163**.

3.3 COMPLIMENTS MODULE

Open records within the Compliments Module are classified as the following types:

Type	Data
Advice	15

Bereavement	53
Comment	347
Compliment	3429
Concern	440
Exec Correspondence	1
Help	24
Information	65
Let's Talk	16
Support	1403
Total	**5793**

In respect of "Concerns" recorded within the Compliments module, these are distributed as follows:

	2014	2015	2016	2017	2018	2019	2020	2021	Total
Bridgend Locality		1							1
Clinical Support Services	2	2							4
Corporate Medical Director (Including IT,Health Records)		1							1
Learning Disabilities		1							1
Mental Health	5	2							7
Mental Health and Learning Disabilities Delivery Unit			1	4	1				6
Morriston Hospital Service Delivery Unit			2	4	6	38	56	64	170
Musculoskeletal	5	1							6
Neath Port Talbot Hospital Service Delivery Unit		1	1	1	1	2		2	8
Neath Port Talbot Locality	5	2							7
Nursing & Patient Experience				1					1
Operations (previously Planning)	7	7	2	3	1	2	1		23
Primary and Community Services			1	5	3	2	2	1	14
Princess of Wales Hospital Service Delivery Unit	11	4	4	2	9				30
Regional Services (including Cancer, Cardiac)	5	5							10
Singleton Hospital Service Delivery Unit		1	1	1	23	10	42	12	90
Surgical Services	3	3							6
Swansea Locality	13	7							20
Women & Child Health	5	2							7
Workforce & Organisational Development	1								1
(blank)	17	10							27
Total	79	50	12	21	44	54	101	79	440

Proposal 6
a) All records other than "Concerns" be batch closed by the Datix Team.
b) All Concerns relating to 2020 or earlier be batch closed by Datix Team
c) Service Groups review those records classed as Concerns and recorded in 2021 and close them directly.

Adopting **ALL** of the proposals in this paper in respect of feedback/compliments reduces the number of records review from **5793** to **79**.

3.4 UPLOADED DOCUMENTS & AUDIT TRAIL

When transferring data from Datix Web to Datix Cymru, consideration needs to be given to the following:
a) New records entered manually will be time-stamped with the most recent date of entry – not the original date.
b) Documents already uploaded to open cases (incidents, complaints, claims etc)

Proposal 7
a) It is proposed that a common identifier / syntax be used to identify cases transferred from the old to the new Datix Cymru system, so that links to original dates still recorded within the read-only Datix Web system are maintained.
b) It is proposed that unless the numbers of documents are small (local decision) then it be agreed that for transferred cases, documentation already uploaded can remain in the read-only Datix Web system – the audit trail above, enabling staff to access as required.

4. RECOMMENDATIONS

INCIDENTS MODULE

4.1 Agree closure of the following incidents records without further investigation:

Proposal 1a) Incidents referred to other organisations (services to develop local means to track outcomes where this is desired locally)
Proposal 2b) No harm incidents
Proposal 2c) Near misses
Proposal 3a) 'Low harm' incidents
Proposal 4) Pressure damage incidents, where damage is reported as developing prior to admission with no prior healthcare involvement.

4.2 Agree the following incidents require full investigation in order to close:

Proposal 1bi) (Known) Redress incidents
Proposal 1bii) GP Form incidents
Proposal 1biii) Incidents categorized 'blank' by Type
Proposal 2a) All Obs, Gynae & Neonatal incidents
Proposal 3a) Moderate harm & above (or blank) incidents

Adopting ALL of the above would reduce the number of records requiring investigation & closure from 4733 to 932. If all except proposal 3b (closing low harm incidents) are adopted, an additional 963 records would require investigation and the total number remaining would be 1895.

COMPLAINTS MODULE

4.3 Agree the following complaints module records be closed and data exported for management outside of the system (eg using spreadsheets):

Proposal 5c) GMC & NMC Referrals
Proposal 5d) Professional Concerns & Safeguarding

4.4 Agree the following complaints module records require full investigation so these cases should be concluded in that way or transferred into the new system):

Proposal 5a) Court of Protection (Patient Experience team to transfer to new system)

Proposal 5b) Formal PTR, Out of Time Complaints, Redress & Re-opened Complaints

Adopting ALL of the above would reduce the number of records requiring investigation & closure, or transfer, from 278 to 163.

COMPLIMENTS MODULE

4.5 Agree that:

Proposal 6a) All records other than "Concerns" can be batch closed by the Datix Team.
Proposal 6b) All Concerns relating to 2020 or earlier be batch closed by Datix Team.

4.6 Agree that:

Proposal 6c) Service Groups review those records classed as Concerns and recorded in 2021 and close them directly.

Adopting ALL of the above would reduce the number of records review from 5793 to 79.

EMBEDDED DOCUMENTS & AUDIT TRAIL

4.7 Agree that:

Subject to the provision of an audit trail linking a record transferred into the new system back to its original entry in the old, that documentation already uploaded in the old system can remain in the read-only DatixWeb system – the audit trail enabling staff to access as required. **(Proposals 7a, 7b)**

Severity (degree of harm) code descriptors

No harm
No harm (impact not prevented) - Any incident that ran to completion but no harm occurred to people receiving NHS funded care
Low
Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS-funded care
Moderate
Any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care
Severe
Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons
Death
Any unexpected or unintended incident that directly resulted in the death of one or more persons