HEALTH BOARD RISK REGISTER
August 2022

RISKS ASSIGNED TO THE QUALITY & SAFETY COMMITTEE

Datix ID Number: 738 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 1** **Target Date: 31/08/2022**	**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:** September 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. Recent implementation of All Wales Immediate Release Protocol puts additional pressure on already overcrowded ED dept.	
Level of Control = 50%		**Rationale for target score:** Our annual plan is to implement models of care that reflect best practice. This will improve patient flow, length of stay and reduce emergency demand.	
Date added to the HB risk register 26.01.16			

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

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

Additionally, actions to improve the discharge of clinically optimised patients (risk HBR80) expected to assist with patient flow, are anticipated to free capacity to assist to address this risk HBR1 also.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Re-establish short stay unit on ward D at Morriston. Realign wards to specialties at Morriston Hospital including short stay unit on Ward D.	SGD (Morriston)	31/12/2022
Review roles & service models in order to increase SDEC working hours and throughput of patients sustainably.	SGD (Morriston)	01/12/2022
OPAS developing a proposal to assess elderly patients at home	SGD (Morriston)	Complete
OPAS – exploring internal & external funding options	SDEC Clinical Lead	31/01/2023
Introduce Band 6 navigator role in ED for better streaming of patients	SGD (Morriston)	Complete
Five-day in-reach by virtual wards will commence in August.	PCT SGMD	Complete
AMSR programme due to be implemented in December 2022 – subject to OCP.	COO	01/12/2022

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 is meeting monthly	The need to deliver sustained service.

Additional Comments / Progress Notes

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.
28/07/2022: OCP commenced 13/06/2022. Due to conclude 29/07/2022. Short stay unit delayed slightly due to significant covid pressures.
22/08/2022: OCP concluded. Two-week evaluation being undertaken.
21/09/2022: Evaluation concluded – shared staff side 8/9. Project now planning the implementation phase. Linked to AMSR risk.

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:** September 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.	
Level of Control = 40%			
Date added to the HB risk register January 2016		**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 QI programmes, drive improvement, & effectively measure outcomes.	

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. • Infection Prevention & Control related training provided programmes. • Surveillance of infections, with early identification of increased incidence, and instigation of controls. • Infection Prevention Improvement Plans, monitored by Infection Control Committee and Management Board. • Provision of cleaning service to meet National Standards of Cleanliness. • Engineering controls for water safety, ventilation, and decontamination.	Drive improvements in prudent antimicrobial prescribing	Cons. Antimicrobial Pharmacist	31/03/23
	Develop ward to board Dashboard on key Tier 1 infections	HoN IP&C & Digital Intelligence	31/12/22
	Achieve compliance with IPC mandatory training	Service Group Triumvirates	31/03/23
	Reduce Key Tier 1 Infections to no more than WG maximum quarterly profile	Head of Infection Control	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. • Infection Prevention Improvement Plans for HB and Service Groups with progress reported at SG Infection Control Committees, HB Infection Control Committee and at Management Board. These include trajectories to meet national targets and report performance against them. This is also reported to Quality & Safety Committee. • Ongoing monitoring of infection control rates.	• 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.

• IPC, antimicrobial, decontamination and cleaning audit programmes. • Compliance and validation systems for water safety, ventilation systems and decontamination.	• Lack of robust system for Board oversight regarding IPC and ANTT training compliance due to ESR limitations.

Additional Comments / Progress Notes

Progress update re Tier 1 infection reduction goals - 31/07/22 - cumulative infection cases 01 April – 31 July 2022:

- C. difficile - 56 (cumulative profile - 32 maximum)
- E. coli bacteraemia - 90 (cumulative profile - 85 maximum)
- Pseudomonas aeruginosa bacteraemia - 12 (cumulative profile - 8 maximum)
- Staph. aureus bacteraemia - 52 (cumulative profile - 27 maximum)
- Klebsiella spp. bacteraemia - 33 (cumulative profile - 25 maximum)

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:** September 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) • Planned care trajectories developed and submitted to WG as part of IMTP. • Governance process put in place to monitor performance against trajectories internally, and with Welsh Government	Exploring options to maximise efficiency and productivity through validation and efficient use of existing capacity	Deputy COO & Service Group Directors	Complete
	External & internal validation has commenced. Impact to be reviewed during October 2022.	Deputy COO	31/10/2022

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.
28/07/2022: Action commenced: Implement demand management initiatives between primary and secondary care to reduce the number of new patients awaiting outpatient appointments (some initiatives identified and being taken forward - review for opportunities will continue). Action complete: Implement a full range of interventions to support patients to be kept active and

well whilst on a waiting list – focusing on cancer patients awaiting surgery and long waiting orthopaedic patients. Action complete: Develop robust demand & capacity plans for delivery in 2022/23. Planned care trajectories developed and submitted to WG as part of IMTP. 21/09/22: Trajectories have been revised and show more favourable position but are still falling short of ministerial ambition. The Service Groups jointly with Deputy COO are looking at further efficiency opportunities

Datix ID Number: 1514 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**		**HBR Ref Number: 43** **Target Date: 30th 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:** September 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. Team Leader band 7 WTE is a qualified BIA and supports in the most complex cases. 1 band 6 BIA WTE commenced 1st August 2022. 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 Liquid Personnel to address the backlog of DoLS assessments. Bid successful£102k from WG for additional funding to address the ongoing DoLS breaches and MCA training.	Business case for revised service model (cannot be finalised prior to WG consultation)	Head of Nursing LPS	09/12/2022
	Agency commissioned to support backlog of assessments	GND Primary and Community	Ongoing
	Overtime agreed to fund sign off from nurse assessor team to process the backlog assessments	GND Primary and Community	Ongoing
	Recruitment process underway for substantive BIA	GND Primary and Community	Actioned. To commence 01.08.2022

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

27.06.2022 - BIA has now been appointed and due to start 1st August 2022.
Current backlog is 56.
Additional 3 BIA's have been allocated by Liquid Personnel to meet the backlog of DoLS. Currently 37 assessments have been undertaken since commenced 11 weeks ago which is significantly below the projected number. Escalated to Liquid Personnel lead who has increased the allocation of BIA's. Agreement for 10 assessments to be completed on a weekly basis which would meet the backlog and ongoing DoLS submissions to prevent breaches. This is being reviewed on a weekly basis. No change to current risk score.
WG Draft Code of Practice remains in consultation period until 14th July 2022. A regional and separate health board response is being developed and led by LPS Head of Nursing.
Phase 1 bid has been agreed by WG with allocation of £102k. Phase 2 funding has been made available. Bids to be submitted by 1st August 2022 for up to £152K, to support workforce plans including the recruitment of staff and the wider preparations needed in order to prepare for the LPS and can include;

- Development of data capacity
- Additional DoLS backlog work
- Additional advocacy arrangements
- Additional training needs identified through development of local workforce and training plan

This funding bid is to be submitted 1st August 2022.
11.08.2022 – Newly appointed BIA commenced on 1st August 2022.
Current DoLS backlog is 42. Liquid Personnel have completed 58 to date with 192 remaining of the 250 assessments commissioned. Due to the summer period there has been a reduction in weekly assessments completed by Liquid Personnel (approximately 3-4 a week). It is anticipated that the number of completed assessments will increase by September 2022. This is being reviewed on a weekly basis with the lead coordinator for Liquid Personnel. There remains to be no changes to the current risk score.
Consultation regarding the Draft Code of Practice was submitted to WG as planned. Phase 2 bid was submitted on the 1st August 2022 to WG by LPS Head of Nursing for additional £152,000 funds to support workforce plans, recruitment of staff and wider preparation in order to prepare for LPS.
23.09.2022 – Current DoLS backlog is 42. Liquid Personnel have completed 116 assessments to date with 134 remaining of the 250 assessments commissioned. Number of assessments completed by Liquid Personnel has increased and it is anticipated that all commissioned assessments will be completed by December 2022. Further assessments to be commissioned utilising WG funding from Phase 1 bid to support with assessments until end of financial year. Phase 2 bid has been agreed. Proposal to be put forward to provide additional staff to support the implementation for LPS and MCA training.

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:** September 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. Due to improvements being made within the service the current score is on track to be reduced next month.	
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

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

As a result of focussed work, the vacancy rate has improved considerably. Utilisation of agency will continue to improve the backlog, and support the trajectories received.

% Patients waiting < 28 days

The number of referrals reduced to 138 in August, compared to 259 in May when referrals were at their highest this year. The proportion of referrals redirected/not accepted has increased in August to 55% reflecting the average for 21/22.

The number of patients on the waiting list at the end of August has decreased from 324 in May to 100.

The current waiting time for assessment as at 23th September, is included within the table below.

Team	Total waiting	Waiting >28 days	% compliance	Average wait (weeks)
CAMHS Swansea Bay	100	31	69%	2.7

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. Update: August 2022 – work has been progressed to develop options for the repatriation of CAMHS, and these are due to be reviewed by Management Board in August. A service specification has been drafted, and engagement is ongoing. Trajectories have now been received aligned to the schemes in the Improvement Plan – these will be monitored via the monthly commissioning arrangements. Update: September 2022 – Service Specification complete and preferred option confirmed for future repatriation of service to Swansea Bay UHB. Recommended that risk is downgraded in October 2022. Two actions completed - Service Specification being developed. Engagement on Specification is now complete, document has been finalised and endorsed by CTM and SBUHB via the commissioning arrangements in place. Board to consider future delivery arrangements. Option appraisal complete – preferred option approved by Management Board and by Health Board members at the September meetings.

Datix ID Number: 1761 **Health & Care Standard: Timely Care 5.1 Access**		**HBR Ref Number: 50** **Target Date: 31/10/2022**	**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:** September 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 5 x 5 = 25 Target: 4 x 3 = 12		**Rationale for current score:** Risk score updated based on being off trajectory for SCP and Backlog increasing.	
Level of Control = 70%		**Rationale for target score:** Target score reflects the challenge this area of work present the Board and where small numbers of patients impact on the potential to breach target.	
Date added to the HB risk register April 2014			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Tight management processes to manage each individual case on the Urgent Suspected Cancer Pathway. Enhanced monitoring & weekly monitoring of action plans for top 6 tumour sites. • Initiatives to protect surgical capacity to support USC pathways have been put in place • Additional investment in MDT coordinators, with cancer trackers appointed in April 2021. • Prioritised pathway in place to fast track USC patients. • Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. This will form part of the remit of the Cancer Performance Group. • Weekly cancer performance meetings are held for both NPTS and Morriston Service Groups by specialty. • The top 6 tumour sites of concern have developed cancer improvement plans. • Additional work being undertaken as part of diagnostic recovery and theatre recovery workstreams. • Endoscopy contract has been extended for insourcing.	Phased and sustainable solution for the required uplift in endoscopy capacity that will be key to supporting both the Urgent Suspected Cancer backlog and future cancer diagnostic demand on Endoscopy Services.	Service Group Manager	31/03/2023
	Demand & capacity plans worked through for top 6 tumour sites.	Deputy COO	Complete

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
Backlog trajectories updated at Management Board and will be going to Performance & Finance Committee in August. Cancer Performance Group established to support execution of the services delivery plans for improvements and meeting regularly.	Performance and activity data monitored, but delays to treatment continue while sustainable solutions found.

Additional Comments / Progress Notes

27/06/2022: Deputy COO with support for CIT have developed Cancer Backlog trajectories for top 6 tumour sites.
22/08/2022: Backlog trajectories have been presented to Management Board and will be going to Performance & Finance Committee in August.

21/09/2022: PFC received the trajectories and tumour site specific recovery plan. Endoscopy capacity remains a constraint and updated recovery plan is to be presented at Management Board in October.

Datix ID Number: 146 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**		**HBR Ref Number: 58** **Target Date: 31/03/2023**	**Current Risk Rating** **4 x 4 = 16**
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 in **Ophthalmology** results in a delay in treatment and potential risk of sight loss.		**Date last reviewed:** September 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 4 = 16 Target: 4 x 2 = 8		**Rationale for current score:** Risk rating increased to 20 in July 2020 due to Covid-19 pandemic but has now been decreased due to the progress made by the department to reduce the number of delayed followed appointments.	
Level of Control = 40%		**Rationale for target score:** Mitigation plan via outsourcing of work to optometrists where possible and re-introduction of pre-covid capacity 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?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
• Deputy COO holds Gold Command meetings on a monthly basis to monitor progress.	Regular liaison with patients on extended waiting list/times and validation.

Additional Comments / Progress Notes

12/09/2022 – Risk reviewed and no further updates.

Datix ID Number: 1587 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 61** **Target Date: 31st May 2023**	**Current Risk Rating** **4 X 4 = 16**
Objective: Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morriston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies.		**Director Lead:** Inese Robotham, Chief Operating Officer **Assuring Committee:** Quality and Safety Committee/Strategy Planning and Commissioning Committee	
Risk: Paediatric dental GA/Sedation services provided under contract from Parkway Clinic, Swansea. Medical Safety risk GAs performed on children outside of an acute hospital setting.		**Date last reviewed:** September 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: 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.
29.07.2022: T&F group to be re-established in September 2022.
23.08.2022: Reviewed at HoS meeting - PCT planning with service director in Morriston Hospital. No change to risk at present.
12.09.2022: Risk reviewed and no further updates.

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:** September 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 4 = 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.	

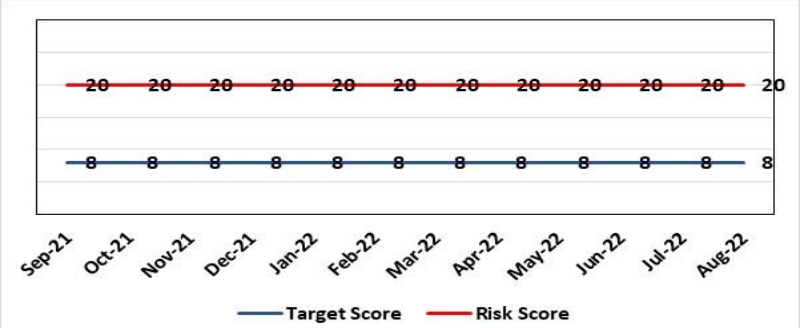
Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
All staff are required to complete the GAP e-learning on an annual basis. Compliance is monitored via the Training & Education forum. All staff have received an email 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

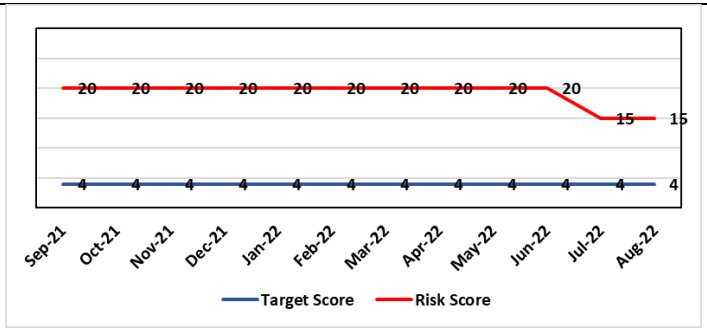
Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
The third trimester ultrasound capacity will increase by a minimum 2200 scans per annum in year one increasing to 4400 in year 2. The detection rate of IUGR/SGA will increase leading to improved	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.
08/07/2022 - Admin support still unavailable. Clinics have commenced but unable to record capacity on WPAS.
04/08/2022 - Trainee midwifery sonographers will not be able to complete their training by September because their competencies cannot be signed by this time.

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:** September 2022 **Rationale for current score:** The K2 central monitoring system has been purchased by the health board however is not yet installed. A project team is being established to ensure oversight of installation and training. Full use of the system will be available from December 2022 when the risk will reduce as appropriate.	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 5 = 20 Target: 4 x 2 = 8 **Level of Control** = 50% **Date added to the HB risk register** 31st December 2011		**Rationale for target score:** A central monitoring station will enable senior clinicians to support decision making across the service, and from home, leading to senior involvement in management decisions toward improved outcomes. All CTG traces will be stored electronically and therefore will not fade and cannot be lost.	
Controls (What are we currently doing about the risk?)		**Mitigating actions (What more should we do?)**	
All staff receive annual training in fetal surveillance as mandated by Welsh Government. SBU have appointed a midwife and obstetric lead for training and development of staff Compliance with training is reported annually in 2021/2022 the training year has been extended due to the service ability to release staff for training A "fresh eyes" protocol in place requiring intrapartum CTG classification hourly by two clinicians which is monitored via audit of records A "jump call" policy is available to request additional support where there is disagreement over CTG classification CTG prompt labels in use to support staff with CTG categorisation.		**Action**	**Lead** / **Deadline**
		Fetal surveillance leads to set up training team for transition to use of electronic labour record. TNA analysis to be completed for all staff	Fetal surveillance leads / 31/12/2022
		For the project Board to complete a risk assessment to manage the changeover from paper based to electronic monitoring to ensure all risks are captured	Project Board / 31/07/2022
Assurances (How do we know if the things we are doing are having an impact?) All Wales Fetal Surveillance Standards for 6hrs Fetal Surveillance Training per year		**Gaps in assurance (What additional assurances should we seek?)** Assurance all staff are able to transition to a new way of working	
Additional Comments / Progress Notes 27/05/2022 - Project board has held first meeting. Projected installation date December 2022- January 2023. SIGNAL installation to coincide in January 2023. 7/06/2022 – Project group have held first meeting, development of sub groups. Training sub group essential to ensure all staff are able to transition to new way of working. Highlighted as a key action. 08/07/2022 - Potential delay with installing Central Monitoring, however still currently on track for December 2022.			

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 3 = 15**
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:** September 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 3 = 15 Target: 2 x 2 = 4		**Rationale for current score:** Risk reduced to 15 (July) – last 3 months have now consistently delivered 100 additional patients per month via CDU.	
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 December 2022
	Relocation of SACT linked to AMSR programme and phase 2 of home care expansion case brought forward	Service Director Lead for Cancer	January 2023 (dependant on AMSR moving Sept 2022)

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

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

Additional Comments / Progress Notes

27/08/2022 - Average waiting times have improved to 3.5wks. Work remains ongoing to deliver improvements in waiting times as per SACT WCN reported targets for P1,P2 and P3. due to further rise in Covid additional 3 chairs have not been reintroduced yet.

12/09/22 - We continue to see stabilising of CDU waiting times although there remains operational concerns with specific points in pathways effecting efficiency and effectiveness of delivery linked to aseptic and consultant workload pressures. We monitoring monthly compliance of SACT WCN reports. Which shows slight deterioration performance in August compared to July, but still average waiting remains around 3wks.

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:** September 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	01/04/2023 (on track)
	Operationalise plans for offering hypo fractionated prostate treatment	Service Manager Cancer Services	30/11/2022 (on track)

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

Additional Comments / Progress Notes

11.08.22 Now offering hypofraction in-house due to cessation of Rutherford activity.

13.09.22. Wait Times have dipped in August with the biggest contributing factor being late localisation. Demand- After 2 months of high demand, the levels returned to a more 'normal' level in August. It will be interesting to see if this was due to consultant leave and if the demand returns to higher levels once everyone is back. Demand for breast treatment has seen the highest rise over the past 12 months with a 39% increase (325 pts increasing to 451 pts). Capacity- August was a very busy month on the linacs as we treated the high levels of demand seen in July. With four matched linacs in operation we were able to start 206 courses of treatment, almost matching our previous highest record.

Datix ID Number: 1418 **Health & Care Standard: 5.1 Timely Access**		**HBR Ref Number: 69** **Target Date: 31st January 2023**	**Current Risk Rating** **5 X 4 = 20**
Objective: Best values outcomes from high quality care		**Director Lead**: Inese Robotham, Chief Operating Officer / Gareth Howells, Executive Director of Nursing **Assuring Committee:** Quality & Safety Committee	
Risk: Risk issues related to **adolescent patients being admitted to Adult MH inpatient wards**- Inappropriate settings resulting in 'Safeguarding Issues' The WG has requested that HBs identify Secondary Care in -patient facilities for the care of adolescents- in Swansea Bay University Health Board Ward F NPT hospital is the dedicated receiving facility with one bed identified.		**Date last reviewed:** September 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.	Next service group review of effectiveness of current controls.	MH&LD Head of Operations & Clinical Directors	1st October 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

29/07/2022 – MHLD SG confirmed there is no change on the status of this risk.
22/08/2022 – Action Closed: *The service group will review the effectiveness of current controls.* A further review date has been set.

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:** September 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 4 = 20 Target: 2 x 3 = 6		**Rationale for current score:** 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.	
Level of Control = 60%			
Date added to the HB risk register 30th April 2021		**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	30/12/2022
	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 women's 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.
08.07.2022 – Continue to monitor IOL, critical staffing continues.

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** **3 x 4 = 12**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Richard Evans, Executive Medical Director **Assuring Committee:** Quality & Safety Committee	
Risk: Nosocomial transmission Nosocomial transmission in hospitals could cause patient harm; increase staff absence and create wider system pressures (and potential for further harm) due to measures that will be required to control outbreaks.	**Date last reviewed:** September 2022	
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 3 x 4 = 12 Target: 3 x 4 = 12	**Rationale for current score:** 11.08.2022 – Risk reduced to 12. Reasoning: (1) incidence reducing in the community (2) incidence reducing in hospital (3) current variants associated with low mortality in vaccinated population (4) communication to families has not resulted in adverse.	
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. 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.	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
	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	01/12/2022

Assurances **(How do we know if the things we are doing are having an impact?)** Monitor Outbreaks throughout the HB / Review Nosocomial Deaths and lessons learnt	**Gaps in assurance** **(What additional assurances should we seek?)** 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.
27.07.2022 - Significant progress being made to review cases of hospital acquired COVID 19 resulting in patients death.
The HB has started to contact families to notify them followed up by written information on the process.

Working with the DU to standardise processes within each HB. Scrutiny Panels being established for September to feedback lessons learnt to Service Groups and estimate level of harm. Legal and Risk services have been asked to support reviews to ensure we are following correct processes. Board updated on a regular basis with progress.

Datix ID Number: 1832 **Health & Care Standard: : 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 80** **Target Date: 30/09/2022**	**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:** September 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 (COPs) 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%			
Date added to the HB risk register May 2021		**Rationale for target score:**	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Clinically optimised numbers are monitored and reviewed weekly by the MDU. Delays are reported and escalated to try to ensure timely progress along a patient's pathway. • Review on a patient by patient basis – with explicit action agreed in order to progress transfer to appropriate clinical setting. • Critical constricts in relation to access/time delays for social workers and assessment for package of care and social placement – lead times in excess of 5 weeks. • Patient COVID-19 status has added an additional level of complexity to decision making. • The health board has procured 63 additional care home beds to provide additional discharge capacity.	A dedicated task & finish group to be established to develop plans to close 90 contingency beds, as per AMSR plan. A plan will be presented to Management Board in September.	Project Director	Closed
	Two focused groups established to look at different categories of COPs and provide senior oversight. To commence in August.	PCT Nurse Director	Closed
	Deputy COO identified as lead for length of stay reduction and admission avoidance and will be putting in place a weekly oversight framework.	Deputy COO	31/10/2022
	CEO will meet with clinical leads to explore further opportunities for changing pathways with the aim of reducing length of stay. A meeting to be arranged by COO.	COO	04/10/2022
	COO and Medical Director to meet with WAST MD to review current pathways into ED with aim to identify opportunities for admission avoidance.	COO/EMD	31/10/2022

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

Additional Comments / Progress Notes

28/07/22: Action completed: The HB has engaged and are having bi-weekly meeting with LA colleagues and the national lead for the Social Care taskforce.
22/08/22: As per risk HBR88 - Due to unforeseen need for leave of Project Director, the previously identified action (*A dedicated task & finish group to be established to develop plans to close 90 contingency beds, as per AMSR plan. A plan will be presented to Management Board in September.*) has been closed and alternative arrangements put in place: The PCT Service group Nurse Director has put in place a governance structure – Two groups will be established – the PCT Nurse Director will chair one focusing on patients with longest stays; the PCT Head of Nursing will chair the group reviewing patients who are experiencing delays in discharge processes (eg waits for therapies).
21/09/22: Detailed presentation on the length of stay reductions and admissions avoidance schemes was received by Management Board 21/09/2022. Progress against delivery will be monitored by Management Board on a bi-weekly basis.

Datix ID Number: 2788 Health Care Standards: 7.1 Workforce	HBR Ref Number: 81 Target Date: 31st October 2022	Current Risk Rating 5 x 5 = 25
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 Vacancies and unplanned absences resulting from Covid-19 related sickness, alongside other long term absences including maternity leave, have resulted in critical staffing levels, which undermine the ability to maintain the full range of expected services safely, increasing the potential for harm, poor patient outcomes and/or choice of birthplace. Poor service quality or reduction in services could impact on organisational reputation.	**Date last reviewed:** September 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 5 x 5 = 25 Target: 4 x 4 = 16	**Rationale for current score:** Pressure on staffing increased at the end of June 2022 as a result of increasing short term sickness, particularly COVID-19 related - 12.24wte midwives are absent due to COVID-19 which equates to 7.6% of the overall clinical midwifery workforce. Vacancies exist within the service however and two rounds of recruitment for Band 6 midwives have failed to fully appoint to the vacancies available. A third round of recruitment is progressing to interview stage. Some aspects of service provision have been suspended in order to ensure resource is best directed to support safe provision. Increased to 25.	
Level of Control = %	**Rationale for target score:** It is intended that through actions currently identified to address vacancies we can reinstate services fully and reduce the likelihood of the need to suspend elements further.	
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 • Birth rate plus Intrapartum acuity tool completed 4 hourly to guide safe service provision and escalation; • Escalation meeting now daily to review rotas and reallocate staff as required – this is Director led • Morning safety huddle for community midwifery teams • Additional shifts offered via Bank, additional hours and overtime – targeted enhanced overtime rates offered for 3 weeks (from 24/06/2022) with authorisation of Executive Director of Nursing and subject to daily review. Plus enhanced bank rate offered to registered midwives. • Utilisation of off-contract midwifery agency authorised by Executive Director of Nursing (from 24/06/2022) – prospective bookings in place to end of October. • Band 5 graduates (2021 and 2022) offered preferred substantive hours – this has provided an additional 3.86wte. • On-Call Manager Rota in place. • Medical team support used when required. • Continue to suspend services in the FMU at NPT.	Complete recruitment for band 6 midwives	Deputy Head of Midwifery	30/09/2022
	Complete workforce paper with HR and finance to establish vacancy position and develop vacancy tracker going forward. Support for Cwm Taf secured to develop this.	Head of Midwifery	05/10/2022
	Complete Birthrate+ Cymru assessment	Head of Midwifery	Closed as separate action – to be considered as part of above
	A task & finish group has been established to review the current midwifery establishments and roster	SG Nurse Director	30/09/2022 Complete

<table>
<tr><td rowspan="3">• International recruitment campaign initiated with MEDACS.
• Offer of additional support worker shifts particularly in the postnatal area for additional support for women
• Absences in senior roles supported mitigated as follows: Head of Safeguarding supporting the governance team; Temporary extension of Interim Midwifery Matron post to support oversight of the governance team; Retired Head of Midwifery mentoring new Deputy Head; Intrapartum Lead Midwife (Cwm Taf) is supporting development of future workforce requirements; WG offer of advice/support where required.
• Regular communication with stakeholders includes: Early warnings to Welsh Government; Verbal and formal communication with CHC; Internal communications on home births, RCM updates; weekly staff briefings and bulletins.</td><td>templates with Finance.</td><td></td><td></td></tr>
<tr><td>Recruiting to a Band 8A Lead Midwife role for Intrapartum Services.</td><td>SG Nurse Director</td><td>17/10/2022 (Initiation of process)</td></tr>
<tr><td>Review the role and capacity of the HCSW to maximise registered midwife capacity.</td><td>Deputy Head of Midwifery</td><td>31/10/2022</td></tr>
<tr><td>Assurances (How do we know if the things we are doing are having an impact?)
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 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. The following assurance mechanisms in place currently:
Birth-rate Plus Intrapartum acuity tool completed 4 hourly
Daily Director-led midwifery staff escalation meetings which considers sickness & other absences and daily review of safety and quality outcomes. The Group Head of Quality Safety & Risk is supporting daily oversight of Datix incidents (commenced July 2022). Red flag events are monitored and reported in accordance with NICE Guidance 2021:
• Cancelled elective caesarean sections;
• Missed or delayed care;
• Delayed or cancelled induction of labour;
• Delay of 2 hours or more between admission for induction of labour and beginning of process;
• Delay of 30 minute or more between presentation and triage.</td><td colspan="3">Gaps in assurance (What additional assurances should we seek?)
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 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.</td></tr>
<tr><td colspan="4">Additional Comments / Progress Notes
03/08/2022: Management Board has approved proposal to suspend home births until end Sept to support effective deployment of staff on open services.
Work being undertaken to maximise the centralisation of community services between Neath, Swansea and Port Talbot including a modified schedule of routine antenatal and postnatal care directed by RCOG/RCM recommendations to support better deployment of staff resource.
Enhanced bank rate implemented until further notice and continued use of off contract agency midwifery staff.
CHC have been formally informed of the suspension of home birth services.
12.08.2022 – Situation reviewed – Risk score increased to 25 following discussions with WG as we are still unable to resume home births or reopen the birth centre.
3 actions complete - Shortlist for band 6 midwifery vacancies following closure date. Fourth recruitment round to be initiated. Interview dates to be confirmed. SBAR to be prepared for vacancy panel to advertise for Band 5 midwives where band 6 recruitment cannot be achieved.
Updated 12.9.22 - Daily meetings still taking place. Risk score remains the same at 25.
A task & finish group has been established to review the current midwifery establishments and roster templates with Finance. Update - 4/10/22 - establishments reviewed and compared to BR+; paper sent to Mgt Board due to be presented 4th November. Action completed – Task and Finish group established.</td></tr>
</table>

Datix ID Number: 2554 **Health & Care Standard:** Standard 5.1 Timely Access		**HBR Ref Number: 82** **Target Date: 1st 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, and Consultants from the Morriston General on-call and Paediatric Anaesthesia rotas, 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:** September 2022	
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 4 = 16 Target: 3 x 1 = 3		**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.	
Level of Control =		**Rationale for target score:** This is a small clinical service with staff with highly specialised skills. While a small service may always be vulnerable to challenges (eg staff) the intention will be to operate a more resilient clinical model that is supported by other clinical groups.	
Date added to the HB risk register December 2021			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• The general ITU consultants, and some Consultants from the Morriston General and Paediatric Anaesthetists to support the Burns service on a temporary basis, supporting the remaining burns anaesthetic colleagues to provide cover for the Burns service. • 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. • Capital works will be completed by mid-2023 to co-locate the burns patients within the GICU footprint. • 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	WG have agreed funding in principle for capital works to progress. Scoping document submitted to WG and discussions ongoing about expediting a decision on an outline/full business case.	Morriston Service Group	30th November 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.
27.06.22 – Action complete: Submission of bid for capital funding to Welsh Government for both phases of work required.
11.08.22 – EMD has secured agreement for continued support of the Burns service by anaesthetics and critical care pending the completion of capital works. While there is willingness to provide that cover, staffing vulnerabilities remain in those clinical areas.

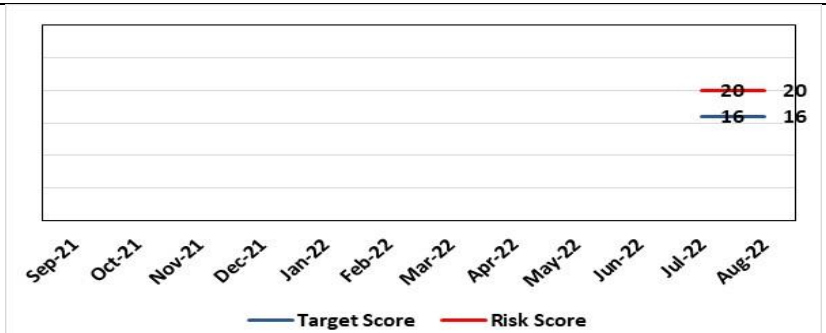
Datix ID Number: 3036 **Health Care Standards: 4.1 Dignified Care, 2.1 Managing Risk & 7.1 Workforce**		**HBR Ref Number: 84** **Target Date: 31st December 2022**	**Current Risk Rating** **4 x 4 = 16**
Objective: Best value outcomes		**Director Lead:** Richard Evans, Executive Medical Director **Assuring 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:** September 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.	Develop actions for improvement as advised by RCS	Executive Medical Director	31st January 2023
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. Update 20/06/22 - Weekly meetings occur for the project leads, Fortnightly meeting occur at a Silver level with service manager, head of nursing, Clinical director and unit medical director to monitor progress. Monthly Exec led meetings are held with the executive medical director, these meetings monitor governance and risk associated with the delivery of the recommendations, to ensure that processes and safety concerns are discussed and any changes made are sustainable for the future of the service. All progress is fed back to Welsh Health Specialised Services Committee. A further review process is now underway via RCS Action plan any outstanding actions will be reviewed via the RCS action Plan. 01/07/22 – Action complete: Implementation of local improvement plan targeting areas of concern and implementing actions to reduce variation. 11/08/22 – Additional visit from RCS to review an individual surgeon's outcomes. Verbal feedback received with no immediate patient safety concerns. Report from site visit still awaited. Regular escalation meetings with WHSSC note continued improvement is systems and processes in the service.

Datix ID Number: 2561 **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:** Christine Morrell, 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. The size of the gap in terms of staff resource is now better understood. • 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. • Implementation of the Act for those of above compulsory school age (post-16) commences in September 2023, though transition planning will commence from September 2023. Significant preparedness work is required to mitigate the risks this will present. 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:** September 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).	
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		**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.	
Controls (What are we currently doing about the risk?)		**Mitigating actions (What more should we do?)**	
		Action	**Lead**	**Deadline**

• 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 operational approach. • Advice has been received from WG to resolve key areas of particular ambiguity relating to Health Board duties under the Act. • Regarding demand / capacity and staffing resource challenges, WG has a phased implementation timetable for the Act for the period through to summer 2024. From summer 2024, the Act will be fully in 'delivery as usual'. The phased implementation offers partial short-term mitigation of the risks. • Awareness has been raised at Board level through Development session and thrice-yearly updates are provided to the Quality and Safety Committee. • A multi-agency group supported by the national ALN post-16 Implementation Lead has been formed to progress key activity in relation to post-16 implementation.	Work with LA partners to be progressed to establish and implement a prudent, longer-term operational model through which statutory referrals / requests to the Health Board will be made.	DECLO	15/10/2022
	Finalise ALN workplan to be progressed by the ALN Operational Group, including allocation of leads to individual workstreams	DECLO	30/09/2022
	Work with Performance colleagues to ensure greater visibility in Performance and Q&S dashboards of data relating to compliance with statutory duties	DECLO	30/10/2022
	Work with Informatics colleagues to ensure robust data regarding compliance with statutory duties	DECLO	30/10/2022
	Work with LA colleagues to establish future SLA arrangements for Paediatric Therapies services and to establish the impact of any changes on the Health Board	Interim Head of Speech & Language	30/10/2022
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. • National ALN Reform Steering Group has been formed and will include Health representation (SBU Deputy DOTHS). This will provide a national forum for consideration of risks.	**Gaps in assurance (What additional assurances should we seek?** • Extent of gap in staffing resource (gap between work required and capacity available) has been provisionally quantified, but data is imperfect and there remains some uncertainty. This is in a context where demands will increase significantly over the next year.		
Additional Comments / Progress Notes 13.09.2022 – good progress is being made on work to improve operational processes. It is anticipated that thi will be completed and in implementation within 1 month. An externally-facilitated workshop to establish a shared vision and identifty priorities for collaboration has been held (action closed) and next steps are being agreed with partners. The ALN Operational Group is making good progress on finalising the workplan, with leads having been identified for most areas, including for post-16 work, which has been identified as a key area of risk. Work with Performance and Informatics colleagues to address data quality issues and improve the visibility of key ALN data is being progressed. Start date for ALN Project Manager confirmed (20.09.2022). Action closed - Externally-facilitated work with LA partners to ensure that operational activity and discussions are grounded in a shared vision for collaborative working under the ALN Act, with a workplan to support this.			

Datix ID Number: 3110 **Health Care Standards: 4.1 Dignified Care, 2.1 Managing Risk & 7.1 Workforce**		**HBR Ref Number: 88** **Target Risk Date: 31/12/2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Best value outcomes		**Director Lead:** Inese Robotham, Chief Operating Officer **Assuring Committee:** Performance & Finance Committee **For Information:** Quality & Safety Committee	
Risk: Non-delivery of AMSR programme benefits There is a risk that the Acute Medical Service Re-Design (AMSR) programme may not deliver the expected performance & financial benefits in a timely way. The principal potential causes of this risk are: workforce (OCP and recruitment requirements), capacity constraints linked to significant number of clinically optimised patients (COP), financial affordability linked to 90 beds in Singleton hospital that are due to close in Q3 2023.		**Date last reviewed:** September 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:** Current score reflects the size and complexity of the programme. Whilst there are substantial mitigations in place, the residual risk remains high.	
Level of Control = %		**Rationale for target score:** When measures identified are implemented it is anticipated that this will increase the likelihood of success.	
Date added to the risk register July 2022			

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

• AMSR Programme Board reporting to UEC (Urgent & Emergency Care) Board
• Dedicated workstreams & workstream leads – all work streams have weekly assurance meetings where the sub groups provide updates on their specific tasks
  ○ OCP (Organisational Change Policy) workstream – supporting staff engagement
  ○ Workforce workstream – Focus on recruitment & retention. Dedicated sub groups with recruitment trackers and action plans.
  ○ AMU (Acute Medical Unit) model workstream - focus on development of the operating policy for the AMU, including the interaction with the admitting units, WAST and specialist wards. Triage process has been agreed – system same as Emergency Department. Draft Standard Operating Procedure (SOP) created.
  ○ SDEC (Same Day Emergency Care) collaborative workstream – focus on further development of SDEC model. SOP developed, focusing on hospital pre admission, data sessions to assist with finalising pathways.
	Workforce plan to be presented at the Management Board in September	Service Director (Morriston)	Complete

	Robust OCP process; consultation end date was 29/07/2022.	Chief Operating Officer	Complete
	Targeted programme for reduction of COP focussing on improved operational efficiency (reduced length of stay improved discharge processes), implementation of Discharge-to-Assess and effective utilization of existing community capacity, strategic partnership solutions with Local Authority partners. Programme Plan to be presented at September 2022 Management Board.	Project Director	Closed

<table>
<tr><td rowspan="2">

Specialist wards workstream – focus on role & operating model of specialist wards and interfaces. Agreement on patient criteria with preference of sub-acute /round rounds for singleton wards/ SOP template for all wards. Future – dedicated sub group on Discharge and flow hosting a work shop to standardise process across the health board & internal flow from Morriston to Singleton and Neath.
Estates workstream focus on capital work.

• Communications – Project team have employed Freshwater to assist with communications for the programme. Focusing on shop floor communication across all hospitals with use of storyboards and TV screens providing updates at main entrances.
• Governance arrangements agreed for go / no go gateways via management board
• Assurance to Performance & Finance Committee (PFC) and (Quality & Safety Committee (QSC) and escalation to Health Board if required.
</td><td>Two focused groups established to look at different categories of COPs and provide senior oversight. To commence in August.</td><td>PCT Nurse Director</td><td>Complete (Groups Commenced)</td></tr>
<tr><td>The costs of service transfer will be met through transformation of out of hospital pathways. Should savings not be fully identified, by December 2022, there will be an increased CIP (Cost Improvement Plan) commitment in 2023/24. Progress review to be undertaken in December 2022.</td><td>Project Director</td><td>31/12/2022</td></tr>
<tr><td colspan="2">Assurances (How do we know if the things we are doing are having an impact?)
Regular gateway reviews via Management Board
Assurance to PFC and QSC and escalation to Health Board if required.</td><td colspan="2">Gaps in assurance (What additional assurances should we seek?)
Capacity and capability gaps to support the programme and drive forward actions and provide adequate assurance.
Operational site pressures impacting on AMSR programme deliverables.
Lack of progress in reducing bed occupancy for medicine patients.</td></tr>
<tr><td colspan="4">Additional Comments / Progress Notes
01/08/2022: OCP commenced 13/06/2022 and concluded on 29/07/2022. Feedback is being collated.
Programme on reducing clinically optimised patients is being scoped by the Project Director.
Estates works progressing to plan.
22/08/22: As per risk HBR80 - Due to unforeseen need for leave of Project Director, the previously identified action (Targeted programme for reduction of COP focussing on improved operational efficiency (reduced length of stay improved discharge processes), implementation of Discharge-to-Assess and effective utilization of existing community capacity, strategic partnership solutions with Local Authority partners. Programme Plan to be presented at September 2022 Management Board.) has been closed and alternative arrangements put in place: The PCT Service group Nurse Director has put in place a governance structure – Two groups will be established – the PCT Nurse Director will chair one focusing on patients with longest stays; the PCT Head of Nursing will chair the group reviewing patients who are experiencing delays in discharge processes (eg waits for therapies).
21/09/2022: Project is planning the implementation phase. Two main risks remain: Workforce and Capacity. Workforce risk is managed through a dedicated workstream looking at both local and international recruitment. See HBR1 in respect of LOS & capacity.</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