HEALTH BOARD RISK REGISTER JUNE 2021

(Revised to reflect in-month updates 15/07/2021)

RISKS ASSIGNED TO THE QUALITY & SAFETY COMMITTEE

Risk Schedules

<table>
<tr><td colspan="2">Datix ID Number: 738
Health & Care Standard: 5.1 Timely Care</td><td>HBR Ref Number: 1
Target Date: 31st March 2022</td><td>Current Risk Rating
4 x 4 = 16</td></tr>
<tr><td colspan="2">Objective: Best Value Outcomes from High Quality Care</td><td colspan="2">Director Lead: Rab McEwan, Chief Operating Officer
Assuring Committee: Performance and Finance Committee
For Information: Quality & Safety Committee</td></tr>
<tr><td colspan="2">Risk: If we fail to comply with Tier 1 target – Access to Unscheduled Care then this will have an impact on patient and family experience. Challenges with capacity /staffing across the Health and Social care sectors.</td><td colspan="2">Date last reviewed: Management Board – July 2021</td></tr>
<tr><td>Risk Rating
(consequence x likelihood):
Initial: 4 x 5 = 20
Current: 4 x 4 = 16
Target: 3 x 4 =12

Level of Control
= 50%

Date added to the HB risk register
26.01.16</td><td> 
</td><td colspan="2">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.

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.</td></tr>
<tr><td colspan="2">Controls (What are we currently doing about the risk?)</td><td colspan="2">Mitigating actions (What more should we do?)</td></tr>
<tr><td colspan="2">• 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.</td><td colspan="2"><table>
<tr><th>Action</th><th>Lead</th><th>Deadline</th></tr>
<tr><td>Implementation of Phone First for ED as one the initiatives set out in the National Unscheduled Care Programme – six goals.</td><td>Chief Operating Officer</td><td>31st October 2021</td></tr>
<tr><td>Phased implementation of the Acute Medical Services Redesign. Business case for ambulatory care element of service redesign submitted WG.</td><td>Chief Operating Officer</td><td>31st October 2021</td></tr>
</table></td></tr>
<tr><td colspan="2">Assurances
(How do we know if the things we are doing are having an impact?)
• New Urgent & Emergency Care Board to meet monthly</td><td colspan="2">Gaps in assurance
(What additional assurances should we seek?)
The need to deliver sustained service.</td></tr>
<tr><td colspan="4">Additional Comments
Risk transferred to Urgent & Emergency Care Board to task 11.05.2021.</td></tr>
</table>

Datix ID Number: 739 **Health & Care Standard: 2.4 Infection Prevention & Control & Decontamination**		**HBR Ref Number: 4** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Christine Williams, Interim Director of Nursing & Patient Experience **Assuring Committee:** Quality and Safety Committee	
Risk: Failure to achieve Welsh Government infection reduction goals, and a higher incidence of Tier 1 infections than average for NHS Wales. Risk of nosocomial transmission of infection.		**Date last reviewed:** Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 =12		**Rationale for current score:** Health Board incidence of key Tier 1 infections per 100,000 population above All Wales rates, indicating Health Board's population at greater risk of infection. High occupancy rates & frequent ward moves associated with increased risk of infection transmission. Lack of decant facilities compromises environment deep cleaning & decontamination, and planned preventative maintenance programmes. Varying levels of IPC responsibility embedded across all disciplines and groups. Incomplete systems for recording compliance with IPC training for all staff groups. Need improved systems to allow Delivery Groups to review compliance reports for cleanliness scores, ventilation validation/compliance, water safety, and decontamination.	
Level of Control = 40%			
Date added to the HB risk register January 2016		**Rationale for target score:** Adequately maintained & clean environments facilitate good IPC & minimise infection risks. Reduced occupancy & frequency of patient moves mitigate against infection transmission. Compliant ventilation systems and water safety minimise infection risks. Access to timely data on infections, training, antimicrobial stewardship, cleaning at ward/unit/practice level enables Service Groups to identify areas for focused Quality Improvement programmes, drive improvement, & effectively measure outcomes.	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Policies, procedures, protocols and guidelines supplement the National Infection Control Manual. • Seven-day infection prevention & control service provides advice and support HB staff. • Medical microbiology & infectious diseases team provides expertise and support. • Infection Prevention & Control related training provided programmes. • Surveillance of infections, with early identification of increased incidence, and instigation of controls. • Provision of cleaning service to meet National Standards of Cleanliness. • Engineering controls for water safety, ventilation, and decontamination.	Ensure maintained, clean and safe patient care environments, equipment/devices.	Facilities, Support Services & Service Group Directors	31st March 2022
	Review feasibility of increasing single room capacity.	SGD, Operational Services & Patient Flow	31st March 2022
	Reduce bed occupancy & patient moves.	SGD, Operational Services & Patient Flow	31st March 2022
	Use timely data to drive QI programmes.	HoN IPC, Digital Intelligence & SGD	31st March 2022

Assurances **(How do we know if the things we are doing are having an impact?)** • Clear Corporate and Service Group IPC Assurance Framework in place. • Ongoing monitoring of infection control rates, with weekly feedback corporately & to Service Groups.	**Gaps in assurance** **(What additional assurances should we seek?)** Review single room capacity. Poor condition of hospital estate requires investment. High activity limits access for planned preventative maintenance and necessary HTM validation/compliance checks. Seek improved Corporate and Service Group

• Infection Control Committee receives assurance reports, monitors infection rates, and identifies key actions to drive improvement. • Training compliance. • IPC, antimicrobial, decontamination and cleaning audit programmes. • Compliance and validation systems for water safety, ventilation systems and decontamination.	oversight of compliance with ventilation, water safety, decontamination & cleaning checks. Challenge to sustain cleaning workforce to achieve National Minimum Standards of Cleanliness. Review plans to reduce bed occupancy rates and patient multi-ward moves. Investment in ESR Self-service to provide data on IPC-related training compliance. Investment in digital intelligence systems to provide Board to Ward oversight of infection, antimicrobial, cleanliness, and training data.

Additional Comments

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

Clinical teams require renewed focus on:

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

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

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

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

Datix ID Number: 840 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 16** **Target Date: 31st March 2022**	**Current Risk Rating** **5 x 5 = 25**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Rab McEwan, 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:** Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 5 = 25 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 is obviously increasing 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 Risk to an acceptable level	
Date added to the HB risk register January 2013			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Post Covid 19 the focus is on minimising harm by ensuring that the patients with the high clinical priority are treatment first. The Health Board is following the Royal College of Surgeons guidance for all surgical procedures and patients on the waiting list have been categorised accordingly. • There is a bi-weekly Recovery meeting for assurance on the recovery of our elective programme. • The annual plan is based on specialty level capacity and demand models at specialty level that set out the baseline capacity and identify solutions to bridge the gap. Non-recurring pump – prime funding is available to support initial recovery measures. Monthly performance reviews track progress against delivery. • A focused intervention is in train support to the 10 specialties with the longest waits.	Develop and implement a full range of '**treat while you wait'** interventions at specialty level to minimise harm.	Service Directors	30th September 2021

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

23.04.2021 – Action closed - Development of a whole system model for NPTH as a centre for Orthopaedic and Spinal services, to include the scoping of ambulant trauma options and capital requirements - Strategic Outline Case submitted to WG awaiting outcome.

15.07.2021 - Theatre activity has now increased to over 85% pre-Covid levels and further sessions will be commissioned with support from an insourcing companies for staff. In addition outsourcing to independent hospital has commenced with the further provision of theatre sessions to be utilised by surgeons and anaesthetics from Sept 2021.

Datix ID Number: 1514 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**		**HBR Ref Number: 43** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 4 = 16**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Christine Williams, Interim Director of Nursing & Patient Experience **Assuring Committee:** Quality and Safety Committee	
Risk: If the Health Board is unable to complete timely completion of DoLS Authorisation then the Health Board will be in breach of legislation and claims may be received in this respect.		**Date last reviewed:** Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 3 x 2 = 6		**Rationale for current score:** Although processes have been planned or implemented, the impact is yet to be measured over a longer term, and the challenges of managing a large backlog of breaches.	
Level of Control = 40%		**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**
Supervisory body signatories in place BIA rota now implemented but limited uptake due to inability to release staff 2 x substantive BIA posts and additional admin post in place DoLS database updated and DoLS dashboard devised to enable more accurate monitoring and reporting Regular reporting to Mental Health and Legislative Committee (MHLC) (Nov 20) QIA completed for re-introduction of DoLS BIAs attending Ward as part of Reset and Recovery April 2021 QIA reviewed and service stood down in light of increased COVID incidence Oct 2020, service recommenced April 2021 Managing and supporting all referrals remotely New legislation changes expected in April 2022 which will require a different service model, business case to meet existing and future requirements will be progressed March 21.	Delivery of DOLS Action plan reviewed monthly (change coding above also)	Director Primary & Community	Monthly Review
	DoLS dashboard in place, monitoring applications and breaches via dedicated BIAs and Admin.	UND Primary and Community	Monthly Review
	Report to Mental Health and Legislative Committee advising cessation of DoLS assessors visiting wards to minimise spread of COVID. Expertise, advice and support available to wards via substantive BIAs	UND Primary and Community	Monthly Review
	Business case for revised service model. Report around changes from DoLS to LPS on track. Discussions with Corporate Nursing in progress to agree next steps	UND Primary and Community	31st July 2021

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

Additional Comments

All actions attributable to safeguarding completed and Internal Audit aware. DoLS and MCA Training provided to doctors and managers by Solicitor from Legal & Risk Services in January and February 2021. Progress in implementing / reinstating controls has been updated and future dates refreshed, including an extension to the target date for the business case for the revised service model.

Datix ID Number: 1563 **Health & Care Standard: Safe Care 5.1 Access**		**HBR Ref Number: 48** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 4 = 16**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee:** Performance and Finance Committee, Health Board **For Information**: Quality & Safety Committee	
Risk: Failure to sustain Child and Adolescent Mental Health Services		**Date last reviewed:** Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 4 x 2 = 8		**Rationale for current score:** Difficulties with sustainable staffing affecting performance.	
Level of Control = 50%		**Rationale for target score:** New service model and improved performance	
Date added to HB the risk register 31/05/2018			

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
• Performance Scrutiny - is undertaken at monthly commissioning meetings between Swansea Bay & Cwm Taf Morgannwg University Health Boards. Improved governance -ensures that issues and concerns are discussed by all interested parties including local authorities to support the network identify local solutions. • New Service Model agreed and being established by Summer 2019 which should give further stability to service.	**Action**	**Lead**	**Deadline**
	Additional investment expected - from Welsh Government	CAMHS network	30th September 2021
	Staffing of service being strengthened & supplemented by agency staff	CAMHS network	30th September 2021

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

Additional Comments

Cwm Taf achieved the non-urgent 28 day target for specialist CAMHS and primary CAMHS in 2020, with performance deteriorating due to staff being relocated to Ty Llidiard to support pandemic. Performance has improved in 2021 towards achievement of targets.
01.04.21 – Action update – Additional demands as a result of Covid expected and will need additional investment either from MH development monies or from direct Welsh Government funding.

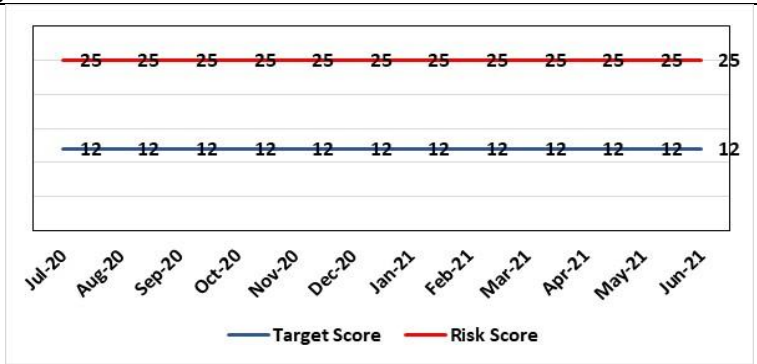
Datix ID Number: 922 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**		**HBR Ref Number: 49** **Target Date: 31st July 2021**	**Current Risk Rating** **4 x 3 = 12**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Richard Evans, Medical Director **Assuring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

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

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

Additional Comments

Reports now received from RCP on (1) initial casenote review (2) site visit in July 2019 (3) second cohort casenote review; action plans implemented in response
Improvement activity continues to have oversight of the Executive Medical Director at fortnightly Gold Command meetings. Regular briefings and reports are provided to key stakeholders including WHSSC, Welsh Government and Hywel Dda UHB.
WHSSC have de-escalated the TAVI service from its current Stage 3 to Stage 2, in recognition of significant improvement in the service.
Recommend reduction in risk score from 16 to 12.

Datix ID Number: 1761 **Health & Care Standard: Timely Care 5.1 Access**		**HBR Ref Number: 50** **Target Date: 31st March 2022**	**Current Risk Rating** **5 x 5 = 25**
Objective: Best Value Outcomes from High Quality Care		**Director Lead**: Rab McEwan, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee **For Information**: Quality & Safety Committee	
Risk: Access to Cancer Services – There is a risk of harm to patients with cancer due to delayed presentation, referral, diagnosis or treatment.		**Date last reviewed:** Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 5 x 5 = 25 Target: 4 x 3 = 12		**Rationale for current score:** There has been a reduction in presentation and referrals for cancer. The cancer backlog has increased and treatment times have got longer due to Covid-19 related reductions in surgical capacity.	
Level of Control = 70%		**Rationale for target score:** Target score reflects the challenge this area of work present the Board and where small numbers of patients impact on the potential to breach target	
Date added to the HB risk register April 2014			

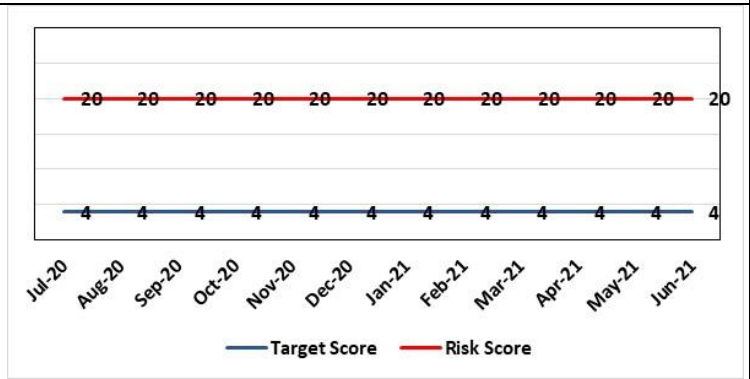
Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Tight management processes to manage each individual case on the unscheduled care (USC) Pathway. • Initiatives to protect surgical capacity to support USC pathways have been put in place in RGH and PCH to protect core activity. • Additional investment in MDT consideration, with 5 cancer trackers appointed in April 2021. • Prioritised pathway in place to fast track USC patients. • Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. • Weekly cancer performance meetings are held at both Singleton and Morriston Delivery Units. • The tumour sites of concern is in development. One of the areas is Lower GI where clinic capacity has increased by 4 times in April. • Endoscopy contract has been extended.	Phased and sustainable solution for the required uplift in endoscopy capacity that will be key to supporting both the Urgent Suspected Cancer backlog and future cancer diagnostic demand on Endoscopy Services. Harm review process to be implemented.	Service Group Manager	1st November 2021
	To explore the possibility of offering SBAR RT for high risk lung cancer patients in SWWCC.	Service Manager Surgical Services	30th September 2021

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

Additional Comments

The need to deliver sustained performance.
Whilst every effort is being made to maintain cancer treatment, surgical cancer activity in particular is being impacted upon by both the reduction in elective theatre capacity and availability in critical care beds due to the COVID-19 outbreak.

Covid screening is in place for all patients starting their 1st cycle of SACT and for all Lung RT patients. Action - Establishment of mobile unit to carry out PET/CT scans for Swansea and South West Wales patients. – Completed Action - Continue to expand our Surgery capacity to allow our complex cancer surgeries to deal with any backlog of patients – Completed 01.03.21: Action Completed – Introduce COVID testing for Oncology and Haematology 15.07.2021: The analysis of cases in top six cancer sites has been completed and a plan to resolve these was agreed in Management Board on 7th July 2021.

Datix ID Number: 146 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**		**CRR Ref Number: 58** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Excellent Patient Outcomes		**Director Lead**: Rab McEwan, Chief Operating Officer **Assuring Committee**: Quality and Safety Committee	
Risk: Failure to provide adequate clinic capacity for follow-up patients **Ophthalmology** results in a delay in treatment and potential risk of sight loss.		**Date last reviewed:** Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 5 = 20 Target: 4 x 1 = 4		**Rationale for current score:** Risk rating increased to 20 in July 2020 due to Covid-19 pandemic backlog has continued to grow.	
Level of Control = 40%		**Rationale for target score:** Mitigation plan via outsourcing will reduce the backlog to pre-covid levels.	
Date added to the HB risk register December 2014			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• All patients are categorised by condition in order to quantify issue. • Additional IS capacity secured to increase activity from July 2021, implementation plan under development. Welsh government funding secured for 2021.	An overall Regional Sustainability Plan to be delivered	Service Group Manager Surgical Specialties	31st March 2021 (Bi-weekly ongoing)

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
• Deputy COO in regular liaison with IS on contract progress.	Regular liaison with patients on extended waiting list/times and validation.

Additional Comments

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

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

Some clinically urgent Cataract operations have also been undertaken.

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

Datix ID Number: 1587 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 61** **Target Date: 31st March 2022**	**Current Risk Rating** **4 X 4 = 16**
Objective: Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morriston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies.		**Director Lead:** Rab McEwan, 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:** Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 4 x 4 = 16 Target: 4 x 2 = 8		**Rationale for current score:** There is no immediate access to crash team/ICU facilities in in Parkway Clinic – the client group are undergoing G/A/sedation. Paediatric GA/Sedation services provided under contract from Parkway Clinic, Swansea continue due to lack of capacity for these patients to be accommodated in Secondary Care	
Level of Control = 60%		**Rationale for target score:** Relocation of the paediatric GA service [provided by Parkway Clinic] to a hospital site being treated as a priority	
Date added to the HB risk register 4th July 2018			

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Consultant Anaesthetist present for every General Anaesthetic clinic. • Assurance Documentation supplied by Parkway Clinic including confirmation of arrangements in place with WAST and Morriston Hospital for transfer and treatment of patients • New care pathway implemented - no direct referrals to provider for GA. • Multi-drug sedation ceased from Sep 2018 in line with WHC 2018 009 • Revised SLA/Service Specification • HIW Inspection Visit Documentation provided to HB • All extended GA cases require approval from paediatric specialist prior to treatment	Transfer of services from Parkway.	Interim Head of Primary Care	31st May 2021

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

Additional Comments

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

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

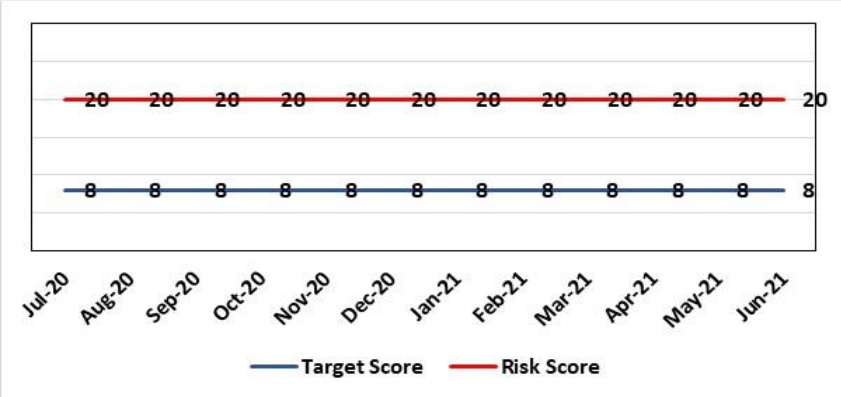
presented the Senior Leadership on 18 November 2020. Risk remains - for review in November following meeting with Senior Leadership on 18th November 2020. Task and Finish Group re-established first meeting on 1st December to progress transfer to Morriston Hospital by 31st May 2021. The limited theatre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

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

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

Additional Comments

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

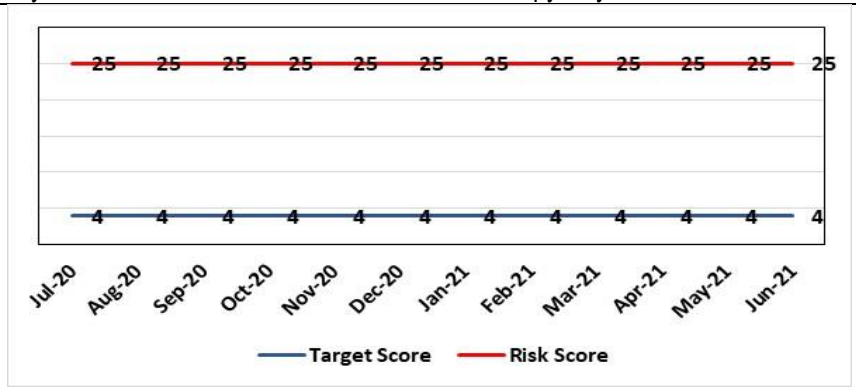
Datix ID Number: 329 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 65** **Target Date: 31st March 2022**	**Current Risk Rating** **4 X 5 = 20**
Objective: Digitally enabled Care		**Director Lead**: Christine Williams, Interim Director of Nursing and Patient Experience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

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

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

Additional Comments

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

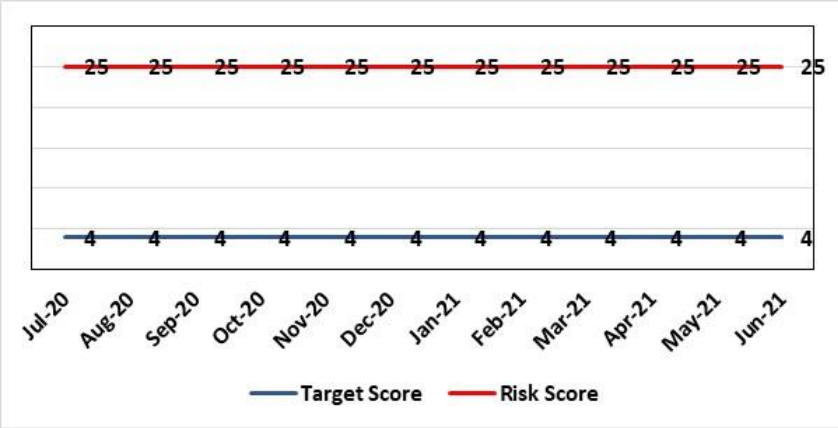
Datix ID Number: 1834 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 66** **Target Date: 31st March 2022**	**Current Risk Rating** **5 X 5 = 25**
Objective: Best values outcomes from high quality care		**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee:** Quality and Safety Committee	
Risk: Unacceptable delays in access to SACT treatment in Chemotherapy Day Unit		**Date last reviewed:** Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 5 = 25 Target: 2 x 2 = 4		**Rationale for current score:** Increased risk to 25 as waiting times starting to re-increase for Long chair regimes, discussed at oncology business meeting.	
Level of Control =			
Date added to the HB risk register 30/11/2019		**Rationale for target score:** Reduced delays in treatment will reduce risk of harm	

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Review of CDU by improvement science practitioner Increase nursing staff x 1 at risk, to ensure all nurses are working appropriately. Review of scheduling by staff to ensure all chairs used appropriately. Looking at options around expansion of home care delivery to free up chair capacity in CDU	Expansion of home care delivery and additional chair capacity - SACT group.	Associate Service Group Director-Cancer Division	Completed
	Business case endorsed by CEO for shift of capacity to home care to be considered by the Management Board.	Executive Medical Director	31st July 2021
	A second business case is being developed to propose relocation of CDU to a vacant ward area, which would increase chair capacity.	Executive Medical Director	31st Oct 2021

Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
Extra nurse in place reliant on agency. Senior team meeting to review findings of service review paper. Additional funding agreed to support increase in nurse establish to appropriately run the unit during their main opening hours	Capital & Revenue assumptions & resources for second business case for increasing chair capacity in 2022/23 to meet increased demand.

Additional Comments

Working with MSD/GE around potential partnership agreement to look at C&D mapping and best practice elsewhere. Covid has impact on demand for chairs due to need to socially distance. Loss of 3 Chairs (due to IPC controls for COVID) has impacted on capacity. Currently running alternate Saturdays in CDU to mitigate loss. Current wait time for SACT >21 days for the majority of patients. Business case for shift of capacity to home care to be considered by the Management Board in July. Second business case to increase chair capacity in development.

Datix ID Number: 89 **Health & Care Standard: 5.1 Timely Care**		**HBR Ref Number: 67** **Target Date: 31st March 2022**	**Current Risk Rating** **5 X 5 = 25**
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:** Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 5 = 25 Target: 2 x 2 = 4		**Rationale for current score:** Waiting times deteriorating for elective delays patients, particularly prostates discussed in Oncology business meeting.	
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.	Additional RT capacity plan	Service Manager Cancer Services	30th July 2021
	Explore the possibility of undertaking SABR treatment for lung cancer patients at SWWCC. Awaiting confirmation from WHSSC on whether they will commission SABR from SBUHB.	Executive Medical Director	31st Aug 2021

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

Additional Comments

27.04.21 Update - Risk remains 25 due to limited CT and LINAC capacity. Wait time for RT >28 days for the majority of patients.
Exploration of further opportunities to (a) increase hyperfractionation for other diseases (b) opportunity to outsource.
New CT due to be operational mid-May 2021. If on schedule and additional capacity (hyperfractionation and outsourcing) is confirmed, risk should reduce to 16.
16.06.21 Update – Started sourcing for prostate RT – 70 pts over 6 months. Hypo fractionation case for prostate with CEO for consideration.

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

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

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

Additional Comments

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

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

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

Datix ID Number: 1418 **Health & Care Standard: 5.1 Timely Access**		**HBR Ref Number: 69** **Target Date: 31st March 2022**	**Current Risk Rating** **5 X 4 = 20**
Objective: Best values outcomes from high quality care		**Director Lead**: Rab McEwan, Chief Operating Officer/Christine Williams, Interim Director of Nursing and Patient Experience **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:** Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 2 x 3 = 6 Current:5 x 4 = 20 Target: 2 x 3 = 6		**Rationale for current score:** Risk score increased to 20.	
Level of Control =			
Date added to the HB risk register 27/02/2020		**Rationale for target score:**	

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
Safeguarding Training for Staff, Joint protocol with Cwm Taf LHB [CAMHS] currently subject to review, Local SBUHB policy on providing care to young people in this environment. This includes the requirement for all such patients on admission to be subject to Level 3 Safe and Supportive observations.	Long Length of Stay reduction programme in Mental Health	Service Director	31st July 2021

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
Individual Rooms with ensuite facilities, joint working with CAMHS, monitoring of staff training, monitoring of admissions by the MH & LD DU Legislative Committee of the HB.	

Additional Comments

09.06.21 Update - The risk remains at 20 as while the provision is not ideal no other alternative has been identified. Welsh Government Mental Health Improvement monies have been bid for to extend CAMHS crisis and hospital liaison services to be 24/7, which if successful should enhance the support available in such circumstances.

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

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

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

Additional Comments

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

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

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

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

Additional Comments

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

Datix ID Number: 1832 **Health & Care Standard: : 3.1 Safe and Clinically Effective Care**		**HBR Ref Number: 80** **Target Date: 31st March 2022**	**Current Risk Rating** **4 x 5 = 20**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Rab McEwan, Chief Operating Officer **Assuring Committee:** Quality & Safety Committee	
Risk: There are high numbers of clinically optimised patients who are unable to be discharged from a medicine bed due to various issues/delays. The number is now returning to pre-COVID level of +50.		**Date last reviewed:** Management Board – July 2021	
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 2 = 8 **Level of Control** = 25% **Date added to the HB risk register** May 2021		**Rationale for current score:** • Sustained levels of clinically optimised patients leading to overcrowding within ED, use of inappropriate or overuse of decant capacity in ED and delays in accessing medical bed capacity, clearly emerged as themes. • Constraints in relation to all patient flows out of Morriston to a more appropriate clinical setting, identified and included in an expanded risk. **Rationale for target score:**	
Controls (What are we currently doing about the risk?)		**Mitigating actions (What more should we do?)**	
• Clinically optimised numbers are monitored and reviewed weekly by the MDU. Delays are reported and escalated to try to ensure timely progress along a patient's pathway. • Review on a patient by patient basis – with explicit action agreed in order to progress transfer to appropriate clinical setting. • Critical constricts in relation to access/time delays for social workers and assessment for package of care and social placement – lead times in excess of 5 weeks. • Patient COVID-19 status has added an additional level of complexity to decision making.		**Action** To be agreed	**Lead** / **Deadline**
Assurances **(How do we know if the things we are doing are having an impact?)** •		**Gaps in assurance** **(What additional assurances should we seek?)** .	
Additional Comments			

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