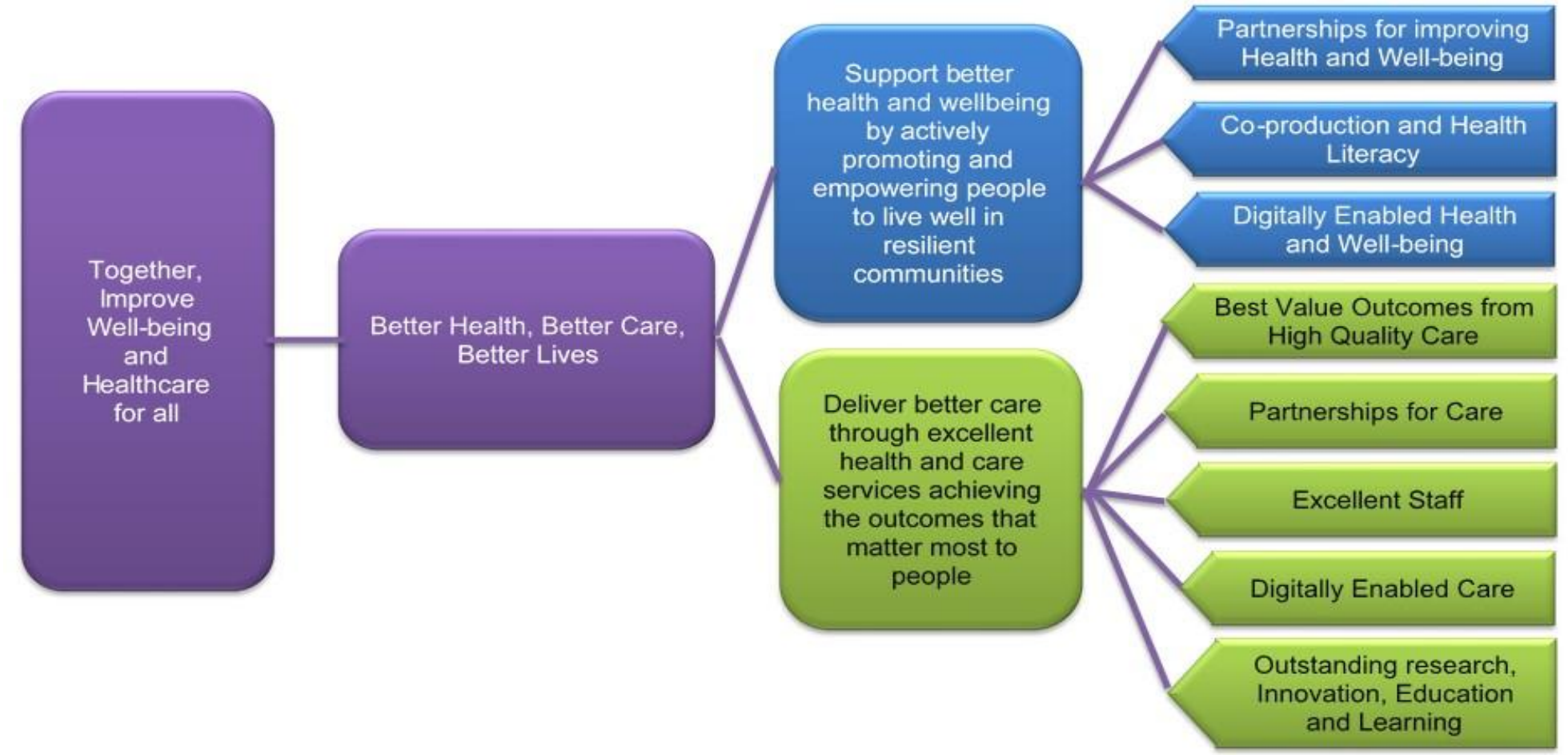
HEALTH BOARD RISK REGISTER
March 2021

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

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



HEALTH BOARD RISK REGISTER
DASHBOARD OF ASSESSED RISKS – March 2021

Impact/Consequences						
	5			**53:** Compliance with Welsh Language Standards **54:** No Deal Brexit	**39:** IMTP Statutory Responsibility **41:** Fire Safety Regulation Compliance Increased from 12 to 20 **60:** Cyber Security **68:** Pandemic Framework Reduced from 25 to 20 **70:** Data Centre outages	**16:** Access to Planned Care **50:** Access to Cancer Services **64:** H&S Infrastructure Increased from 20 to 25 **66:** Access to Cancer Services - SACT **67:** Access to Cancer Services - Radiotherapy
	4			**13:** Environment of Health Board Premises **36:** Electronic Patient Record **52**: Engagement & Impact Assessment Requirements	**01:** Access to Unscheduled Care Service **27:** Sustainable Clinical Services for Digital Transformation **37:** Operational and strategic decisions are not data informed **43:** DOLS Authorisation and Compliance with Legislation **48:** Child & Adolescence Mental Health Services **49:** TAVI Service **57:** Non-compliance with Home Office Controlled Drug Licensing requirements **61:** Paediatric Dental GA Service – Parkway **69:** Adolescents being admitted to Adult MH wards	**03:** Workforce Recruitment of Medical and Dental Staff **04:** Infection Control **15:** Population Health Improvement **51:** Compliance with Nurse Staffing Levels (Wales) Act 2016 **58:** Ophthalmology Clinic Capacity **63:** Screening for Fetal Growth Assessment in line with Gap-Grow (G&G) **65:** CTG Monitoring in Labour Wards **73:** There is potential for a residual cost base increase post COVID-19 as a result of changes to service delivery models and ways of working.
	3					**72:** Impact of COVID-19 pandemic on the Health Board Capital Resource Limit and Capital Plan for 2020-21.
	2					
	1	**62:** Sustainable Corporate Services COVID-19 across Wales remains fluid and uncertain. Reduced from 20 to 1 Risk closed				
C X L		**1**	**2**	**3**	**4**	**5**
		Likelihood				

Risk Register Dashboard

Strategic Objective	Risk Reference	Description of risk identified	Initial Score	Current Score	Trend	Controls	Last Reviewed	Scrutiny Committee
Best Value Outcomes from High Quality Care	1 (738)	**Access to Unscheduled Care Service** Failure to comply with Tier 1 target for Unscheduled Care could impact on patient and family experience of care.	20	16	→	↓	March 2021	Performance and Finance Committee
	4 (739)	**Infection Control** Failure to achieve infection control targets set by Welsh Government could impact on patient and family experience of care.	20	20	→	→	March 2021	Quality and Safety Committee
	13 (841)	**Environment of HB Premises** Failure to meet statutory health and safety requirements.	16	12	→	↓	March 2021	Health and Safety Committee
	16 (840)	**Access to Planned Care** Failure to achieve compliance with waiting times, there is a risk that patients may come to harm. Also, financial risk not achieving targets.	16	25	→	↑	March 2021	Performance and Finance Committee
	37 (1217)	**Information Led Decisions** Operational and strategic decisions are not data informed.	12	16	→	↑	March 2021	Audit Committee
	39 (1297)	**Approved IMTP – Statutory Compliance** If the Health Board does not have an approved IMTP signed off by Welsh Government, primarily due to the inability to align performance and financial plans it will remain in escalation status, currently "targeted intervention".	16	20	→	↑	March 2021	Performance and Finance Committee

41 (1567)	**Fire Safety Compliance** Fire Safety notice received from the Fire Authority – MH&LD Unit. Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance.re safety regulations. **Increased from 12 to 20**	15	20	→	↑	March 2021	Health and Safety Committee
43 (1514)	**DoLS** If the Health Board is unable to complete timely completion of DoLS Authorisation then the Health Board will be in breach of legislation and claims may be received in this respect.	16	16	→	→	March 2021	Quality and Safety Committee
48 (1563)	**CAMHS** Failure to sustain Child and Adolescent Mental Health Services (CAHMS).	16	16	→	→	March 2021	Performance and Finance Committee
49 (922)	**Trans-catheter Aortic Valve Implementation (TAVI)** Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI)	25	16	→	↓	March 2021	Quality and Safety Committee
50 (1761)	**Access to Cancer Services** Failure to sustain services as currently configured to meet cancer targets could impact on patient and family experience of care.	20	25	→	↑	March 2021	Performance and Finance Committee
57 (1799)	**Controlled Drugs** Non-compliance with Home Office Controlled Drug Licensing requirements.	20	16	→	↓	March 2021	Audit Committee

	63 (1605)	**Screening for Fetal Growth Assessment in line with Gap-Grow** Due to the scanning capacity there are significant challenges in achieving this standard.	12	20	→	↑	March 2021	Quality and Safety Committee
	64 (2159)	**Health and Safety Infrastructure** Insufficient resource and capacity of the health, safety and fire function to maintain legislative and regulatory compliance. **Increased from 20 to 25**	20	25	→	↑	March 2021	Health and Safety Committee
	66 (1834)	**Access to Cancer Services** Delays in access to SACT treatment in Chemotherapy Day Unit	25	25	→	→	March 2021	Quality and Safety Committee
	67 (89)	**Risk target breaches – Radiotherapy** Clinical risk – Target breeches of radical radiotherapy treatment	16	25	→	↑	March 2021	Quality and Safety Committee
	69 (1418)	**Safeguarding** Adolescents being admitted to adult MH wards	20	16	→	↓	March 2021	Quality & Safety Committee
	72 (2449)	**Finance** Impact of COVID-19 pandemic on the Health Board Capital Resource Limit and Capital Plan for 2020-21	20	15	→	↓	March 2021	Performance and Finance Committee
	73 (2450)	**Finance** There is a potential for a residual cost base increase post COVID-19 as a result of changes to service delivery models and ways of working.	20	20	→	→	March 2021	Performance and Finance Committee
Excellent Staff	3 (843)	**Workforce Recruitment** Failure to recruit medical & dental staff	20	20	→	→	March 2021	Workforce and OD Committee

	51 (1759)	**Nurse Staffing (Wales) Act** Risk of Non Compliance with the Nurse Staffing (Wales) Act	16	20	↑	↓	March 2021	Workforce and OD Committee
	62 (2023) **Reduced from 20 to 1** **Risk Closed**	**Sustainable Corporate Services** Health Board's Annual Plan and organisational strategy, and with the skills, capability, behaviours and tools to successfully deliver in support of the whole organisation, and to do so in a way which respects and promotes the health and well-being of our staff and their work-life balance.	20	1	→	↓	March 2021	Workforce and OD Committee
Digitally Enabled Care	27 (1035)	**Sustained Clinical Services** Inability to deliver sustainable clinical services due to lack of digital transformation.	16	16	→	→	March 2021	Audit Committee
	36 (1043)	**Storage of Paper Records** Failure to provide adequate storage facilities for paper records then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if there is poor records management in some wards.	20	12	→	↓	March 2021	Audit Committee
	60 (2003)	**Cyber Security – High level risk** The level of cyber security incidents is at an unprecedented level and health is a known target.	20	20	→	→	March 2021	Audit Committee
	65 (329)	**CTG Monitoring on Labour Wards** Risk associated with misinterpreting abnormal CTG readings in delivery rooms.	16	20	→	↑	March 2021	Quality & Safety Committee

	70 (2245)	**National Data Centre Outages** The failure of national systems causes severe disruption across NHS Wales, affecting Primary and secondary care services.	20	20	➔	➔	March 2021	Audit Committee
Partnerships for Improving Health and Wellbeing	15 (737)	**Population Health Targets** Failure to achieve population health improvement targets leading to an increase in preventable disease amongst the population resulting in increased morbidity impacting on operational and financial pressures.	15	20	➔	↑	March 2021	Quality and Safety Committee
	58 (146)	**Ophthalmology - Excellent Patient Outcomes** There is a failure to provide adequate clinic capacity to support follow-up patients within the Ophthalmology specialty.	12	20	➔	↑	March 2021	Quality and Safety Committee
	61 (1587)	**Paediatric Dental GA Service – Parkway** Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morriston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies.	15	16	➔	↑	March 2021	Quality and Safety Committee
	68 (2299)	**Pandemic Framework** Risk of declared pandemic due to Coronavirus Infectious Disease outbreak 2020. **Reduced from 25 to 20**	20	20	➔	↓	March 2021	Quality and Safety Committee

Partnerships for Care	52 (1763)	**Statutory Compliance** The Health Board does not have sufficient resource in place to undertake engagement & impact assess in line with Statutory Duties	16	12	➔	🡻	March 2021	Performance & Finance Committee
	53 (1762)	**Welsh Language Standards** Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.	15	15	➔	➔	March 2021	Health Board (Welsh Language Group)
	54 (1724)	**Brexit** Failure to maintain services as a result of the potential no deal Brexit	20	15	➔	🡻	March 2021	Health Board (Emergency Preparedness Resilience and Response Group)

Risk Schedules

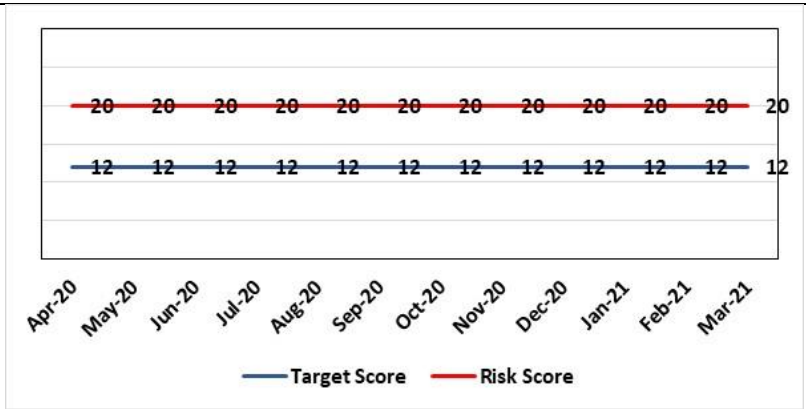
Datix ID Number: 738 **Health & Care Standard: 5.1 Timely Care**	**HBR Ref Number: 1** **Target Date: 31st March 2020**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee
Risk: If we fail to comply with Tier 1 target – **Access to Unscheduled Care** then this will have an impact on patient and family experience. Challenges with capacity /staffing across the Health and Social care sectors.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 4 = 16 Target: 3 x 4 =12	**Rationale for current score:** Due to current measures related to COVID 19 including the cancellation of all non-urgent activity, Emergency Department and MIU attendance have reduced by nearly 50%, red call performance is at 65% and 4hr handover for the last 3 weeks has been in excess of 75%. Both Morriston and Singleton have predominantly been at risk level 1 for the past 2 months. It is recognised that this is not likely to be maintained as we go into the winter months and therefore remains a high risk.
Level of Control = 50%	**Rationale for target score:**
Date added to the HB risk register 26.01.16	The service delivery units have been implementing models of care that reflect National priorities and there is evidence that these are starting to impact positively on patient flow, length of stay and demand management. Workforce capacity issues continue to be challenging in some key specialty areas.

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• Programme management arrangements are in place to improve Unscheduled Care performance. • Daily Health Board wide conference calls/ escalation process in place. • Regular reporting to Executive Team, Executive Board and Health Board/Quality and Safety Committee. • Increased reporting as a result of escalation to targeted intervention status. • Targeted unscheduled care investment to support changes to front door service models/ workforce redesign/ patient flow. • Weekly unscheduled care meeting implemented, led by COO and attended by Service Directors • Development of new Acute Medical Services Model focused on increasing the provision of ambulatory care. • Development of a Phone First for ED model in conjunction with 111 to reduce demand.	Implementation of Phone First for ED as one the initiatives set out in the National Unscheduled Care Programme – six goals.	Chief Operating Officer	31st March 2021
	Phased implementation of the Acute Medical Services Redesign. Business case for ambulatory care element of service redesign submitted WG.	Chief Operating Officer	31st March 2021

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

Current Risk Rating 4 x 4 = 16	Additional Comments Due to current measures related to COVID 19 including the cancelled all non-urgent activity, Emergency Department and MIU attendance have reduced by nearly 50%, red call performance is at 65% and 4hr handover for the last 3 weeks has been in excess of 75%. Both Morriston and Singleton have been risk level 1 for the past 2 weeks. It is recognised that this is not likely to be maintained and therefore remains a high risk. 23.4.20 Action closed 31.01.21 - Group established to focus on a reduction in the number of Medically Fit for Discharge (MFFD) patients with Local Authority. Action closed 7.1.21 - Mobile unit to allowing cohorting of patients at entrance of Morriston ED to release ambulance crews. Mobile due to be delivered end of November and in place early December.

Datix ID Number: 843 **Health & Care Standard: Staff & Resources 7.1 Workforce**	**HBR Ref Number: 3** **Target Date: 31st March 2021**
Objective: Excellent Staff	**Director Lead:** Kathryn Jones, Interim Director of Workforce and Operational Development **Assuring Committee:** Workforce and OD Committee
Risk: Workforce recruitment of medical & dental staff	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 5 =20 Target: 4 x 3 = 12	**Rationale for current score:** National shortages of numbers in some areas can lead to: • Unable to recruit sufficient numbers of trainees to fulfil rotas on all sites • Unable to attract non training grades to complete rotas • Unable to fill Consultant grade posts in some specialties with adverse effects on patient safety and industrial relations. Unable to recruit sufficient registered nursing staff.
Level of Control = 70%	**Rationale for target score:**
Date added to the HB risk register April 2012	This remains a challenge and is also a national problem.



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

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

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Medical training initiatives pursued in a number of specialties to ease junior doctor recruitment	Interim Director W&OD.	31st March 2021
The Medical Workforce Board continues to monitor recruitment and junior doctor's rotas.	Interim Director W&OD.	31st March 2021
Continue to recruit internationally.	Interim Director W&OD.	31st March 2021

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

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

Gaps in assurance
(What additional assurances should we seek?)
Locum cover
Adequate supply of doctors who can work in this country
Ability to flexibly deploy doctors in training.

Current Risk Rating
4 x 5 = 20

Additional Comments
Risk covers all hospitals and multiple specialties. Participated in BAPIO in November, appointed 25 doctors. Working with Medacs to replace long term locums e.g. in Haematology and Histopathology. Developing an Invest to Save Bid for international overseas recruitment for nursing to upscale the activity for 20/21. Recruitment remains a challenge but is also a national problem. The problem persists but the restriction on

	overseas travel is not the same as in the first phase. We are still recruiting staff from overseas but have had to provide hotel accommodation for them to quarantine for 14 days before they can commence work. Supply issues to the COVID areas however have been mitigated by using doctors from other specialties where demand is currently low and we are looking to over establish locum posts in medicine, ITU and Anaesthetics. Some issues with the lack of NHS experience for many locums which means we have had to consider some off contract agencies.

Datix ID Number: 739 **Health & Care Standard: 2.4 Infection Prevention & Control & Decontamination**	**HBR Ref Number: 4** **Target Date: 31st March 2021**
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: Failure to achieve **infection control** targets set by Welsh Government, increase risk to patients and increased costs associated with length of stays.	**Date last reviewed:** March 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:** Currently under targeted intervention for rates of infection, achievement of targets are variable with monthly fluctuations.
Level of Control = 40%	**Rationale for target score:**
Date added to the HB risk register January 2016	Once the infection control team is fully recruited to, ICNet is functioning to its full capability the infection control team will be able to support the clinical areas more and drive service improvements. In addition, a negative pressure isolation facility is being built into the new emergency department at Morriston hospital providing another facility to appropriately manage patients at the front door. Review and implementation of a robust clean of patient rooms following an infection will reduce the risk of cross infection.

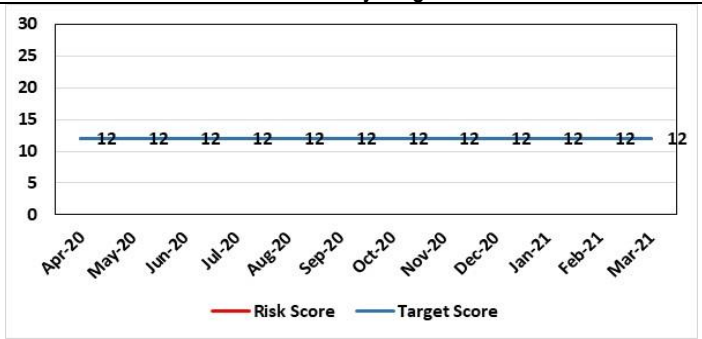
Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• Regular monitoring on infection rates • Policies, procedures and guidelines in place • Regular reporting through internal processes • ICNet information management system for infections is in place • Infection control team support the clinical teams for issues relating to infection control • A permanent infection control doctor has been recruited • Recruitment is ongoing. Decontamination lead & assistant director of nursing in infection control appointed. • Bug stop quality improvement programme • Incident reporting	Ongoing infection control team involvement in site level estates projects to ensure appropriate isolation facilities are factored in from the outset	Senior Infection Control Matron	31st March 2021

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

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

	From an All Wales perspective, not yet achieving NHS Wales Infection Reduction Expectations. 26.05.20 - Incidence of C. difficile infection has been increasing over the last 7 months from an average of 11 cases per month to an average of 13 cases per month. The Welsh Government target is <8 cases per month. There has been an improvement in E. coli and Klebsiella bacteraemia cases, but these are still above the Welsh Government targets. 09.07.20 - incidence of C. difficile has increase further to an average of 16 cases per month in the first quarter (this is double the Welsh Government monthly expectation). The incidence of Staph. aureus bacteraemia also is higher than Welsh Government expectations, however, there continues to be reductions in E. coli and Klebsiella bacteraemia cases. Public Health Wales will make C. difficle genomic results available to the Health Board (current anticipated date Sept. 2020). This may facilitate a better understanding of the epidemiology of this infection within the Health Board. 18.08.20 - recruitment now complete. All staff now in post and on induction. 3.11.20 - In the Written Statement: Escalation and Intervention Arrangements on 7th October 2020, Minister for Health & Social Services, VG, announced that there has been a clearer approach to performance and an improvement in some of the measures under consideration, including infections. As a consequence of improved performance in a number of the TI areas, SBUHB has been de-escalated to 'enhanced monitoring'. It is challenging to attain improvements in reduction of targeted infections. However, there has been year-on-year improvement in the following key infections: Staph. aureus, E. coli, Klebsiella, and Pseudomonas aeruginosa bacteraemia cases. Of concern, there has been an approximate 75% year-on-year increase in C. difficle cases. COVID has led to increased compliance with training for PPE. Increased ICN presence clinically supporting DUs with the increase in resource and a full 7 day ICN service. 29/01/21 - the rate of increase in C. difficile cases has slowed, from a 75% increase year-on-year in November, to an approximate 20% increase in January 2021. There has been an improvement in Staph. aureus, E-coli and Pseudomonas aeruginosa bacteraemia, but a worsening of position in relation to Klebsiella spp. bacteraemia. Increased clinical presence of ICNs on wards, the extension of the service to include Primary Care and a 7 day service continues, DD 26.02.2021 - With Covid nosocomial transmissions reducing, a greater emphasis on the Tier 1 targets will be made. Some in depth scrutiny working with microbiology to commence for Klebsiella. LH

Datix ID Number: 841 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**	**HBR Ref Number: 13** **Target Date: 31st March 2021**
Objective: Best Value Outcomes	**Director Lead:** Chris White, Chief Operating Officer/Sian Harrop-Griffiths, Director of Strategy **Assuring Committee**: Health and Safety Committee
Risk: Health & Safety Compliance – Environment of Premises. Risk relates to compliance in terms of appropriate accommodation in line with Health and Safety Regulations.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 =12 Target: 4 x 3 = 12	**Rationale for current score:** HSE issued ten improvement notices. Lack of accommodation to meet statutory/health and safety requirements could have an adverse impact on citizens, staff, financial and operational performance.
Level of Control = 90%	**Rationale for target score:**
Date added to the HB risk register April 2012	Risk assessments of premises.



Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
• Key areas where performance linked to health & safety/fire issues flagged through Health & Safety and Quality & Safety Committees and actions agreed to mitigate impacts. • Issues raised through site meetings held regarding service changes for all 4 acute hospital sites. • Primary Care developments required.	**Action**	**Lead**	**Deadline**
	Develop a strategy to improve primary & community services estate.	Service Group Director P&C	31st March 2021
	Develop BJC's to improve the infrastructure of the 3 acute hospital sites (not including NPTH).	Assistant Director - Estates	31st March 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?)
The Cabinet Secretary for Health & Social Services set the initial pipeline of health and care centres to be delivered by 2020-21 and the following projects identified for the Health Board • Penclawdd Health Centre - refurbishment/redevelopment proposal (£0.800m at 16-17 prices) – now completed • Murton Community Clinic – refurbishment/redevelopment proposal (£0.400m at 16-17 prices) – now completed • Swansea Wellness Centre – new build development (£10.000m at 16-17 prices) SOC submitted to WG. FBC under development for submission June 2021. Cost projection significantly higher that stated here but WG aware and are members of the Project Board. • BJC Environmental Infrastructure replacement of Estates AHU plant and Morriston electrical Sub Station 6 all designed up and tendered through Design for Life procurement process.	

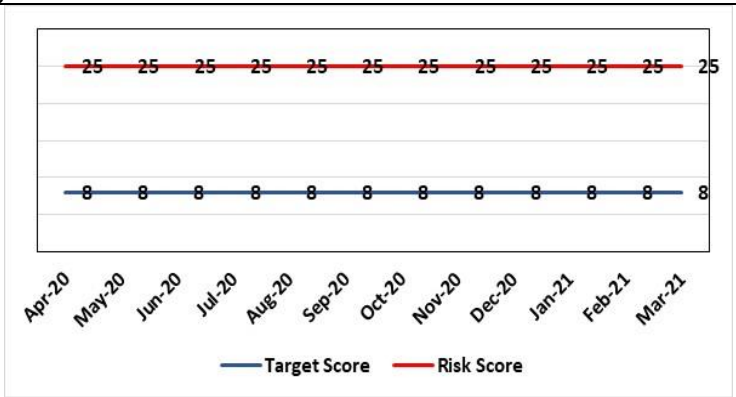
Current Risk Rating 4 x 3 = 12	Additional Comments Planned interviews to take on board a SCP 1ST / 2ND Week of November 20. 3 months to undertake verification of our design by the SCP then submit to the WG for approval and funding

Datix ID Number: 737 **Health & Care Standard: Staying Healthy 1.1 Health Promotion**		**HBR Ref Number: 15** **Target Date: 31st March 2021**
Objective: Partnerships for Improving Health and Wellbeing		**Director Lead:** Keith Reid, Director of Public Health **Assuring Committee:** Quality and Safety Committee
Risk: If we fail to achieve **population health improvement targets** leading to an increase in preventable disease amongst the population resulting in increased morbidity impacting on operational and financial pressures.		**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 **Current: 5 x 4 = 20** Target: 3 x 3 = 9		**Rationale for current score:** If we fail to prevent a serious outbreak by effectively achieving herd immunity in the population through immunisation and vaccination programmes, or to effectively manage an outbreak by disrupting the spread, this will result in serious harm to individual, maybe death, and pressure on health services, disruption to flow, business continuity and reputational damage to the health board and public health team.
Level of Control = 60%		**Rationale for target score:**
Date added to the HB risk register 26.01.16		Manage preventable disease.

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• Public Health Strategy and work plan • Internal Audit Management Plan • Strategic Immunisation Group • MMR Task & Finish group • Childhood Imms Group; • Primary Care Influenza Group • Support from PHW Health Protection	Deliver immunisation awareness training for pre-school settings to promote key vaccination messages	Consultant Public Health Medicine	31st March 2021
	Contribute to the implementation of recommendations made in the "MMR Immunisation: process mapping of the child's journey" report.	Consultant Public Health Medicine	31st March 2021
	Continue to promote the benefits of immunisation through Healthy Schools and Pre-Schools e-bulletins	Consultant Public Health Medicine	31st March 2021

Assurances **(How do we know if the things we are doing are having an impact?)** • School imms target is over 70%, we are the 2nd highest in Wales. All other childhood imms targets below trajectory.	**Gaps in assurance** **(What additional assurances should we seek?)** The need to deliver sustained service.
Current Risk Rating **5 x 4 = 20**	**Additional Comments** Scrutiny by internal audit, raise awareness, encourage uptake, target population. Co-production work with the public. The impact of COVID-19 has been to disrupt usual population health activities. This

	disruption is ongoing. Control measures have had a mixed impact on behaviours associated with health eg ability to undertake exercise has been negatively affected. There will be a legacy of adverse psychological effects which will require community-based approaches to mitigate. This is likely to require a sustained response over several years. COVID-19 has had a disproportionate impact on those with existing poor health or underlying risk factors and also impacted more severely on those areas of high deprivation. Overall inequities in health are likely to increase as a consequence. The risk rating probably needs to be increased to 20 – likelihood is probably 5 and impact 4 – it will require the development of a mitigation strategy in response.

Datix ID Number: 840 **Health & Care Standard: 5.1 Timely Care**	**HBR Ref Number: 16** **Target Date: 31st March 2021**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee
Risk: Access and Planned Care. If we fail to achieve compliance **with waiting times** there is a risk that patients may come to harm. Further, the health board will face financial risk with Welsh Government if the agreed target is not met.	**Date last reviewed:** March 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:** The cancellation of all non-urgent activity 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 volumes. 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:**
Date added to the HB risk register January 2013		There is scope to reduce the likelihood score to reduce the Risk to an acceptable level

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Post Covid 19 - there is no requirement to meet RTT target in 2020/21 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. • A risk assessment based system for outpatient is awaited. • Monthly planned care supported delivery board in place, chaired by CEO. Monthly performance reviews track progress against delivery. Flexible resource identified to manage in-year waiting times risks. Weekly executive support meetings in place in high risk areas. Outsourcing of capacity is being considered for some specialist services. • Weekly calls with Units to support delivery and monitor performance. • Monthly performance and finance meetings between executive team and service directors. • Modest investment package agreed to support additional activity to increase capacity.	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.	Service Directors	16th June 2021
Assurances **(How do we know if the things we are doing are having an impact?)** • Weekly meetings in place to ensure patients with greatest clinical need are treated first.	**Gaps in assurance** **(What additional assurances should we seek?)**		
Current Risk Rating **5 x 5 = 25**	**Additional Comments** The cancellation of all non-urgent activity due to COVID-19 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 volumes. The significant reduction in theatre activity is obviously		

	increasing the number of patients now breaching 36 and 52 week thresholds. Action completed - Patient Prioritisation and Management 1/12/2020. Action closed - Develop sustainability plans for specialties through the emerging Clinical Services Plan. Speciality sustainability plans will be reflected in the Annual Plan 21/22, as part of the Planned care work programme. 19.03.21: Action closed - Scope and undertake an option appraisal process for a PACU model at Singleton and NPTH to support enhanced care complexity - PACU in place for surgical cases in Singleton and no requirement at this point in time for PACU at NPTH.

Datix ID Number: 1035 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**HBR Ref Number: 27** **Target Date: 31st March 2021**
Objective: Digitally enabled care	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Audit Committee
Risk: Digital Transformation Inability to deliver sustainable clinical services due to lack of Digital Transformation. There are insufficient resources to: • invest in the delivery of the ABMU Digital strategy, • support the growth in utilisation of existing and new digital solutions • replace existing technology infrastructure and the end of its useful life.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 4 = 16 Target: 5 x 2 =10 **Level of Control** = 50% **Date added to the HB risk register** 2012	
	Rationale for current score: C – Reliance on digital ways of working has increased. Loss of IT service has a greater impact on ability to provide clinical care. Lack of investment in new digital solutions to make services more effective will mean clinical service provision will become unsustainable. L- The Digital response to COVID has ensured that our people and essential services have continued to be provided during the pandemic. This response has meant the issuing of over 2,000 mobile devices and the escalation of a number of digital solutions that had previously flagged as Tier 2 in the IMTP planning process such as MS365 and attend anywhere. As a result of the support arrangements required to maintain sustainable digital services needs to be increased eg. Volume of calls a month to the IT helpdesk have increased by approximately 50%. CTM have also started the process to start ceasing parts of the Digital Services SLA. AS flagged during the disaggregation process Digital services for SBUHB would not be sustainable if 28% of resources were transferred to CTM due to economies of scale etc.
	Rationale for target score: C – Of failure will increase as the reliance and proliferation of the use of digital solutions increases. L – Investment will mean the support mechanisms, rate of failure and ability to deliver solutions that meet the needs of users will improve sustainable digital services. There will however always be an inherent risk of failure of IT solutions.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• Digital strategy has been approved by the Health Board • Capital priority group for the HB considers digital risks for replacement technology which is fed into the annual discretionary capital plan • IBG process allows for investment requests in projects to be submitted to the HB for	Ensure business cases requiring digital services include appropriate implementation and support costs. (Timescales amended as this is an ongoing action)	Assistant Informatics Business Manager	31st March 2022

consideration and provides scrutiny to ensure Digital resources required are considered for all projects • Informatics prioritisation process has been introduced to ensure requests for digital solutions are considered in terms of alignment to the strategy objective, technical solutions and financial implications • HB has invested £900k recurrently in the project staffing resources to facilitate the delivery of the Informatics Strategic Outline Plan • Working closely with WG to identify funding streams to support investment in digital including the approval of the Informatics Strategic Outline Plan • Digital services revenue have been submitted as part of the 21/22 annual plan process	Work with finance and the Health Board leadership team to identify additional revenue streams (Timescales amended as this is an ongoing action)	Assistant Informatics Business Manager	31st March 2022
Assurances **(How do we know if the things we are doing are having an impact?)** • Progress has been made in securing capital investment both internally and externally for new developments • IBG and CPG processes are in place and ensuring highest technology replacement risks are being addressed • There are 22 active projects in place and being delivered • Digital enablement is a cornerstone of the organization strategy. Two of the strategies, 8 areas, of focus are digital enablement. • WG have announced (Oct 19) £50m investment into Digital Transformation in 19/20. The HB are awaiting final confirmation of its allocation which is indicated to be £1,390k capital and £1,060k revenue. Whilst this is under what was requested it will be utilised against priority requirements for the HB.	**Gaps in assurance** **(What additional assurances should we seek?)** Lack of certainty over future funding streams makes planning and implementation difficult/less effective Revenue model for support unclear given the financial pressures of the organisation.		
Current Risk Rating **4 x 4 = 16**	**Additional Comments** This is further impacted by the boundary change which could have significant impact on resources and capability to deliver digital services going forward. Internal processes have been established to ensure that all informatics costs are included in Business cases developed by Informatics. Representation from Informatics at IBG and the Scrutiny Panel. Strategic Outline Plan based on the three year IMTP will be presented to the Health Board on the 30th January 2020. Three year plan to be developed in line with the Health boards IMTP Planning process The Strategic Outline Plan will be based on the Three Year Plan which will be developed in line with the Health Boards IMTP Planning process. The updated Strategy digital overview, priorities and maturity assessment was presented to January 2020 Health Board. –The Action has therefore been closed off 31/1/2020 within Datix and progress reported through to Audit Committee. 17.03.21: Action completed – Ensure informatics prioritisation process is embedded into the ways of working so that resource implications of digital solutions are transparent and agreed at outset of projects.		

	The Digital Leadership Group members were asked to prioritise their top three digital projects for 2021/22. Revenue consequences of new initiatives have been planned at approval stage for HEPMA & Signal and included in the Annual Plan revenue requirements. Submitted two bids for HEPMA & TOMS for funding 2021/22.

Datix ID Number: 1043 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**		**HBR Ref Number: 36** **Target Date: 31st March 2021**
Objective: Digitally enabled care		**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Audit Committee
Risk: Paper Record Storage: Lack of a single electronic record means there is greater reliance on the provision of the paper record. If we fail to provide adequate storage facilities for paper records then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced if there is poor records management in some wards.		**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 3= 12 Target: 3 x 3 =9		**Rationale for current score:** C - Inability to find records for patients could delay care/increase length of stay over 15 days. Could also mean patients receive incorrect treatment L - we know this happens from incidents raised
Level of Control = 70%		**Rationale for target score:**
Date added to the HB risk register June 2016		C - Inability to find records for patients could delay care/increase length of stay over 15 days. Could also mean patients receive incorrect treatment L – RFID and digitalisation of the health record will reduce the constraints of the current filing methodology and reduce the volume of paper being added to the record. Further digitalisation of the paper record will reduce the reliance of clinicians on the paper record.

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

- Outpatient continuation Sheet has been rolled out and will form part of the plan to move Outpatients to paper light.
- MTED has been rolled out across Morriston and commenced in NPT
- Nursing Documentation (WNCR) piloted successfully in NPT
- Temporary retention and destruction plans are in place.
- Alternative storage arrangements are being identified and utilised where appropriate.
- Ward protocols and audits have been rolled out across sites.
- RFID project now approved. Implementation process has started and will change the way records are filed and release storage capacity.
- Roll out plan for WCP is in place and being enacted as outlined in the SOP
- All records must be documented and risk assessed in the Information Asset Register (IAR)
- Develop a case for improved storage solution both for paper and digitally.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Develop case for improved storage solution for both paper and digitally.	Head of Health Records & Clinical Coding	30th September 2021
Commence implementation of WNCR at NPTH	Interim Chief Information Officer	19th April 2021
Complete convergence with WCP (replace ABMU Clinical Portal with Welsh Clinical Portal at all inpatient locations)	Interim Chief Information Officer	29th October 2021

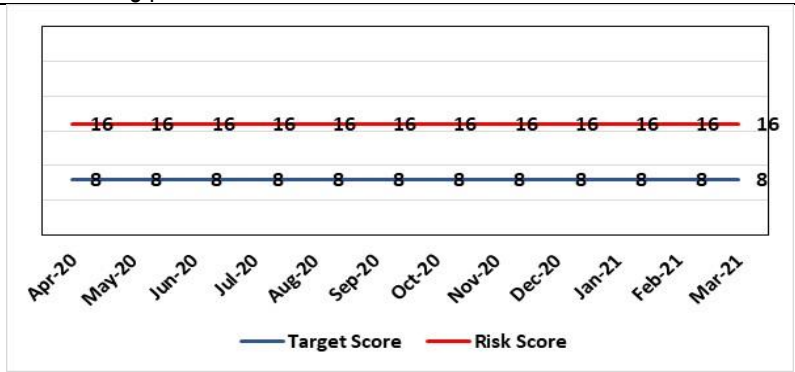
Assurances
(How do we know if the things we are doing are having an impact?)

- RFID has been implemented for the acute record improving the management of records

Gaps in assurance
(What additional assurances should we seek?)
Investment required supporting the delivery and operational costs of the Digital strategy.

• Health Records performance reports to be developed in line with RFID technology Attainment of the Tier 1 Health Board target for clinical coding completeness which relies on the timely availability and quality of the Paper record • Monitoring complaints and incident reporting Gaps in Assurance Investment required supporting the delivery and operational costs of the Digital Strategy. Reliance on NWIS for delivery of the solution for a fully electronic patient record. Impact of the infected Blood Enquiry on the health boards ability to destroy notes is increasing the pressure on storage capacity and negating some of the mitigating actions that are being put in place	Reliance on NWIS for delivery of the solution for a fully electronic patient record Impact of the Infected Blood Enquiry on the Health Boards ability to destroy notes.
Current Risk Rating **4 x 3 = 12**	**Additional Comments** All records must be documented and risk assessed in the Information Asset Register (IAR). This will mean that the risk can be quantified and understood. **Action - All SDU and corporate leads** Health Records Department will work with HB colleagues to develop a case for improved storage solution both for paper and digitally. In regard to the plans for the HB wide storage work, given the delay with the implementation of RFID, the timescales have been moved back slightly. Timescales for this work is as followed (based on current allocation of resources / no additional support. A dedicated project resource would get this done quicker) Scoping and requirements gathering exercise by October 19 - Options developed – Q4 2019-20 - Business case - Q1 2020-21 - Implementation Q3/4 2020-21 Discussions are ongoing with Welsh Health Supplies and Welsh Government on the availability of All Wales Records solution, the outcome of this scoping work will inform the options of the Business Case. Electronic results availability completed by August 2019. Other electronic documents ongoing. Timescales for completion of the Health Board storage work have slipped due to the impact of COVID and are now as follows:- - Options developed — Q1 20/21 - Business case - Q2 20/21 - Implementation Q1 21/22 Discussions are ongoing with Welsh Health Supplies and Welsh Government on the availability of All Wales Records solution, the outcome of this scoping work will inform the options of the Business Case. Electronic results availability completed by August 2019. Other electronic documents ongoing.

	16.03.21: Progress Update - Health Records A scoping exercise has been undertaken across the Health Board to quantify the storage issues for All types of records as it has been evident for some time that the current capacity available to store records both within the main hospitals and off site storage areas is insufficient, and that current practices cannot continue, and a Health Board wide solution is required. The outcome of the scoping exercise will be shared with the Health Board Space Management Work Stream. Once completed, a Business Case will be written, to document the scale of the issues that the Health Board is facing in storing all types of records on an indefinite basis. These updates are also being provided as part of the Health records papers that are submitted to IGG. In terms of the development of a case for the improved storage solution for the acute paper record. This risk still continues even with the roll-out of RFID technology across the acute health record service and location based filing due to the embargo that continues to be in place as a result of the infected blood inquiry, in that no records can be destroyed. Within the Acute Health Records Service and across numerous Health board services that manage and store their records separately from the acute record thousands of records continue to be moved off site to a third party storage supplier called the Maltings at a significant cost to the Health Board due to a lack of capacity on-site to store the records. Following the completion of implementation of E-Prescribing (WCP at Singleton Hospital) in June 2021, the proposal is to implement WCP across all remaining inpatient locations across SBU by the end of Q2 2021-22. Implementation commences 19 April 2021 – project board to agree to scale up across NPTH two weeks after go live, in advance of further enhancements becoming available. Proposal likely to be to continue across NPTH, upgrade and then implement across Singleton Hospital this year. 17.03.21: Two Actions completed – Continue with the roll out of WCP and Continue with roll out of digitisation of health record with a focus on Outpatients and Nursing documentation Timescales for completion of the Health Board storage work have slipped due to the impact of COVID and are now as follows:- Scoping exercise completed Feb 2021 (Q4) Business Case for completion 30/9/21 (Q2- 21/22) Implementation - 22/23 Q1

Datix ID Number: 1217 **Health & Care Standard: Effective Care 3.1 Safer & Clinically Effective Care**		**HBR Ref Number: 37** **Target Date: 31st March 2021**
Objective: Best Value Outcomes from Quality Care		**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Audit Committee
Risk: Operational and strategic decisions are not data informed:- • Business intelligence and information already available is not utilized • Users are unable to access the information they require to make decisions at the right time • Gaps in information collection including patient outcome measures		**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 4 = 16 Target: 4 x 2 = 8		**Rationale for current score:** C – Opportunity cost of not acting on data could mean opportunities for improvement are missed, failures are not identified in a timely manner resulting in adverse national publicity and/or delays in care/increased length of stay. L - Dashboard utilisation is lower than would be anticipated
Level of Control = 70%		**Rationale for target score:**
Date added to the HB risk register June 2016		C- will remain the same or increase due to increased reliance in information L- Investment in BI will lead to more information be available and used. The higher the use of information at operational level will lead to better quality data.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• COVID19 Dashboards Developed and are being used to inform the decision making process at Gold • Business Intelligence Strategy developed but not presented to Board due to COVID19 • The Health Board has continued to invest in the provision of interactive dashboards with the addition of the Power BI Business Intelligence software and infrastructure to support it. • 33 dashboards in place including Cancer, Patient Flow, Outpatients, Mortality, Clinical Variation, Primary & Community Care Delivery Unit Dashboard and Ward Dashboard • Safety Huddle implemented in Morriston is improving data quality and improving operational working • Business Intelligent Information Manager appointed, who will take the lead for creating a Business Intelligence Strategy and Implementation Plan • Investment and revised ways of working introduced within the coding department have achieved coding targets and data quality • Flexible operational management of Coding Teams on a daily basis to cope with demand. Training programme in place for new coders. • Short term funding secured at year end to support mtg tier 1 targets, does not resolve ongoing issues • Information Dept. working with service leads in Planning and Finance to develop meaningful indicators also utilising dashboards to present information in a user friendly way	Investment and implementation of system to record patient outcome measures	Assist Information Business Manager	24th September 2021
	Produce Business Intelligence Strategy and get signed off by the Board	Assist Information Business Manager	30th April 2021
	Produce BI strategy implementation plan outlining investment requirements in capacity and capability	Assist Information Business Manager	30th June 2021
	Produce BI strategy implementation plan outlining investment requirements in capacity and capability push back from June	Assist Information Business Manager	30th September 2021

• New technologies being reviewed for advanced analytics and integration into a new Health Board analytics platform. • Ensuring that the Health Board has representation on national groups such as the newly formed Advanced Analytics Group (AAG), all Wales Business Intelligence and Data Warehousing Group and Welsh Modelling Collaborative.			
Assurances (How do we know if the things we are doing are having an impact?) More evidence based and proactive decisions being made. Dashboard technology; assist in developing indicators / triangulating information to identify issues	**Gaps in assurance (What additional assurances should we seek?)** Culture of the organisation needs to change to focus on information and Business intelligence for operational rather than reporting purposes. Capability of operational staff to utilise the tools and capacity to act on the intelligence provided.		
Current Risk Rating **4 x 4 = 16**	**Additional Comments** PROMS currently being collected in Lung Cancer (Morriston) August 2019, Cataracts August 2019, Hip & Knee (Morriston) November 2018, and Breast Cancer June 2019 using PKB. Also Heart failure, April 2019, in one Community Clinic. COVID19 Dashboards Developed and are being used to inform the decision making process at Gold 13.08.20 – Please note amended timescales against the actions. 10.03.21 – Progress delayed on actions due to Covid-19		

Datix ID Number: 1297 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**	**HBR Ref Number: 39** **Target Date: 31st March 2021**
Objective: Demonstrating Value and Sustainability Risk in Brief: If the Health Board fails to have an approvable IMTP for 2018/19 then we will lose public confidence and breach legislation.	**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee**: Performance and Finance Committee / Strategy, Planning and Commissioning Group Health Board
Risk: Operational and strategic decisions are not data informed:- Health Board does not have an IMTP signed off by WG, primarily due to the inability to align performance and financial plans. WG also advised that the Health Board needed to have a clear strategic direction by developing an Organisational Strategy and refreshing our Clinical Services Plan. In September 2016, the Health Board was escalated to 'targeted intervention' and having an approved IMTP is a key factor in improving our WG monitoring status.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 4 = 20 Target: 4 x 2 = 8 **Level of Control** = 70% **Date added to the HB risk register** July 2017	
	Rationale for current score: Our Organisational Strategy was approved by the Board in November 2018 This Annual Plan includes a balanced financial plan. We have agreed with Welsh Government that we will continue our detailed planning and submit an approvable IMTP when ready. We have continued the work from January onwards on our detailed plans to submit an approvable IMTP when ready. Quarterly and half year plans submitted for 2020/21. WG expectations for 21/22 to be confirmed in November, but likely to be an annual plan for all organisations for 21/22 to be submitted March 21
	Rationale for target score: If the IMTP is approved it is likely our targeted intervention status will be improved when next reviewed and the risk can be closed.

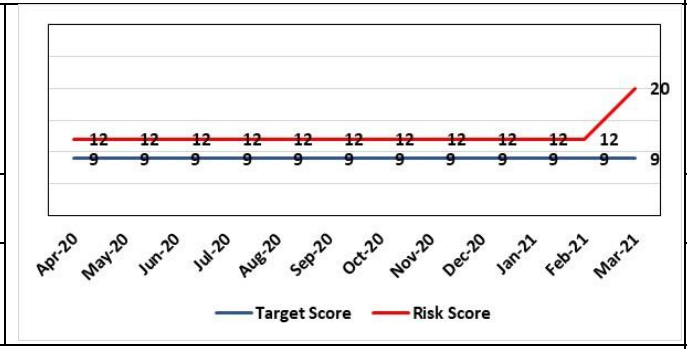
Controls (What are we currently doing about the risk?)

- Organisational Strategy approved by the Board in November 2018
- Clinical Services Plan approved by the Board in January 2019
- Annual Plan submitted to Board and approved in January for submission to Welsh Government, accepted as a draft
- Good feedback received on the document.
- Due to the complexities of the Bridgend transfer, the CEOs of CTM and SB UHBs have formally asked WG for support to resolve the issues and formal arbitration process was initiated by WG.
- The results of the arbitration is now received as is the outcome of the Due Diligence Review.
- The Transformation Programme to deliver the Organisational Strategy and CSP including programme approach was established in April 2019
- Continuous planning through our CSP Programme and IMTP process will work up detailed plans to develop an integrated three year plan in line with the national timescales.
- The new Operating Model and Delivery Support Team will contribute to delivery of the financial plan.
- An Annual Plan in a three-year context was submitted to Board and approved in March 2020 for

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Development of Annual Plan within 3 year context to be considered By board in Jan 21	Director of Strategy, Director of Finance & Director of Workforce & OD.	31st March 2021
Final plan to be submitted to Board for approval for submission to WG.	Director of Strategy	31st March 2021

submission to Welsh Government, accepted as a record of progress • Good feedback received on the document. • National IMTP Processes suspended in March due to the Covid-19 outbreak – and remain suspended • Quarterly Operational Plans developed and submitted in line with national guidance • Welsh Government written statement published on the 7 October 2020 advising that SBUHB been de-escalated from targeted intervention status to 'enhanced monitoring' status.			
Additional Comments IMTP Executive Steering Group in place for development of the integrated medium term plan. Integrated Planning Group in place to co-ordinate Transformation and planning activities and approaches • Performance and Finance Plans are be assured by the P&F Committee before presentation to Board •Through monthly IMTP briefings, TI meetings and bi-annual JET meeting with WG – planning approach and emerging plans discussed and WG fully supportive of the direction of travel.	**Gaps in assurance (What additional assurances should we seek?)** EIA in development for PFC assurance QIAs in development for joint PFC/Q&S assurance		
Current Risk Rating **4 x 5 = 20**	**Additional Comments** Need to note that P&F only looks at finance and performance, not the whole IMTP approval – that sits with Board. The W&OD Committee eg reviews the workforce plan. The HB submitted an Annual Plan to WG in March 2020 as a record of progress with our planning as the WG IMTP processes have been suspended due to the Covid-19 outbreak.		

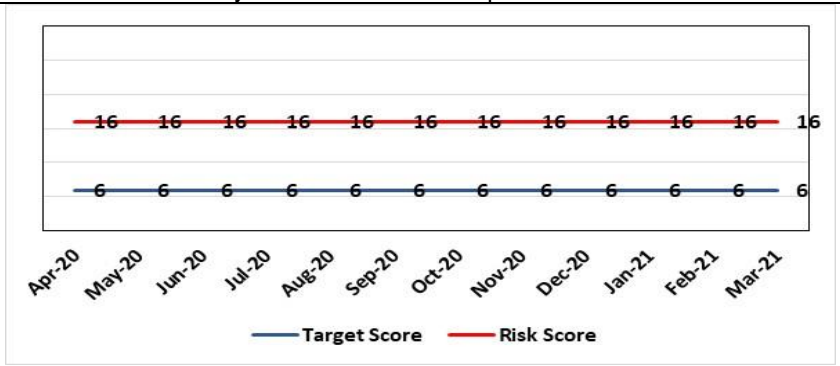
Datix ID Number: 1567 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**	**HBR Ref Number: 41** **Target Date: 31st March 2021**
Objective: Best Value Outcomes	**Director Lead:** Christine Williams, Interim Director of Nursing and Patient Experience **Assuring Committee:** Health and Safety Committee
Risk: Fire Regulation Compliance – one improvement notice received relating to MH&LD Unit. Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 **Current: 5 x 4 = 20** Target: 3 x 3 = 9 **Level of Control** = 50% **Date added to the HB risk register** 31/05/2018		**Rationale for current score:** Improvement notice in relation to MH&LD Unit. Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations. General compliance with fire regulations and WHTM/WHBN requirements **Rationale for target score:** Target Score should be lower

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Fire risk assessments. • Evacuation plans (vertical and horizontal). • Fire safety training. • Professional advice sought on compliance of panels. • East flank panels removed • Business case being developed for south panel removal and updating.	**Action**	**Lead**	**Deadline**
	Change in fire evacuation plans and alarm and detection cause and effect	Head of Health & Safety	3rd May 2021
	Replacing the existing cladding and insulation with alternative specifications and inserting 30 minute fire cavity barriers where appropriate	Service Improvement Manager	14th May 2021

Assurances **(How do we know if the things we are doing are having an impact?)** • Monitoring through the H&S committee to receive assurance and or identify gaps for key compliance and adherence to applicable legislation. • NWSSP internal audits • Site visits/tours to identify compliance and gaps in compliances. • Completion of FRA's within targeted schedule	**Gaps in assurance** **(What additional assurances should we seek?)** Unclear if additional resources will be available
Current Risk Rating **5 x 4 = 20**	**Additional Comments** Professional assessment of panel compliance being taken forward with NWSSP-SES, building control and WG colleagues. W/c 26/8/19 Cladding being removed from East and West end of main block. Escape route on west end redirected with approval of Fire and Rescue Service. Removal of flank cladding completed at end of 2019. Business case being developed for removal of cladding on south side of building. Review of numbers of fire wardens completed by

	Unit and new wardens being trained. Rationale for current score: Improvement notice in relation to MH&LD Unit. Uncertain position in regard to the appropriateness of the cladding applied to Singleton Hospital in particular (as a high rise block) in respect of its compliance with fire safety regulations. General compliance with fire regulations and WHTM/WHBN requirements Also: Phase 2 cladding replacement works scheduled to commence October 2020. Scheduled meeting with MWWFRS in August 2020 to cover cladding and general fire precautions for SBUHB sites. Priority completion of fire risk assessments for sleeping risk. Review of health and safety team resources being undertaken, with a target date of November 2020 to present to H&S committee. Provisional review undertaken, business case in draft format, costs being verified with finance on the draft options. Business case to be submitted to Execs in Q4. Fire resources are included in the overall H&S review. Progress Update 03.12.20 - enabling works commenced 30.11.20 Cladding works delayed due to availability of decant beds as a result of Covid and Winter Bed Pressures. Health Board made aware in update paper to Board 26.11.20. Revised start date 01.03.21 but this is dependent upon the decant space available at the time. Action completed: Finalise Business Case for permanent remediation of the external wall cladding to comply with HTM 05-02 and Building Control Regulations Approved Document B. Update 25.02.21: Regular meetings with contractor and Singleton site on planning for the forthcoming works of cladding removal and replacement on the front elevation. Scaffolding works to commence on 03.03.21, with actual works scheduled to commence in April 2021. Site walk arounds have been undertaken to agree site compounds and fire escape routes. Regular meetings scheduled to ensure appropriate levels of communications are in place and continue. HB will be linking with Mid and West Wales Fire and Rescue Services to ensure they are aware of the phases of work and progress. 11.03.21: Given the current works programme for the removal of the cladding (2.5years), there will be high levels of risk to manage locally given current resources corporately to actively support this. Additional resources are being requested on a permanent basis, with temporary arrangements in place to address overdue risk assessments. The HB will continue to work with MWWF to ensure they are kept up to date. Risk raised to 20.

Datix ID Number: 1514 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**	**HBR Ref Number: 43** **Target Date: 31st March 2021**
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:** March 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?)

- 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 Sept 2020
- QIA reviewed and service stood down in light of increased COVID incidence Oct 2020
- Managing and supporting all referrals remotely
- New legislation changes expected in 21/22 which will require a different service model, business case to meet existing and future requirements will be progressed March 21.

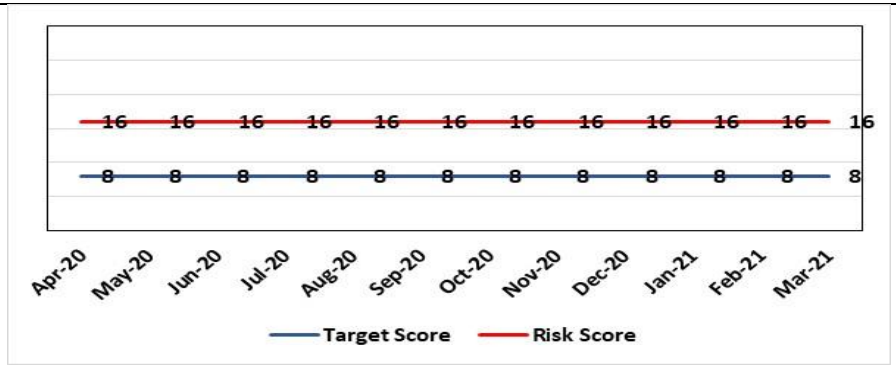
Mitigating actions (What more should we do?)

Action	Lead	Deadline
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	UND Primary and Community	31st March 2021

Assurances

Gaps in assurance

(How do we know if the things we are doing are having an impact?)	(What additional assurances should we seek?)
• Regular scrutiny at Safeguarding Committee and by DoLS Internal Audit; monitoring via DoLS Dashboard which is due to be rolled out imminently and will provide real-time accurate data. • Update report to MHLC regarding quarter 1 and 2 activity 2020, impact of COVID and focus on urgent cases via virtual process and plan to progress business case by year end.	
Current Risk Rating **4 x 4 = 16**	**Additional Comments** All actions attributable to safeguarding completed and Internal Audit aware.

Datix ID Number: 1563 **Health & Care Standard: Safe Care 5.1 Access**		**HBR Ref Number: 48** **Target Date: 31st March 2021**
Objective: Best Value Outcomes from High Quality Care		**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee:** Performance and Finance Committee, Health Board
Risk: Failure to sustain Child and Adolescent Mental Health Services		**Date last reviewed:** March 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:** The specialist CAMHS Network is delivered by Cwm Taf University Health Board on behalf of ABMU.
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 is supporting the delivery of Waiting List Initiative clinics to support the position.	CAMHS network	31st March 2021
	The Network is seeking to recruit agency staff to fill existing and upcoming vacancies to ensure that core capacity is maximised.	CAMHS network	31st March 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?)**
Current Risk Rating **4 x 4 = 16**	**Additional Comments** The service is now in the 2nd cycle of CAPA with new job plans agreed from January, with updated demand & capacity mapping. WLI Clinics initiated at POW Hospital, Bridgend which enabled the 80% target to be achieved by end of end March. This was also achieved for NPT area. However Swansea had a significant backlog, which is starting to be addressed with waiting list initiatives from March 2018. Primary & specialist CAMHS services are delivered by Cwm Taf University Health Board on behalf of ABMU (although this will only be for Swansea & NPT from 1/4/19).

	Cwm Taf achieved the non-urgent 28 day target for specialist CAMHS by the end of March 2019. Their ability to sustain this performance is dependent on consistency and availability of staff which due to the small numbers in the various CAMHS teams can affect achievement of waiting times significantly. Target achieved in March 2019, then missed for a number of months, but achieved from September 2019. However performance is still inconsistent, and will remain so until the existing 3 teams have been integrated into one service across West Glamorgan. New service model being implemented from June 2020 which will stabilise service. A new pathway for CAMHS patients is currently being developed which provides advice on the appropriate actions for dealing with these children and young people and will reduce the need to hold them in the Emergency Department at Morriston.

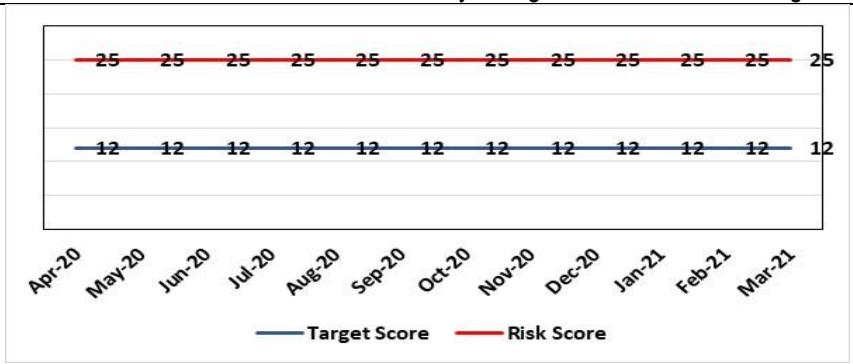
Datix ID Number: 922 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**HBR Ref Number: 49** **Target Date: 31st July 2021**
Objective: Best Value Outcomes from High Quality Care	**Director Lead:** Richard Evans, Medical Director **Assuring Committee:** Quality and Safety Committee
Risk: Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI)	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 4 x 4 = 16 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	31st July 2021

Assurances **(How do we know if the things we are doing are having an impact?)** 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	**Gaps in assurance** **(What additional assurances should we seek?)**
Current Risk Rating **4 x 4 = 16**	**Additional Comments** Business case for WHSSC funding has been agreed. There is considerable reputational risk to the organisation on the outcome of the Royal College of Physicians review. RCP reports received for first cohort casenote reviews and site visit. Action plans implemented. All posts identified as essential in the RCP reports have been appointed to. Improvement activity continues to have oversight of the Executive Medical Director at fortnightly Gold Command meetings. Extensive validation of pathway start dates for cardiothoracic and TAVI patients from external health boards.

	Regular briefings and reports are provided to key stakeholders including WHSSC, Welsh Government and Hywel Dda UHB. The service has felt some impact from COVID, particularly at peaks of COVID prevalence, but the service has continued to operate. The RCP have undertaken a review of a second cohort of casenotes and their report is awaited. Actions completed 08.03.21: • Commission external review of the service by the Royal College of Physicians • Commission further case note review by the Royal College of Physicians WHSSC informed the Health Board of its decision to de-escalate the TAVI service from its current Stage 3 to Stage 2 of the WHSSC Escalation process, having recognised that the service has delivered a significant improvement in the overall quality of the TAVI programme including the reduction in waiting times despite the pandemic.

Datix ID Number: 1761 **Health & Care Standard: Timely Care 5.1 Access**	**HBR Ref Number: 50** **Target Date: 31st March 2021**
Objective: Best Value Outcomes from High Quality Care	**Director Lead**: Chris White, Chief Operating Officer **Assuring Committee:** Performance and Finance Committee
Risk: Access to Cancer Services - Failure to sustain services as currently configured to meet cancer targets	**Date last reviewed:** March 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:** 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
Level of Control = 70%	**Rationale for target score:**
Date added to the HB risk register April 2014	Target score reflects the challenge this area of work present the Board and where small numbers of patients impact on the potential to breach target



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

- Tight management processes to manage each individual case on the unscheduled care (USC) Pathway.
- Initiatives to protect surgical capacity to support USC pathways have been put in place in RGH and PCH to protect core activity.
- Prioritised pathway in place to fast track USC patients.
- Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies.
- Overall Cancer target performance plateau at around 90% with ongoing monitoring of related actions in place at F,P&W Committee.
- Small numbers of patients breaching which is impacting on sustained delivery of the 31 and 62 day target.
- Rapid Diagnostic Clinic established at Neath Port Talbot Hospital. Discussions are ongoing with regard to patient flow and the boundary changes. Discussions are being held with the Executive team regarding the future direction and provision of the RDC service. Work is also ongoing to roll out the concept of the RDC across Wales.
- Delivery Units have Cancer Trackers to closely monitor and 'pull' patients through their pathways. Weekly cancer performance meetings are held at both Singleton and Morriston Delivery Units. Also a weekly HB Cross Unit Cancer performance meeting is held. This meeting is led by the Cancer Lead Manager/Cancer Information Team and the Units are challenged on delays and service issues.
- The tumour sites of concern across the HB for breaches are now Breast, Gynaecological and Lower GI. Forecast performance remains a significant risk until sustainable solutions are identified for these tumour sites and new staff appointments to support tracking and pathways are fully embedded within services.

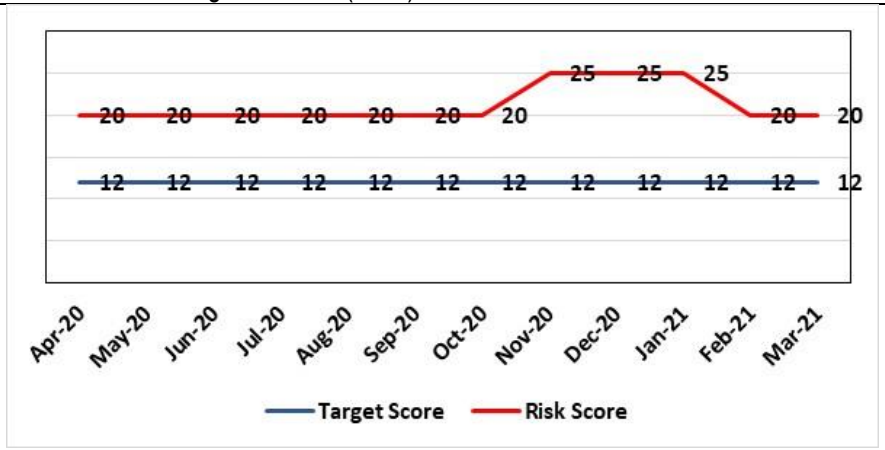
Mitigating actions (What more should we do?)

Action	Lead	Deadline
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	1st April 2021
To explore the possibility of offering SBAR RT for high risk lung cancer patients in SWWCC	Service Manager Surgical Services	30th June 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.
Current Risk Rating **5 x 5 = 25**	**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

Datix ID Number: 1759 **Health & Care Standard: Staff & Resources 7.1 Workforce**	**HBR Ref Number: 51** **Target Date: 31st March 2021**
Objective: Excellent Staff	**Director Lead:** Christine Williams, Interim Director of Nursing **Assuring Committee:** Workforce and OD Committee
Risk: Non Compliance with Nurse Staffing Levels Act (2016)	**Date last reviewed:** March 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:** • Increased risk as a result of reduction in staff availability as a result of staff isolation/sickness - Covid-19. Frequently below minimum staffing number requirements. • Risk escalated to 25 due to the escalating concerns around COVID-19 and requirement around surge plans, including wards being re-purposed and opening and commissioning of new wards.
Level of Control = 80%	**Rationale for target score:** • The Health Board is ensuring we have the structures and processes in place to provide reassurance under the Act and are allocating resources accordingly. • Health Boards are duty bound to take all reasonable steps to maintain nurse staffing levels.
Date added to the HB risk register November 2018	



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

The Health board has put the following controls in place:

Additional Controls re-instated in October 2020 include:

- Workforce Plans have been developed by Unit Nurse Directors & Each Delivery Group to agree staffing in light of escalation to surge & super surge due to COVID-19, with consideration of all reasonable steps
- A Nurse Staffing & Workforce meeting has been set up chaired by the Interim Director of Nursing & Patient Experience. Weekly meetings initially re-instated & have now increased to 3 times weekly with the potential to be increased to daily. The meetings will include a discussion around staffing hotspots, all reasonable steps associated with nurse staffing, deployment of staff, repurposed wards and surge plan, roster scrutiny
- Corporate Nursing Staffing 7 day a week rota reintroduced.
- Health Board wide overview of commissioning of new wards.
- Review of Education Hub & training needs in line with COVID plan.

Additional Control's introduced in March include:

- Daily Silver Nurse staffing Cell meetings chaired by Executive Director of Nursing & Patient Experience to discuss hot spots and the staff available across the Health Board.
- Nurse Bank fully utilised and part of the nurse staffing meetings, Unit Nurse Directors can now sanction non contract agency without Executive approval to maintain a safe service.
- Corporate Nursing 7 day rota introduced.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Daily Staffing Tool has been agreed across the Delivery Groups to maintain a consistent approach.	Director of Nursing & Patient Experience	19th April 2021
The Ward Sister / Charge Nurse and Senior Nurse should continuously assess the situation and keep the designated person formally appraised.	Director of Nursing & Patient Experience	19th April 2021 Monthly ongoing
The Board should ensure a system is in place that allows the recording, review and reporting of every occasion when the number of nurses deployed varies from the planned roster. *(Progress being made, last paper went to Board in November 2019. Paper accepted by the Board)*	Director of Nursing & Patient Experience	22nd April 2021
The responsibility for decisions relating to the maintenance of the nurse staffing level rests with the Health Board should be based on evidence provided by and the professional opinions of the Executive Directors with the portfolios of Nursing, Finance, Workforce,	Director of Nursing & Patient Experience	19th April 2021

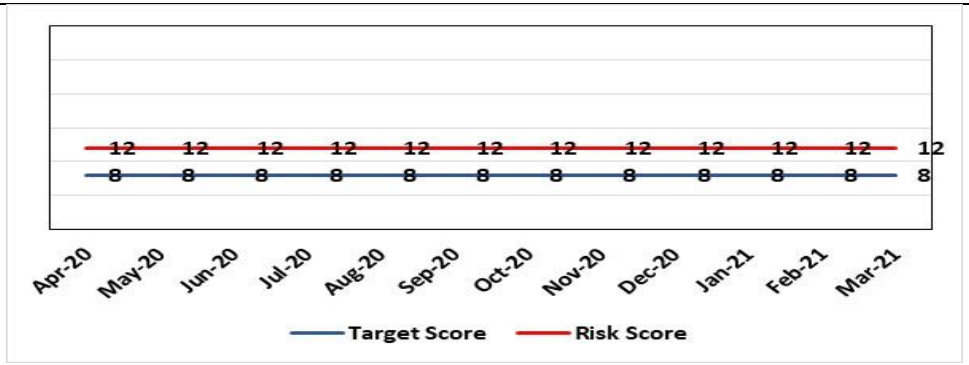
• Database set up to record wards that have been repurposed as novel wards (COVID-19) • Set up COVID-19 Corporate Training and Education Hub which outlines a clear plan for training and education • Approved Registered Staff who have retired from the Nursing Midwifery Council Register in the last three years have been contacted with a view to return to practice and into the Health Board workforce. • Delivery Units have appropriately deployed of ward nurses to key areas. And also administration staff utilised to release nurses into providing care. • Student nurses have returned to clinical practice which has been supported corporately. **Existing Controls** • Confirmed the designated person • Represented the All-Wales Nurse Staffing Group and its sub groups • Contributed with the work undertaken at an all-Wales level on Acuity levels of care. • Undertaken a formal review across all acute Service Delivery Units for calculating and reporting nurse staffing requirements to ensure a Health Board wide consistent approach is adopted. • Presented a Health Board position status paper to both Board & Executive team outlining the preparedness for the Nurse Staffing Act (Wales). • Conducted a review of workforce planning procedures, for 2018 to 2021, which includes; Health Board recruitment events, retention, workforce planning & redesign, training and development. • Developed a monthly Health Board Multidisciplinary Nurse Staffing Act Task & Finish Group, chaired by the Interim Deputy Director of Nursing & Patient Experience, which reports to Nursing and Midwifery Board and Workforce & Organisational Development Committee. • Provided acuity feedback sessions to all Service Delivery Units included in the June audit. • Formally launched the Nurse Staffing (Wales) Act Guidance. • Raised the issue regarding Information Technology barriers around the capture of data required for the Act on an All- Wales and Health Board basis. • Circulated the Welsh Levels of Care and Operational Handbook to Service Delivery Unit Leads. • Confirmed the 32 acute medical & surgical clinical areas that fall within the Act. These areas have been agreed using the criteria set out in the Operational Handbook. • A Rigorous data approval process has been put in place to ensure accuracy of the 6 monthly acuity data prior to sign off. There has also been a number of workshops organised across the organisation to ensure a consistent approach to data collection and there is national work on solutions for electronic capture of acuity data. • The NSA Steering group continues to meet on a monthly basis. • Risks are presented at each meeting • Scrutiny panels are held for each SDU following the submission of acuity templates. • Impact assessment work is being undertaken to prepare for further roll out of the Act.	and Operations. Risk register to be reviewed monthly to ensure compliance	Director of Nursing & Patient Experience	22nd March 2021 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?)**		

• Ongoing robust recruitment and retention plans in place to reduce vacancies in key clinical areas, which is in line with the Health Board recruitment plan. • Accurate reporting of Acuity data and governance around sign off. • Implement mobile devises to be used within adult acute medical and surgical wards included within the Act in readiness for the June Adult Acuity Audit. • Agreed establishments to funded. • Implementation of E-Rostering to enable accurate reporting of Compliance • Implement all Wales Templates, which are visible and signed within the agreed 32 ward areas, informing patients of planned roster. • At least Yearly Board reports outlining compliance and any key risks. August 2019 update In line with the Boundary changes there are now 29 reportable wards which excludes POW. E-rostering has been rolled out in Singleton and Morriston is in the process of being rolled out. Scrutiny panels are in place. Following the investment already provided to the funded establishments. The overall risks have reduced as outlined above. The quality and accuracy of the Acuity data has improved.	
Current Risk Rating **5 x 4 = 20**	Non Compliance with Nurse Staffing Levels (Wales) Act (2016) The Nurse Staffing Levels (Wales) Act, which received Royal Assent on 21st March 2016, places an overarching duty on Local Health Boards and NHS Trusts in Wales to ensure that nurses have time to care sensitively for their patients and codifies current best practice for determining nurse-staffing levels. It requires Local Health Boards and NHS Trusts in Wales to calculate and maintain staffing levels in specific clinical areas, which are Adult acute Medical & Surgical wards. In accordance with the Act, Health Boards/Trusts must submit annual reports to their board and three-yearly reports to Welsh Government in relation to their compliance with the staffing levels, the impact upon the quality of care where the nurse staffing level was not maintained and the actions required in response to this. The Act currently requires the reporting of adult acute medical and surgical inpatient wards, 32 wards in total across the Health Board. In preparation for the Act Service delivery Units have all produced detailed risk assessments in preparation for the Act: Morriston 20 Singleton 16 NPT 6 POW 16 Current Status Singleton 15 Morriston 15 NPT 6. Operating Framework in place. Progress is being made the last paper went to Board November 2019. The paper was accepted by the Board. Letters have been sent to Morriston & Singleton Delivery Unit confirming the outcome of Novembers Board and support for Funding. The templates are being signed. NPT Delivery Unit has already received a letter. 1st June due to COVID-19 a letter was received from the Chief Nursing Officer (Wales) outlining the impact of COVID-19 and actions to be considered. The Bi-Annual Nurse Staffing Act paper was postponed and a COVID-19 paper in relation to the disruption to the Nurse staffing levels Act was presented to May's Board in its place. The paper was based on an All Wales Template.

	Staffing has improved across the Health Board although the score remains the same in light of the uncertain time and a number of factors relating to the Covid-19 situation. Daily Silver Nurse staffing Cell meetings stood down on 30.7.20. The frequency and timings of these meetings will be reviewed at times of COVID Level 4 Super Surge level as per SOP "Nurse Resource during COVID -19". Corporate Nursing 7 day rota stood down will be re-established when required. Reduction in vacancy factor Band 5 - 309 wte Band 2- 13 wte as at 9.7.2020. Student Streamlining - 151 due to commence September 2020. Plan to implement Safecare acuity based rostering tool in September 2020 QIA in progress. Jan 20 Acuity audit. The retrospective triangulation review has been undertaken in July 20. July 20 Acuity audit has been undertaken. The scrutiny panels set up in September 20. Risk Register has been reviewed and remains at 20 due to unpredictability at present with COVID-19 July Acuity Scrutiny panels have been re set for October 2020. Paediatrics Task & Finish Group has been formed in preparation for the extension of the Act. Current Risk remains at 20 due to the uncertainty surrounding COVID. <u>October 2020 update</u> NSA Board paper presented to Septembers Board. Scrutiny panels have taken place in October. Preparing Board paper for November BI-Annual review of staffing. <u>December 2020 update</u> The daily staffing tool remains in place across the four acute sites. A daily staffing/ workforce meeting is also in place, chaired by the Director of Nursing & Patient Experience or nominated Deputy. In place November, remains in place. <u>January 2021 update</u> Nurse Staffing paper SBAR report on 'Impact of COVID 19 on Nurse Staffing Levels' submitted to Gold on 18.12.20. Taken to NMB on 21.1.21 for noting. Plan is to further update and submit to Senior Leadership Team meeting on 3.2.21. Action closed – Operating Framework has been updated and uploaded to COIN. <u>February 2021 update</u> Corporate Risk currently at 25 to reduce to score of 20. Discussed in Nurse Staffing Act Meeting 5.2.21 formally agreed to reduce the score from 25 to 20 based on evidence provided from Delivery Groups Risk Assessments report improved staffing levels decreased Covid pressures. Morriston Singleton & NPT Risk Score 20 MH&LD 15 DN and HV 12.

	Remains high level of vacancies but significant improvement in the Covid- 19 absenteeism A daily staffing tool is completed to provide an overview of the staffing situation in each Delivery Group this supports the decision making process with deployment of staff daily. Roster Scrutiny Panels operate to ensure the rostering Policy and Standards are fully implemented and are being reviewed to encompass triangulation with key quality indicators. The Covid 19 outbreaks in the care homes have had significant impact on the DN service resulting in the DN services supporting the care homes both day and night. Care home support required from the DN is predicted to lessen. Daily Silver Workforce Nurse Staffing Logistics Cell meeting has been reduced to twice weekly. Monday focuses Nurse Staffing Wednesday focuses on Grip and Control of Nurse rosters. Corporate Nurse Staffing 7 day a week rota has been stood down. Nurse Staffing Risk Paper updated monthly for Senior Leadership meetings Transforming Programme & Plan. Grip & Control Efficiency, Modernising Nursing and Valuing Nursing. Recruitment of staff remains a key focus especially HCSW which is seen as a more accessible staff group. Assistant Practitioners are in the process of being recruited to support the Delivery Groups. Student streamlining and Overseas recruitment continues. Visibility of Nursing Leaders within the clinical areas to early identify areas at risk and mitigate where possible. Wellbeing and support services have been enhanced to support staff. Funding has been agreed to continue the Health Board Reflect Reset and Reflect Wellbeing study day for staff. The NMC have published bite size wellbeing information for staff these have been shared through the Health Board NMB meeting.

Datix ID Number: 1763 **Health & Care Standard: Staff & Resources 7.1 Workforce**	**HBR Ref Number: 52** **Target Date: 31st March 2021**
Objective: Partnerships for Care – Effective Governance	**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee:** Performance and Finance Committee
Risk: The Health Board does not have sufficient resource in place to undertake engagement & impact assessment in line with strategic service change	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 4 x 3 = 12 Target: 4 x 2 = 8	**Rationale for current score:** • Current lack of sustainable funding source to secure capacity
Level of Control = 50%	**Rationale for target score:** • All of these areas need to have adequate resourcing and robust processes / policies in place for the organisation to make robust plans, engage public confidence and meet our statutory and public duties.
Date added to the HB risk register November 2018	



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

- Engagement – a temporary post was created for a Head of Engagement for 6 months. The impact of this post was evaluated and will be used to inform the structures change (Operating model). In the meantime the Band 5 has been backfilled to support engagement activities. Robust processes are, however, in place as agreed with the CHC and based on best practice guidance.
- Impact Assessment - A JD has been drafted. The post has now been put forward as part of the CSP support package but funding not secured. As part of restructuring plan to develop Business Partners for Delivery Groups a requirement has been included to support the development of EIAs. Provided this is funded this will bridge this gap.
- Commissioning - two temporary posts are in place until the end of 2019/20 to support the disaggregation programme relating to Bridgend. Will be considered by the Joint Executive Group as part of the resource assessment for the ongoing legacy of the Bridgend transfer.
- Planning - 2 temporary unfunded posts in place (Partnerships Manager and Older people's Programme Manager). Executive Team agreed to fund these, as well as appoint an Acute Care Planning Manager. Core department resources have been aligned to the needs of the CSP and a range of additional posts have been put forward in the resource assessment for the Transformation Portfolio.
- Robust policies and processes to be in place for Impact Assessment going forward.
- Temporary 8a funding finished. Instead funding of additional Band 4 and difference between Band 5 and 6. However unable to appoint Band 4 until April 2021. (Engagement)
- Band 4 post appointed January 2021 after delays due to Covid. Acting Band 6 to be made substantive by end March 2021. (Engagement)

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Agreement of dedicated resource to support Engagement activity – through structure reviews	Director of Transformation	31st March 2021
Conclude work on Exec Equalities portfolios	Interim Assistant Director of Strategy	31st March 2021
Appoint to agreed Planning posts	Interim Assistant Director of Strategy	31st March 2021

Assurances (How do we know if the things we are doing are having an impact?) Temporary additional resource in place for CSP (part of requirements). Now agreed by the Executive Team. Equality Impact specialist advice and support to be considered as part of Exec portfolios for equality review.	**Gaps in assurance** **(What additional assurances should we seek?)** Permanent additional resources not yet available
Current Risk Rating **4 x 3 = 12**	**Additional Comments** As at 23.12.20 there has been no progress to create a IIA post. Need to appoint additional planning staff to support USC, planned care, thoracics, partnerships, TTP and project support. Funding agreed for most posts or externally sourced. Pursuing HR process to get roles agreed and in place.

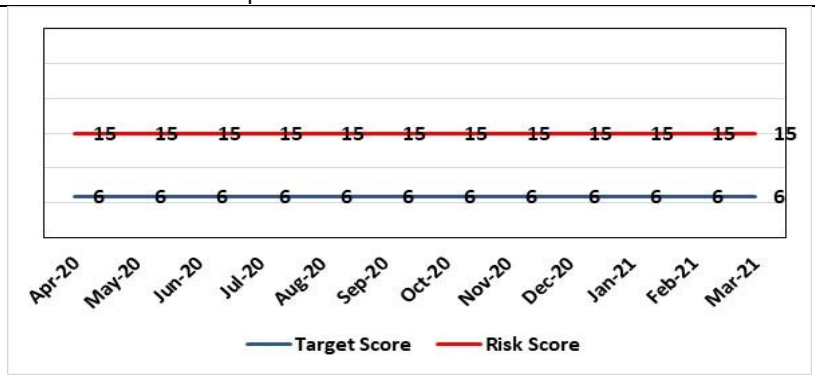
Datix ID Number: 1762 **Health & Care Standard: Staff & Resources 7.1 Workforce**	**HBR Ref Number: 53** **Target Date: 31st March 2021**
Objective: Partnerships for Care	**Director Lead**: Pam Wenger**,** Director of Corporate Governance **Assuring Committee:** Health Board (Welsh Language Group)
Risk: Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 5 x 3 = 15 Target: 3 x 3 = 9	**Rationale for current score:** As a consequence of an internal assessment of the Standards and their impact on the UHB, it is recognised that the Health Board will not be fully compliant with all applicable Standards. This position has been confirmed/verified via an independent baseline assessment.
Level of Control = 60%	**Rationale for target score:** Working through its related improvement plan the likelihood of noncompliance will reduce as awareness and staff training in response to the Standards, is raised.
Date added to the HB risk register November 2018	

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• An independent baseline assessment of the Health Board's position against the Standards has now been undertaken. This is in addition to the Health Board's own self-assessment. • Work to implement the recommendations contained within the above baseline assessment has commenced. • An online staff Welsh Language Skills Survey has been launched. • A new Welsh Language Officer (WLO) has now been appointed, taking up her post in September 2020. • Close constructive working relationships are in place with the Welsh Language Commissioner's Office • Strong networks are in place amongst Welsh Language Officers across NHS Wales to inform learning and development of responses to the Standards. • Proactive communication and marketing activity is being undertaken across the Health Board to raise awareness of Welsh language compliance, customer service standards and training opportunities. • Working with NHS Wales Shared Services (NWSSP) to achieve compliance for workforce and recruitment standards.	Review and update the Welsh Language Standards Action Plan to reflect the findings of the independent baseline assessment	Head of Compliance	30th June 2021
	Following the appointment of the WLO, reinstate quarterly meetings of the Welsh Language Delivery Group.	Head of Compliance	30th June 2021
	Ensure the Board is fully sighted on the UHB's position through regular reporting to the Health Board. Update reports issued to the Executive Team and Board.	Head of Compliance	30th June 2021
	Recruitment of Welsh Language Officer	Head of Compliance	30th June 2021

Assurances (How do we know if the things we are doing are having an impact?) 1. Compliance with Statutory requirements outlined in Welsh Language Act and related Standards. 2. Meetings with the Welsh Language Commissioner. 3. Self-Assessment against the requirements of More Than Just Words. 4. Production of an Annual Report.	**Gaps in assurance** **(What additional assurances should we seek?)** Meetings of the Welsh Language Standards Delivery Group, which is charged with 'overseeing compliance with the Welsh Language Standards and reporting on such to the Executive Board and the Board' need to be reinstated once the Welsh Language Officer has taken up her post.
Current Risk Rating	**Additional Comments**

5 x 3 = 15	The self-assessment and independent baseline assessment has confirmed that the Health Board is not able to fully comply with all the Standards at this time and that the Health Board will need to take a risk management approach to the delivery of the standards. Ongoing gap in the team following the retirement of the Welsh Language Officer in December 2019. A new Welsh Language Officer has been appointed and will be taking up her post imminently. A new Welsh Language Officer (WLO) has now been appointed, taking up her post in September 2020. Since appointment, the WLO's focus has been on: • The review and update of the Welsh Language Standards Action Plan to reflect the findings of the independent baseline assessment • The production of a self-assessment against the requirements of More Than Just Words • The Annual Report The WLO has also met with the Executive Medical Director, who chairs the WLSDG, with a view to re-commencing meetings in January 2021. The resignation of the Welsh Language Officer in December 2020 has adversely impacted upon our ability to progress mitigating actions, notably the reinstatement of the Welsh Language Delivery Group meetings. These actions will now be progressed following the recruitment of the new Welsh Language Officer.

Datix ID Number: 1724 **Health & Care Standard: Safe Care 2.1 Managing Risk & Health & Safety**	**HBR Ref Number: 54** **Target Date: 1st January 2021**
Objective: Partnerships for Care	**Director Lead:** Sian Harrop-Griffiths, Director of Strategy **Assuring Committee:** Health Board (Emergency Preparedness Resilience and Response Group)
Risk: Failure to maintain services as a result of the potential no deal Brexit	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 5 x 3 = 15 Target: 3 x 2 = 6	**Rationale for current score:** The initial risk assessment is based on the fact that significant work needs to take place to understand the risks in terms of the Health Board's ability to maintain services as business as usual. This has been undertaken, but given that there remain some unknowns in terms of future agreements as some are being reviewed during the summer of 2021, the current risk rating will remain.
Level of Control = 70%	**Rationale for target score:** By undertaking the actions highlighted it is anticipated that the arrangements put in place will ensure business as usual even if some future trade agreements pose some risks to some services.
Date added to the HB risk register November 2018	



Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• Emergency Preparedness resilience and response, (EPRR) work programme in relation to the 6 statutory duties is monitored via the EPRR Strategy Group; this includes emergency planning, risk assessment, collaboration, sharing of information, warning and informing and business continuity. • The Health Board continues to respond to the C-19 pandemic and has been in response since 31.01.21. In addition, there have been a number of concurrencies that the Health Board has responded to; emphasising the need for a continued cycle of emergency planning, to be emergency prepared and consequently to improve resilience. There is an EPRR risk register as well as a Brexit specific risk register. • All services have completed a full risk assessment and have identified high risks related to Brexit on the risk register, and there is also a strategic risk log. Services noting high risks have a separate Risk, Action Issues, Decisions, (RAID) log in place. Engagement in health national groups continues to monitor this. • Welsh Government continues to work with NWSSP procurement and commissioned a review of devices and consumables supply chain in Wales to complement the work already completed at UK level. There is national oversight of Procurement specifically for Brexit. • Welsh Government has put in place national communication and co-ordination arrangements, That remain including: ○ A Brexit Ministerial Stakeholder Advisory Forum made up of senior leaders from across the sector, and led by the Cabinet Secretary for Health and Social Services and the Minister for Children, Older People and Social Care;	To review and rehearse promptly the existing business continuity and resilience/contingency arrangements, and to do so working with your local and regional partners, including through your local resilience forums. Plans were exercised during 2018 for a no deal Brexit. Continued planning remained in place and a constant review of risk assessments. In addition, the Health Board has invoked its business continuity arrangements a few times whilst responding to the pandemic and the most was in relation to disruption to supplies of blood science products. The learning from this incident is being taken forward to ensure critical stocks and supplies of just in time products is more robust.	Head of Emergency Preparedness, Resilience & Response	(Monthly meetings resumed in September 2020) 1st April 2021 Meetings during September to November 2020 were more frequent but continue to be monthly and currently focusing on Brexit.

○ An EU Transition Leadership Group, chaired by WG focusing on ensuring operational readiness arrangements for both health and social services in Wales (terms of reference attached); ○ Regular meetings of NHS emergency planners, chaired by Welsh Government, as part of established resilience arrangements; ○ A 4 Nations public health group addressing public health associated risks and health security concerns, and a joint Welsh Government – Public Health Wales working group considering specific Welsh issues; ○ Working in partnership with the Welsh NHS Confederation to ensure ongoing flexible and effective communication and engagement between us and other stakeholders in the health and care system; and Regular updates on Brexit to the monthly NHS Wales Executive Board meetings. ○ Command and control requirements; however, the ECCW for Brexit has now stood down. ○ Work programme monitored via EPRR Strategy Group ○ All services have updated business continuity plans to reflect Brexit issues and C-19 issues ○ Continued engagement in health national groups ○ Continued engagement and oversight with the South Wales Local Resilience Forum. The Strategic Coordination group is in place for C-19 and also receives updates in relation to Brexit. There is also a separate oversight group.			
Assurances (How do we know if the things we are doing are having an impact?) • Work programme in place and monitored via EPRR Strategy Group • All services have up to date business continuity plans • Robust risk management system in place • Preparedness and response assurance procedure specifically for Brexit • Horizon scanning process in place for issues that may arise later during 2021	**Gaps in assurance (What additional assurances should we seek?)** To understand from the review what arrangements need to be in place to minimise the risks in relation to continued issues related to Brexit. The robust risk assessment and RAID log provision allows for careful observation of issues and contingencies to mitigate the risks.		
Current Risk Rating **3 x 5 = 15**	**Additional Comments** There is an obligation to maintain critical services and business as usual in an emergency and this includes Brexit and consequently there is the potential for disruption in commercial and public services and therefore supplies, services, transport, fuel, border issues, EU national issues, immigration, critical infrastructure, energy and command resilience etc. All EPRR and Brexit meetings were postponed temporarily due to the Covid-19 pandemic but resumed during September 2020. Prior to this Services re-commenced a review of the risk assessments and updating of business continuity plans; this remains a continuum. Action – Revision of business continuity plans to take account of Covid-19 - Completed 23.11.20		

Datix ID Number: 1799 **Health & Care Standard: Controlled Drug 2.6 Medicines Management**	**HBR Ref Number: 57** **Target Date: 31st December 2021**
Objective: Best Value Outcomes of High Quality Care	**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee**: Audit Committee
Risk: Non-compliance with Home Office Controlled Drug Licensing requirements. The Health Board has limited assurance regarding whether or not it is compliant with Home Office Controlled Drug Licensing requirements at the present time, nor does it currently have processes in place to ensure any future service change complies.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 4 x 4 = 16 Target: 4 x 2 = 8 **Level of Control** = 40% **Date added to the HB risk register** January 2019		**Rationale for current score:** Risk: That the Health Board is operating in breach of the law by managing controlled drugs without an appropriate Home Office Controlled Drug License. Legal advice provided to the Health Board has indicated that failure to comply with the Home Office Controlled Drug licensing requirements could result in criminal and civil action, both against responsible individuals and the Health Board as a public body. Work has commenced to fully understand the licensing situation along with the drafting of a detailed policy that will ensure compliance going forward. Risk: That the Health Board is maintaining unnecessary Home Office Controlled Drug Licenses. Each Home Office Controlled Drug license costs around £3k plus additional administrative set-up and maintenance costs. Health Board wide scrutiny is required to ensure no unnecessary licenses are held (one such example has recently been discovered). **Rationale for target score:** Once the new policy is complete and has been checked for legal compliance to the Home Office regulations there will be a training session held with all clinical areas supported at Executive level. The work currently underway includes checking areas of concern for compliance with the regulations.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
Legal advice received and principles upon which to decide whether a Home Office Controlled Drug License would be required have been drafted. This forms the basis of a detailed policy that is currently in draft form. This will be sent for legal ratification to ensure compliance to the Home Office regulations. The Home Office have been advised work is currently being completed as a matter of urgency. Areas of specific concern regarding license compliance are being visited to enable an accurate assessment. Additionally, work is underway to develop a governance framework to ensure responsibility for management and use of controlled drugs is fully understood within the delivery units. The framework will enable both the Controlled Drug Accountable Officer and the Health Board Medical Director to discharge their individual accountabilities. The Executive Medical Director, the Executive Director of Nursing and the Chief Pharmacist/CDAO are fully involved and supportive of any potential changes for delivery	HB to develop and implement a control system to ensure compliance with HO license requirements (now and in the future).	Clinical Director Pharmacy	1st April 2021
	HB to undertake a baseline assessment of current CD management in the HB in line with the new HB policy on requirements for HO Controlled Drug licenses	Clinical Director Pharmacy	1st April 2021
	HB to undertake a baseline assessment of HO CD licenses currently held by the HB	Clinical Director Pharmacy	1st April 2021
	HB to send a copy of the new policy on Home Office Controlled Drug license requirements to the HO and begin discussions on areas of disagreement	Clinical Director Pharmacy	1st April 2021

units. .			
Assurances **(How do we know if the things we are doing are having an impact?)** • To date the HB has received legal advice. Pending policy development, the principles contained within the legal advice are referred to when issues are raised in order to provide consistency in arrangements.	**Gaps in assurance** **(What additional assurances should we seek?)** The Health Board will develop a license compliance register, this is expected to be maintained by the Corporate Governance Team thus ensuring there is sufficient segregation of duty.		
Current Risk Rating **4 x 4 = 16**	**Additional Comments** The Home Office are aware that the Health Board have sought independent legal advice regarding the situations where a Home Office Controlled Drug license is required. Advice received to date from the Home Office regarding particular scenarios of Controlled Drug management by the Health Board has differed from the independent legal advice received. The Home Office are currently awaiting the Health Board policy on this matter so that they can review our position. Once completed the policy outlining the Health Board position on Controlled Drug licensing will be shared with both Welsh government and all other Health Boards in Wales as the Swansea Bay UHB position is likely to be used by the Home Office as a precedent. A baseline audit and assessment of current Controlled Drug management across the Health Board (including the degree of 'management and control' exercised) against the recently received legal advice. A baseline audit and review of any Home Office Controlled Drug licenses currently held by the Health Board. Ratification of a specific HB policy on need for HO licenses will go to HB Q&S at the end of August for sign off. After ratification the HB will start negotiations with the HO.		

Datix ID Number: 146 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**CRR Ref Number: 58** **Target Date: 31st March 2022**
Objective: Excellent Patient Outcomes	**Director Lead**: Chris White. Chief Operating Officer **Assuring Committee**: Quality and Safety Committee
Risk: There is a failure to provide adequate clinic capacity to support follow-up patients within the **Ophthalmology** specialty. The consequence of this failure is a delay in patients with chronic eye conditions accessing ongoing secondary care monitoring of diagnosed conditions with the potential risk of permanently impairing eyesight.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 5 = 20 Target: 4 x 1 = 4 **Level of Control** = 40% **Date added to the HB risk register** December 2014		**Rationale for current score:** Sustainable plans underway - short term measures in process of being implemented. Serious incidents being reported to WG. Gold Command exec-led oversight established November 2018. Risk rating increased to 25 January 2019 as instructed by Gold Command. LJ advised change risk score to 16, 03/04/2019 as Probable x Major. Risk rating increased to 20 in July 2020 due to Covid-19 pandemic. **Rationale for target score:**

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• All patients are categorised by condition in order to quantify issue. Second glaucoma consultant appointed November 2018. • Additional accommodation secured to increase capacity; implementation plan under development. Welsh government funding secured for 2019/20 to employ additional activity and deliver some services in a community setting. Virtual clinics established. • Service Manager for Ophthalmology providing regular updates via Planned Care Programme.	**Action**	**Lead**	**Deadline**
	An overall Sustainability Plan to be delivered (Gold command process in place)	Service Group Manager Surgical Specialties	31st March 2021 (Monthly ongoing)

Assurances **(How do we know if the things we are doing are having an impact?)** • A Welsh Government pilot programme was implemented in June 2014. The purpose of the HES project is to use clinic capacity to assess, review and treat patients within clinical priority rather than prioritising new patients based on their waiting time. A Project Management Lead was in post to deliver on the HES objectives.	**Gaps in assurance** **(What additional assurances should we seek?)** Extended waiting times for patients requiring routine clinical intervention, but these are still listed as per RTT guidance.
Current Risk Rating **4 x 5 = 20**	**Additional Comments** Additional Glaucoma practitioner (temporary for 12 months) commenced in post 11/06/2018. 2nd Glaucoma Consultant started 05/11/2018. Advert for substantive consultant as part of regional development with Hywel Dda to be placed in November

	Accommodation in Corridor 3 reconfigured 08/02/2019. Further work needed on accommodation and additional rooms required. Ongoing discussions continue with Singleton Unit so that space can be created to house a co-located Ophthalmology Department Middle grade doctor to commence in post April 2019. Monthly tracker of glaucoma backlog patients indicates reduction of over 800 patients to end of January 2019. Diabetic Retinopathy Virtual Review clinics are to be increased via a WG funded successful bid. Reviewed by AD& PT Sustainable plans are under way and are on target against follow up trajectory backlog. 20/21 sustainable plans are currently being drafted. Risk score reviewed to maintain at 20. Although routine outpatient's appointment are not being undertaken due to COVID-19 those patients at high risk i.e. wet AMD are still being seen and receiving treatment and those patients in other high risk specialties such as glaucoma are being reviewed virtually and if deemed necessary attending for urgent appointments. Since the advent of the Covid-19 outbreak only the following essential Eye services have been maintained during Covid 19. • AMD treatments • Retina services • Rapid Access Eye clinic (RACE - Eye Casualty) As a consequence, the progress made through the previous eye care initiatives has been reversed. During the pandemic the following has been achieved: • Paediatric – 2 consultants have started with a post Covid timetable covering Hywel Dda sessions under SLA contract. • Diabetic Retina – Band 4 Coordinator appointed from interview 19th June 2020. • Glaucoma – Strawberry Place ODTC clinics to resume for 3 months from July 2020 while we look for alterative accommodation, which has now been secure in NPT Resource Centre. Some clinically urgent Cataract operations have been undertaken through May and June 2020. The progress made in reducing follow up patients has been reversed due to significant reduction in capacity during pandemic. Revised action plans to recover the position have been developed but are reliant on post Covid activity levels being restored.

Datix ID Number: 2003 **Health & Care Standard: Effective Care 3.1 Clinically Effective Care**	**HBR Ref Number: 60** **Target Date: 31st March 2021**
Objective: **Digitally Enabled Care**	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Audit Committee
Risk: Cyber Security - high level risk The level of cyber security incidents is at an unprecedented level and health is a known target. The health board has increased digital services (users, devices and systems) and therefore the impact of a cyber-security attack is much higher than in previous years. The introduction of the Network and Information Systems Directive (NISD) in May 2018 means that large fines can be issued to organisations that are not compliant with the Directive. A report from the department of health following the Wannacry incident in May 2017 stated that attack cost the NHS (England) £92m as 19,000 appointments were cancelled and this was before the NISD came into effect. The largest risk to the organisation is on user awareness and unsupported software (old versions which are no longer patched for security vulnerabilities) and devices not managed by the ICT department e.g. medical devices.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 5 x 3 = 15	**Rationale for current score: C and L** The level of cyber security incidents is at an unprecedented level and health is a known target. The health board has increased digital services (users, devices and systems) and therefore the impact of a cybersecurity attack is much higher than in previous years.
Level of Control	**Rationale for target score:**
Date added to the HB risk register July 2019	C- Will remain the same or increase due to increased reliance in information L- The overall likelihood score would increase to (20) if the funding of the 8A and 2 x Band 6 are not recruited.

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
	Action	**Lead**	**Deadline**
• Cyber Security Manager and supporting roles now in place. • The national security tools will highlight vulnerabilities and provide warnings when potential attacks are occurring. Swansea Bay will adopt these tools in financial year 2019/20. • The NHS in Wales is protected by a firewall by NHS Wales Informatics Service (NWIS). • Swansea Bay UHB has advanced firewall protection to protect the network from potential cyber- attacks.	Raise awareness of Cyber Security across the whole Health Board through training and awareness tools and communications.	Cyber Security Manager	31st March 2022 (Ongoing action)

• All emails coming into NHS Wales are scanned using the national email filter. Whilst malicious emails come into the health board on a daily basis, the number are vastly reduced using the email filter and NWIS issue warnings to users affected when the contents are discovered (same day). Users are warned to delete emails and if opened, contact ICT service desk for investigation. • A patching regime has been in place around 18 months which ensures desktops, laptops and servers are protected against any known security vulnerabilities. Anti-virus is in place to protect against known viruses with intelligent scanning on potential viruses not yet discovered. • Access to the internet is controlled through a smart filtering solution which restricts access to potentially vulnerable content. • Work is ongoing in order to replace out of date systems, this is a huge task given the number of clinical and administrative systems in place across the health board. The creation of the service management board will help in terms of getting stakeholder agreement and engagement. Capital funding has also been available to address this. • A Cyber Security training module has been developed and available in the Electronic Staff Record training to ensure staff are fully aware of the risk of cyber security and are vigilant in recognising malicious activity e.g. malicious email. This needs to be adopted as mandatory training.			
Assurances (How do we know if the things we are doing are having an impact?) This will be developed following the appointment of the Cyber Security Manager. In the meantime, the follow up Stratia report has confirmed a major improvement in terms of Microsoft Security patching and SBU are compliant with standards agreed. The Cyber Assurance Framework (compliance with NISD) has been submitted to the Operational Security Service Management Board and plan will be developed nationally to address areas of non-compliance.	**Gaps in assurance (What additional assurances should we seek?)**		
Current Risk Rating **5 x 4 = 20**	**Additional Comments** Band 8a Cyber Security Manager appointed October 2019. Microsoft patching is compliant. NISD CAF completed and submitted to OSSMB. 2 Band (6) Cyber Security staff have now been appointed and are due to commence shortly. (completed) National Security Tool - SIEM Systems integrated, currently working on the final interfaces. NESSUS still awaiting National timescales for NWIS for rollout. Meetings in progress to make Cyber Security Training mandatory across the Health Board. Papers on progress on Cyber Security have been sent to the Senior Leadership Team, Audit committee and Health Board meetings and were well received in each of those. The progress on the establishment of a dedicated Cyber Security team and adoption of local and national cyber tools to improve cyber defences and establish proactive monitoring was		

	noted. The risk score of 20 remains as the largest risk to Cyber Security are the staff that access computer systems such as inadvertently clicking on a malicious link in a Phishing email. The Senior Leadership Team agreed, in principle, for Cyber Security Training to be made mandatory. A further paper for approval, describing the implications for the workforce, will be submitted to a future SLT meeting. National Security Tool -SIEM Systems integrated currently working on final interfaces. NESSUS still awaiting national timescales from NWIS for rollout. Following from the previous update, Cyber Team now use the Security Information and Event Management system (SIEM) daily to provide a dashboard for security monitoring to ensure visibility of potential cyber threats. Training for Cyber staff on operational use of the SIEM is was due in March 2020, but was delayed as a result of COVID and is now scheduled for October. SIEM training has now been completed. Action timescale amended as this is an ongoing requirement.

Datix ID Number: 1587 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**	**HBR Ref Number: 61** **Target Date: 31st March 2021**
Objective: Identify alternative arrangements to Parkway Clinic for the delivery of dental paediatric GA services on the Morriston Hospital SDU site consistent with the needs of the population and existing WG and Health Board policies.	**Director Lead:** Chris White, Chief Operating Officer **Assuring Committee:** Quality and Safety Committee/Strategy Planning and Commissioning Committee
Risk: Paediatric dental GA/Sedation services provided under contract from Parkway Clinic, Swansea. Medical Safety risk GAs performed on children outside of an acute hospital setting.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 5 x 3 = 15 Current: 4 x 4 = 16 Target: 4 x 2 = 8 **Level of Control** = 60% **Date added to the HB risk register** 4th July 2018		**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 **Rationale for target score:** Relocation of the paediatric GA service [provided by Parkway Clinic] to a hospital site being treated as a priority

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

- Consultant Anaesthetist present for every General Anaesthetic clinic.
- Assurance Documentation supplied by Parkway Clinic including confirmation of arrangements in place with WAST and Morriston Hospital for transfer and treatment of patients
- New care pathway implemented - no direct referrals to provider for GA.
- Multi-drug sedation ceased from Sep 2018 in line with WHC 2018 009
- Revised SLA/Service Specification
- HIW Inspection Visit Documentation provided to HB
- All extended GA cases require approval from paediatric specialist prior to treatment

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Transfer of services from Parkway.	Interim Head of Primary Care	31st May 2021

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

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

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

Current Risk Rating
4 X 4 = 16

Additional Comments
Task & Finish Group continue to progress transfer of service to Morriston. 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: 2023 **Health & Care Standard: Staff Resources 7.1 Workforce**	**HBR Ref Number: 62** **Target Date: 31st March 2021**
Objective: Excellent Staff **Risk:** Sustainable Corporate Services aligned to the Health Board's Annual Plan and organisational strategy, and with the skills, capability, behaviours and tools to successfully deliver in support of the whole organisation, and to do so in a way which respects and promotes the health and well-being of our staff and their work-life balance.	**Director Lead:** Kathryn Jones, Director of Workforce & OD **Assuring Committee:** Workforce and OD Committee **Risk Closed – to be removed off April Register**
Risk: Failure to deliver corporate services and organisational objectives due to insufficient staff.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 1 x 1 = 1 Target: 4 x 3 = 12 **Level of Control** = 50% **Date added to the HB risk register** August 2019  	**Rationale for current score:** Constraints, stress and resourcing of corporate services post Bridgend Boundary Change and in light of the change agenda in the Health Board. Current resourcing levels have been benchmarked with other Health Boards, in some areas. The Finance department has been under considerable pressure due to the work required to support the Health Board's Targeted Intervention status and the Bridgend boundary change. **Rationale for target score:** Sustainable services will always encounter turnover and need to develop skill set and capabilities. Target score reflects requirement to resource to be able to meet the operational and Strategic priorities of the Health Board. Failure to do this will negatively impact of financial, service, performance and quality outcomes.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
• Designing and Developing new Operating model for the Health Board • Designing and Developing HB HQ and Corporate structures • Reviewing Directorate requirements • Vacancy Panel to support prioritisation.	**Action**	**Lead**	**Deadline**
	To conclude the recruitment process for the critical corporate posts including the Workforce and OD function	Chief Executive	Completed
Assurances **(How do we know if the things we are doing are having an impact?)** • Decisions late summer / early autumn on corporate services structures, operating model and resourcing.	**Gaps in assurance** **(What additional assurances should we seek?)**		
Current Risk Rating **1 x 1 = 1**	**Additional Comments** Utilise temporary funded capacity to meet immediate areas of risk. Continue to raise resourcing issue at corporate level and through committee governance arrangements. Review of corporate 'critical' posts have been undertaken including resourcing required for investment in the Workforce and OD Function. These posts will be recruited to on a phased basis. As a result of the COVID-19 all recruitment has been put on hold and resources diverted. Business as usual is on hold. The Health Board funded a number of critical posts in 2019. It is therefore proposed to close this corporate risk as investment was made in some key posts. PW		

Datix ID Number: 1605 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**	**HBR Ref Number: 63** **Target Date: 31st March 2021**
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:** March 2021
Risk Rating (consequence x likelihood): Initial: 4 x 3 = 12 Current: 4 x 5 = 20 Target: 3 x 4 = 12 **Level of Control** = 60% **Date added to the HB risk register** 1st August 2019	
	Rationale for current score: CSFM's leading on audit reviewing records of all women where SGA not identified in antenatal period. Scanning capacity under increasing pressure. Meeting arranged with radiology management to discuss introduction of midwife sonographer third trimester scanning. Staff to be informed to submit Datix incident where scan not available in line with standards.
	Rationale for target score: Compliance with Gap & Grow requirements.

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
All staff have received training on Gap & Grow and detection of small for gestational babies. Obstetric scanning capacity across the HB is being reviewed and compliance with criteria for scanning is being monitored. Ultrasound are assisting with finding capacity wherever possible in order to meet standards for screening and complying with Gap & grow recommendations.	Adherence to Gap/Grow Standards	Deputy Head of Midwifery	31st March 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?)**		
Current Risk Rating **4 X 5 = 20**	**Additional Comments** Meeting took place with Deputy Head of Therapies for the HB. Arrangement to meet in January 2020 to review radiology capacity and plan future service needs. This will form part of the antenatal clinic review. Audit of missed cases themes and trends to be presented to the MDT in February 2020. Approval from health		

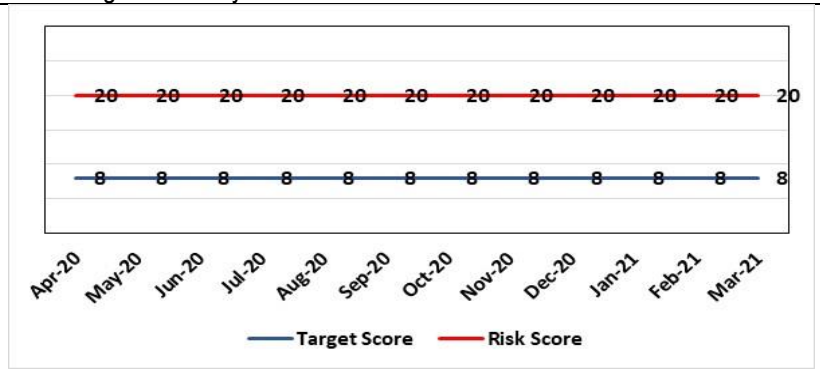
	board to progress training and recruitment of midwife sonographers. Working group in place chaired by exec lead for therapies. Approval from Health Board to progress training and recruitment of midwife sonographers. Working group in place chaired by exec lead for therapies. Oct20 - awaiting advert for MW sonographer roles. G&G training compliance monitored. Rescheduled scan frequency during COVID. Forthcoming interviews on 11.12.2020 for midwife trainee sonographers with a view to commence training in January 2021. Working with radiology to provide training opportunities with antenatal clinics. Midwife Trainee Sonographers have commenced training. Continue to work with radiology to provide a trainer for the trainees. Recruitment for a fixed term 2 year role for a sonographer trainer will commence February 2021. Training currently being provided by appropriately trained obstetrician the two trainee midwife sonographers are making good progress in their university course and practical skills training. An ultrasound machine has been purchased from capital funds and will be installed by 31/03/2021 for midwife sonographer service use. relocation of some gynaecology clinics will free up space for a dedicated room in the antenatal clinic environment.

Datix ID Number: 2159 **Health & Care Standard: Safe Care 2.1 Managing Risk & Promoting Health & Safety**		**HBR Ref Number: 64** **Target Date: 31st March 2021**
Objective: Best Value Outcomes		**Director Lead:** Christine Williams, Interim Director of Nursing and Patient Experience **Assuring Committee:** Health and Safety Committee
Risk: Insufficient resource and capacity of the Health, safety and fire function within SBUHB to maintain legislative and regulatory compliance for the workforce and for the sites across SBUHB. .		**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 **Current: 5 x 5 = 25** Target: 4 x 3 = 12		**Rationale for current score:** The Health Board are in receipt of 10 Health & Safety Executive (HSE) improvement notices concerning health and safety management, violence and aggression and manual handling, limited assurance internal audit reports for water safety management and COSHH, and a fire enforcement notice for one of our sites. Fire risk assessment frequencies are not being kept up to date. Statutory/mandatory training provision and recording will not be sustainable. Unable to support units sufficiently for H&S, case management (V&A), fire and training or to conduct audits/inspections. Potential for litigation, with implications of financial and reputational consequences for not meeting legislative requirements.
Level of Control = 70%		**Rationale for target score:** Compliance with the notices and to have sufficient resources to implement a sustainable health and safety provision to support the legal requirements of the Health Board
Date added to the HB risk register September 2019		Additional resources and updated/refreshed/new systems will enable the Health Board to demonstrate that suitable resources are in place to undertake the roles and responsibilities of the department, and to undertake suitable and sufficient training, provide corporate overview/audit to ensure practices are being employed in the workplace. Risk assessments are being undertaken within required frequencies and periodic audits are taking place to support the various units and departments.

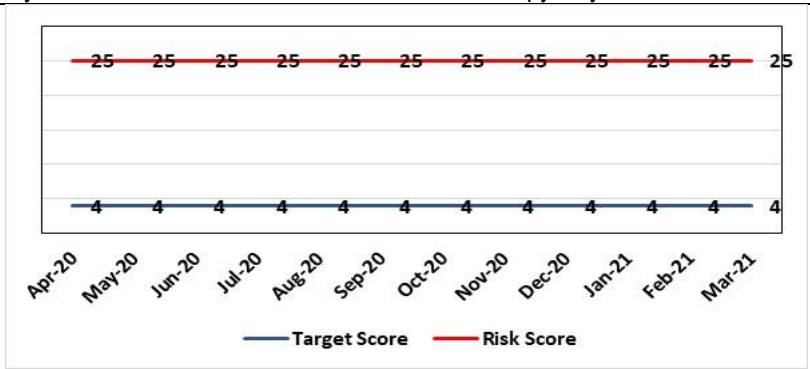
Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
	Action	**Lead**	**Deadline**
• HSE Improvement working group set up to address the HSE recommendations and meets fortnightly to monitor the improvement action plan. • Interim posts of Assistant Director of Health and Safety and Interim Head of Compliance employed on secondment to support strengthening and developing the H&S function • Health and Safety Operational Group meets quarterly and reports to the Health and Safety Committee • Water safety management action plan in place • COSHH procedure reviewed and updated • Fire risk assessments are being undertaken at priority sites (patient areas) to address recommendations of the MAWWFRS	Health and safety department structure to be reviewed and produce proposals, business case	Assistant Director of H&S	31st March 2021
	Health and safety structure review to be presented to the H&S Committee	Assistant Director of H&S	31st March 2021

• Fire training in place and fire wardens in place			
Assurances **(How do we know if the things we are doing are having an impact?)** • Monitoring through the H&S committee to receive assurance and or identify gaps for key compliance and adherence to applicable legislation. • HSE focus group monitor compliance against the 10 improvement notices and report to the H&S operational group and H&S committee. • Site visits/tours to identify compliance and gaps in compliances.	**Gaps in assurance** **(What additional assurances should we seek?)**		
Current Risk Rating **5 X 5 = 25**	**Additional Comments** The re-inspections took place w/c 16 September 2019, visiting NPTH on 16th, Singleton & Morriston Hospital on 17th, Tonna Hospital and NPTH on 18th and NPTH on 20th. All visits went well overall with a number seven of the ten notices closed and three extended to 6th December 2019. A further visit was arranged for 5th December (Theatres at Singleton) where it was confirmed that two more notices were complied with and the other one extended to 31 January 2020. Confirmation via email was received on 7th February that all improvement notices have been complied with. Business case to be written by 31st October 2020. Re-structure review to be presented to H&S committee during 3rd quarter 2020/21. Long term plans to be developed to understand the Health and Safety resource requirements for the Health Board. The restructure is to be reviewed and business case written by 31st October 2020. Due to the pandemic (COVID-19) progress has been minimal and will review when operationally possible, this could be delayed until October/November 2020. Initial review undertaken and an early draft is currently having costs drawn up for the draft options to be submitted to Execs. COVID-19 has had an impact of the progression of this and will be presented on Q4. Due to the pandemic (COVID-19) progress has been minimal and will review when operationally possible, this could be delayed until March 2021. 24.02.21 - Long term plans to be developed to understand the health and safety resource requirements for SBUHB. 09.03.21 – COVID-19 has enforced a pause In a number of areas, with limited access to building to undertake works i.e. compartmentation surveys. Given the reduction in COVID-19 cases it is envisaged that Mid and West Wales Fire & Rescue Service along with other enforcement agencies will restart their audit/inspection programmes. Given that M&WWFRS have already carried out inspection in Hywel Dda over the last 12-24 months and received site wide enforcement notices for Withybush Hospital; Glangwili Hospital and		

	Compartmentation and fire doors at St Caradogs Hospital, there are also enforcement notices issued by South Wales Fire & Rescue Service for CTMUHB and ABUHB. When SBUHB are inspected by M&WWFRS it is highly likely that similar issues will be identified and enforcement notices issued. There is also the potential if the HSE inspect that improvement notices may be issued due to the current level of resources within the health & safety team. Temporary additional resources are in place from March 2021 and a plan in place to reduce the number of overdue fire risk assessments. The increase is based on the current resource position and that there are a number of fire risk assessments overdue and as this RR risk is more about Singleton and the cladding works commencing in April this will add to the risk level score. I also don't believe the original rating was a true reflection and thought this had been replaced by the overall H&S HBRR 64 that has recently been increased to 25 following discussions with CW, CW and DG.

Datix ID Number: 329 **Health & Care Standard: 3.1 Safe and Clinically Effective Care**	**HBR Ref Number: 65** **Target Date: 31st March 2021**
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:** March 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:
Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**
Current controls include all staff undertaking RCOG CTG training and competency assessment. Protocol in place for an hourly "fresh eyes" on 'intrapartum CTG's' and jump call procedures. CTG prompting stickers have been implemented to correctly categorise CTG recordings. Central monitoring is also expected to strengthen the HB's position in defending claims. K2 fetal monitoring system has been identified as the best option for a central monitoring system.	**Action** / **Lead** / **Deadline** Business case prepared for Central monitoring system to store CTG recordings of fetal heart rate in electronic format. / Deputy Head of Midwifery / 31st March 2021
Assurances **(How do we know if the things we are doing are having an impact?)** All Wales Fetal Surveillance Standards for 6hrs Fetal Surveillance Training per year	**Gaps in assurance** **(What additional assurances should we seek?)**
Current Risk Rating **4 X 5 = 20**	**Additional Comments** Submission to IGB in January 2019. CTG envelopes placed in every set of records for safe storage of CTG. Business case completed by maternity service and multi-professional team. Remaining issue outstanding is the financial detail from IT. To ensure submission of case in January 2020 Initial capital funding has been agreed. Meeting held with delivery unit finance director, head of IT and procurement to agree if tendering process required. Paper submitted to describe what specifications are required. Decision awaited from procurement lead if tendering process is required.

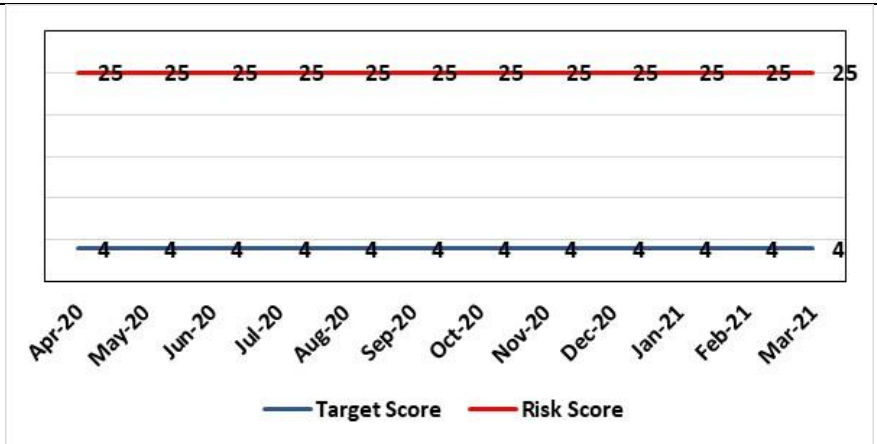
	Tenders have been received, Narrowed down to one suitable provider. Procurement are continuing with the process. Chosen provider for central monitoring system agreed. The chosen monitoring system will include a computerised analysis algorithm as recommended by HIW. Funding for central monitoring approved for 2021/22 Meeting to be arranged with provider and key stakeholders in SBU to commence the project toward installation and training.

Datix ID Number: 1834 **Health & Care Standard: 5.1 Timely Care**	**HBR Ref Number: 66** **Target Date: 31st March 2022**
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:** March 2021
Risk Rating (consequence x likelihood): Initial: 5 x 5 = 25 Current: 5 x 5 = 25 Target: 2 x 2 = 4 **Level of Control** = **Date added to the HB risk register** 30/11/2019		**Rationale for current score:** Increased risk to 25 as waiting times starting to re-increase for Long chair regimes, discussed at oncology business meeting. **Rationale for target score:**

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
Review of CDU by improvement science practitioner Increase nursing staff x 1 at risk, to ensure all nurses are working appropriately. Review of scheduling by staff to ensure all chairs used appropriately. Options appraisal to be completed for SSDU senior management team by service group	**Action**	**Lead**	**Deadline**
	Expansion of home care delivery and additional chair capacity - SACT group	Service Manager Surgical Services	1st April 2021

Assurances **(How do we know if the things we are doing are having an impact?)** Extra nurse in place reliant on agency. Senior team meeting to review findings of service review paper. Additional funding agreed to support increase in nurse establish to appropriately run the unit during their main opening hours	**Gaps in assurance** **(What additional assurances should we seek?)**
Current Risk Rating **5 X 5 = 25**	**Additional Comments** Additional staffing in place from Dec 19 to allow full use of chairs but capacity gap remains. Looking at options around use of additional SACT capacity via Tenovus. Also working with MSD/GE around potential partnership agreement to look at C&D mapping and best practice elsewhere with visit to Leeds being arranged by MSD colleagues. Covid has impact on demand WT continue to improve average wait for Chair time at present is 11days - decrease from 21days. Some of this links to Covid changes, as part of recovery plan need to understand better the future need. Currently lost 3chairs due to Covid-19 and waiting times at 15days at end of June 2020. Meeting with GE/MSD - taking place waiting on partnership agreement paperwork to take through legal team to ensure robust will then start with project plan that we are drafting while paperwork is being finalised between HB and MSD/GE 13.01.21 Work has identified significant gap in our chair capacity- current shortfall 7,

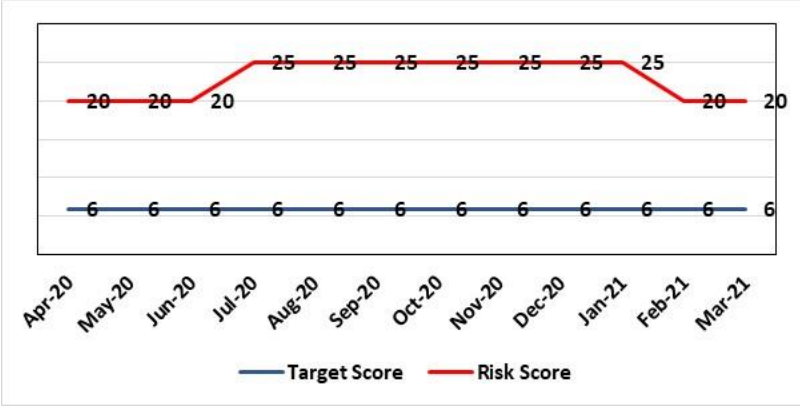
	with an additional 10 chairs required by 2023/24, based on current horizon scanning. Final report confirming this is outstanding. Working on project plan around how we deliver the increased 7 chairs. 03.03.21 - Action closed - Options appraisal paper to be produced for SSDU senior team by service group. Continuing to working with GE/B Braun around modelling work around gap. There some issues with report from GE. However work has identified 2 areas of work: 1. Infrastructure for expansion of home care delivery for low risk drugs- Joint paper between pharmacy and cancer team under development. 2. Scoping up option of 7 additional chairs initially (exact number TBC) in NPTH.

Datix ID Number: 89 **Health & Care Standard: 5.1 Timely Care**	**HBR Ref Number: 67** **Target Date: 31st March 2022**
Objective: Best values outcomes from high quality care	**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee:** Quality and Safety Committee
Risk: Clinical risk-target breeches in the provision of radical radiotherapy treatment. Due to capacity and demand issues the department is experiencing target breaches in the provision of radical radiotherapy treatment to patients.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 4 x 4 = 16 Current: 5 x 5 = 25 Target: 2 x 2 = 4 **Level of Control** = **Date added to the HB risk register** 30/11/2019		**Rationale for current score:** Waiting times deteriorating for elective delays patients, particularly prostates discussed in Oncology business meeting. **Rationale for target score:**

Controls (What are we currently doing about the risk?)	**Mitigating actions (What more should we do?)**		
Requests for treatment and treatment dates monitored by senior management team.	**Action**	**Lead**	**Deadline**
	Additional RT capacity plan	Service Manager Cancer Services	31st March 2021

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

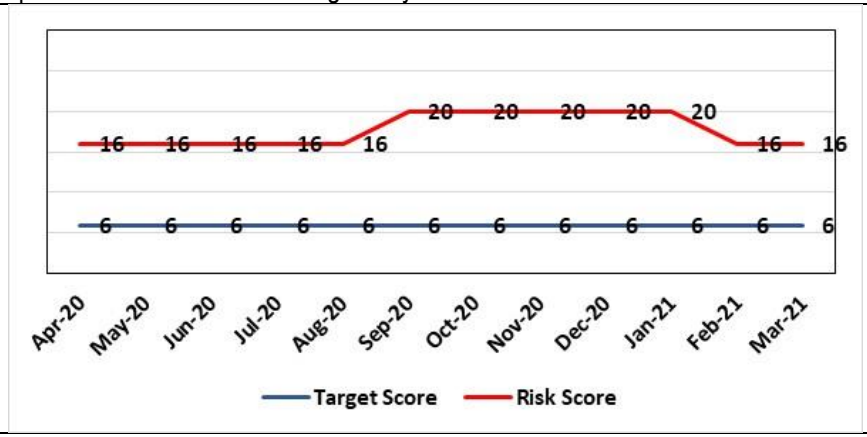
	to attend Rutherford Cancer Centre and patient details being sent to Rutherford Cancer Centre. Seen improvement in some WT performance in RT due to cases being referred to Rutherford and due to changes in practice due to Covid-19. Due to machine breakdowns and covid capacity has been effected to deliver RT. however outsourcing has mitigated some of this but not all. New action agreed 07/07/20- RT Covid Recovery plan is being developed that will include options around, further outsourcing, bringing back SBAR work from VCC, changes to fractions on BREAST and PROSTATE and how we could use this freed up machine capacity differently. This plan is to go to Reset and Recovery meeting as part of Essential Services Covid Recovery plans for Cancer. RT recovery plan (part 1 Breast Hypofractionations) when to Reset and Recovery on 01.09.20 and was approved. 04.01.21 - Delay due to covid in finalising recovery plan. Recovery plan for Breast hypofraction work that releases capacity was agreed and staff being appointed to. Working to start date of Feb 21 for these additional staff. Prostate Case is being finalised plan to go to Reset and Recover end Jan 21/Mid Feb 21. Working with surgeons to finalise pathway. Action closed – Review of patient pathway Number of projects around hypo fractionation treatments have been developed and are being developed. Breast hypo fractionation has been agreed and additional resources were given in Qtr 3-4 to support this. Recruitment to posts is just been finalised. Work for hypo fractionation in prostate in partnership with Urology teams in SBU and HD is in development stage and is included as priority in annual plan. Clinical fellow to support hypo fractionation development work in pancreas has also been supported on fixed term basis and is due to commence in April/May 21. Case for Lung Hypo fractionation has also been developed and is with WHSSC for consideration. Without investment unless we see drop in demand risk will not be reduced.

Datix ID Number: 2299 **Health & Care Standard: 2.4 Infection Prevention and Control (IPC) and Decontamination**	**HBR Ref Number: 68** **Target Date: 31st March 2021**
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, Executive Medical Director **Assuring Committee:** Quality and Safety Committee **Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: **5 x 4 = 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

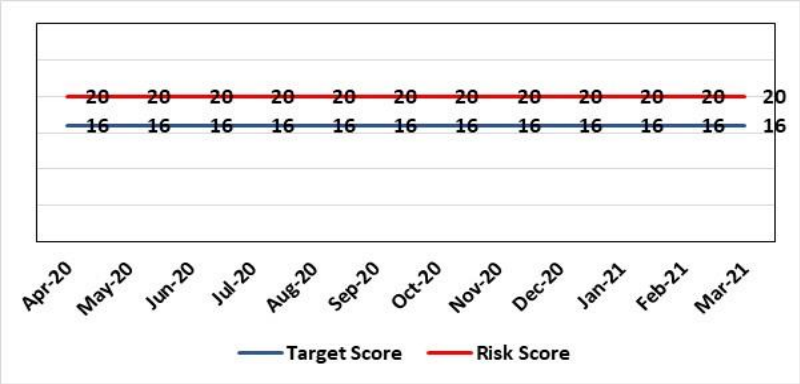
Assurances **(How do we know if the things we are doing are having an impact?)**	**Gaps in assurance** **(What additional assurances should we seek?)**
• Community testing arrangements are active - Early detection. • PPE training and procurement centrally co-ordinated. • Command and control structures 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.

Current Risk Rating 5 X 4 = 20	**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 – reduced as per e-mail RE

Datix ID Number: 1418 **Health & Care Standard: 5.1 Timely Access**	**HBR Ref Number: 69** **Target Date: 31st March 2021**
Objective: Best values outcomes from high quality care	**Director Lead**: Chris White, Chief Operating Officer/Christine Williams, Interim Director of Nursing and Patient Experience **Assuring Committee:** Performance and Finance Committee
Risk: Risk issues Related to **adolescent patients being admitted to Adult MH inpatient wards**- Inappropriate settings resulting in 'Safeguarding Issues' The WG has requested that HBs identify Secondary Care in -patient facilities for the care of adolescents- in Swansea Bay University Health Board Ward F NPT hospital is the dedicated receiving facility with one bed identified.	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 2 x 3 = 6 Current: 4 x 4 = 16 Target: 2 x 3 = 4 **Level of Control** = **Date added to the HB risk register** 27/02/2020		**Rationale for current score:** Risk score reduced to 16. **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.	Review of Service by Swansea Bay Youth	Assistant Head of Operations MH	30th April 2021
	Learning event to be held facilitated by the Serious Incident Team to review a number of recommendations e.g. location of the crisis assessment.	Deputy Director of Nursing	31st March 2021

Assurances (How do we know if the things we are doing are having an impact?) 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.	**Gaps in assurance** **(What additional assurances should we seek?)**
Current Risk Rating **4 X 4 = 16**	**Additional Comments** Action Completed - Revised pathway and guidance for the management of CYP with emotional well- being issues presenting in the ED in Morriston has been developed in conjunction with CAMH service. A paper presented to and approved by Safeguarding Committee on 9th December 2020. Reduce to 16

Datix ID Number: 2245 **Health & Care Standard: 3.1 Clinically Effective Care**	**HBR Ref Number: 70** **Target Date: 31st March 2021**
Objective: Digitally enabled care	**Director Lead**: Chris White, Chief Operating Officer **Assuring Committee:** Audit Committee
Risk: There is a risk of **national data centre outages** which disrupt health board services. The failure of national systems causes severe disruption across NHS Wales, affecting Primary and secondary care services. The delivery of national services including the management of systems, infrastructure and hosting services are the responsibility of NHS Wales Informatics Service (NWIS).	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 4 = 16 **Level of Control** = **Date added to the HB risk register** 27/02/2020		**Rationale for current score:** **C** -The number of outages in 2018 and impact across NHS Wales resulted in a review of NWIS services including the wider Informatics services in NHS Wales. In the June 2019 outage, some services took as long as 2 weeks to recover. **L** -There have been a number of multi system outages over the last 2 years with a number of factors causing outages or resulting in extended outages. Therefore there is a likelihood of a recurrence in the future. **Rationale for target score:** **C** – As reliance on digital solutions for the provision of clinical services grows the impact of outages will also grow. Whilst controls will be put in place to mitigate against the impact of outages this will be offset by the growth in the importance of digital solutions. As a result the consequence score will remain at 4. **L** – The likelihood of national data center outages will never be fully eliminated. The current score of 5 is based on the fact there have been WLIMS outages over recent years.

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

- The national Infrastructure Management Board (IMB) and Service Management Board (SMB) are the boards that oversee Major Incidents, identify risks for national services and make recommendations to improve the availability of national services.
- These boards meet monthly to hold NWIS to account for delivery of services.
- Infrastructure major incident reviews are undertaken with selected board members and recommendations agreed in the board.
- The impact of outages is partly mitigated by the Business Continuity plans that are in place within the Service Delivery Units to allow operational services to continue during a data centre service outage.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Representation at SMB, IMB and NSMB	Head of ICT Operations	1st August 2021 Ongoing action
Representation on EPRR	Informatics Business Manager	1st August 2021 Ongoing action

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

NWIS have a Programme of works to upgrade out of date equipment. The network upgrade Programme was completed this year at the NDC and BDC. The final report on the BDC outage has been received and recommendations put in place to increase maintenance levels and monitoring. NWIS have produced an action plan which is agreed in the IMB and progress monitored. Any deviation from the action plan will be escalated to the SMB and if appropriate to the NHS Wales Informatics Management Board which is chaired by the Chief Executive Officer of NHS Wales and has Executive level board members. In addition, it is recommended that serious consideration should be given to identifying and funding an alternative Tier 3+ facility (in line with the NDC) to host these critical systems. WLIMS 2016 upgrade is required to address some of the technical issues experienced on the existing version. This is planned for September 2020. A re- procurement of a new Pathology Laboratory Information Management system is in progress with timescales An architecture review is underway to assess current services and make recommendations on future services (including hosting services).	
Current Risk Rating **4 X 5 = 20**	**Additional Comments** Action completed 29.01.21: Representation at NWIS Directors Meetings Progress Update 17/3/2021: The main outages have been related to WLIMS infrastructure which consists of the main system and Citrix (used to access the application). Citrix hardware and software was updated in 2020 and the WLIMS upgraded followed with new hardware and WLIMS system upgraded to vL2016 in December 2020. The Blaenavon Data Centre which was not considered fit for purpose as it was rated as tier 2 and not tier 3 as in the case on the commercial Newport Data Centre. The major outage in June 2019 due to an air conditioning failure resulted in replacement equipment being purchased and increased monitoring. Shared Resource Services (SRS) served notice that they would no longer be providing the hosting services from September 2021. NWIS subsequently procured a new data centre hosting facility – CloudCentres Data Centre (CDC) which is a tier 3 facility and have developed a plan to move all services from BDC to CDC by the end of July. NWIS have also introduced more robust change management in order to reduce the likelihood of outages caused by human error. Following the move to the new data centre, in which further outages could occur during the migration, the scoring of this risk will be re-assessed.

Datix ID Number: 2450 **Health & Care Standard: 2.1.1 Managing Financial Risk**	**HBR Ref Number: 73** **Target Date: 31st March 2021**
Objective: Best Value Outcomes from High Quality Care The Health Board underlying financial position may be detrimentally impacted by the COVID-19 pandemic. The COVID-19 pandemic has impacted on the Health Board ability to plan and execute the required level of recurrent savings delivery. There is a potential for a residual cost base increase post COVID-19 as a result of changes to service delivery models and ways of working.	**Director Lead:** Darren Griffiths. Director of Finance (interim) **Assuring Committee:** Performance and Finance Committee
Risk:	**Date last reviewed:** March 2021
Risk Rating (consequence x likelihood): Initial: 5 x 4 = 20 Current: 5 x 4 = 20 Target: 5 x 1 = 5	**Rationale for current score:** • There is a potential for a residual cost base increase post COVID-19 as a result of changes to service delivery models and ways of working - Risk Rated 20 • The residual cost base risk remains unchanged and whilst the Health Board is working hard to control underlying run rate and to seek out savings opportunities wherever possible, there is currently understandable uncertainty as to the resource arrangements for 2021/22 and therefore the risk remains unchanged. • The Health Board financial plan included a required £23m savings delivery. The savings were developed supported by KPMG review. The plans were not fully developed and further work was required during March and April to produce clear plans and milestones. • The COVID-19 pandemic has required a significant management response and therefore the development of these plans have been delayed. • Where clear plans had been developed, in the majority of cases the implementation of the plan has been delayed and may no longer be able to be taken forward due to changes in service delivery models. • Many of the service delivery models across the Health Board have had to change as a result of COVID-19 pandemic. Some of the changes to service delivery and ways of working will remain in place post pandemic which may recurrently increase the cost base of the Health Board.
Level of Control = 25%	**Rationale for target score:** By ensuring that opportunities are taken to drive forward efficiency opportunities and service changes to support improved service and financial sustainability.
Date added to the HB risk register July 2020	

Controls (What are we currently doing about the risk?)	Mitigating actions (What more should we do?)		
The Health Board is doing the following: -	**Action**	**Lead**	**Deadline**

<table>
<tr><td rowspan="2">• Active participation in weekly Director of Finance calls to shape All Wales response
• Finance Review Meetings with Units to explore opportunities to maintain cost control, savings delivery and a proportionate COVID-19 response
• Transparent exchange of position with Finance Delivery Unit
• Review of opportunities through Reset and Recovery to ensure efficiencies are developed and maximised
• Clear understanding of underlying impact of changes to service models and costs of new service models.
• Review all of KPMG pipeline savings opportunities to test whether these can be accelerated in the light of COVID-19 impact.</td><td>Savings opportunities and pipeline to be reviewed and options for development of plans taken forward through SLT</td><td>Director of Finance</td><td>31st March 2021
Monthly ongoing</td></tr>
<tr><td>Impact of reset and recovery to be assessed through QIA process to ensure clear understanding of impact on underlying cost base.</td><td>Director of Finance</td><td>31st March 2021
Monthly ongoing</td></tr>
<tr><td colspan="2">Assurances
(How do we know if the things we are doing are having an impact?)
The Health Board financial performance is reviewed and monitored through:
• Monthly financial recovery meetings
• Performance and Finance Committee
• Routine reporting to Board of most recent monthly position and impact on year end forecast of changes in response to the disease and national funding streams</td><td colspan="2">Gaps in assurance
(What additional assurances should we seek?)
Reporting on savings opportunities and service change impacts to be developed.</td></tr>
<tr><td>Current Risk Rating
5 x 4 = 20</td><td colspan="2">Additional Comments
Monthly financial review and assessment of savings to be included in financial reporting – Action closed. Savings update now part of every FRM with service groups and routinely reported to PFC.
The residual cost base risk remains unchanged and whilst the Health Board is working hard to control underlying run rate and to seek out savings opportunities wherever possible, there is currently understandable uncertainty as to the resource arrangements for 2021/22.</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