CORPORATE RISK REGISTER
December 2025

CORPORATE RISK REGISTER – HEATMAP OF RISKS

Impact/Consequences						
	5			**53:** Compliance with Welsh Language Standards	**60:** Cyber Security **66:** Access to Cancer Services – SACT **69:** Adolescents being admitted to Adult MH wards **107:** EPRR and Recovery	**92:** Finance: Forecast Deficit
	4			**52**: Impact Assessment Requirements **93:** Finance: Reduced capital funds **Reduced from 20** **94:** CAMHS failure to meet required standards of performance **100:** Partnerships & Collaboration **101:** Industrial Action (HCSW) **Closed**	**03:** Recruitment of Consultant Medical and Dental Staff **36:** Paper Record Storage **43:** Deprivation of Liberty Safeguards **61:** Paediatric Dental GA Service **105**: Increased Cost of replacement Pathology System LIMS 108: WCCIS/Connecting care **NEW**	**04:** Healthcare Acquired Infection **64:** H&S Infrastructure **80:** Transfer of Clinically Optimised Patients **85:** Non-Compliance with ALN Act **89:** Healthcare Nursing Staff Levels (HMP) **90:** Subject Access Requests 96: Failure to Develop an Approvable IMTP **104:** Clinical Coding Completeness **106:** Emissions Reduction
	3					
	2					
	1					
C X L		**1**	**2**	**3**	**4**	**5**
		Likelihood				

Corporate Risk Register Dashboard

Strategic Objective	Risk Ref	Description of risk identified	Date Opened	Inherent Score	Current Score	Trend	Last Reviewed	Director Lead	Scrutiny Committee
1 - People of Swansea Bay live healthier, equitable and prosperous lives	52 (1763)	**Statutory Compliance: Engagement & Impact Assessment** The Health Board does not have sufficient resource in place to undertake engagement & impact assess in line with Statutory Duties	Apr 2019	16	12	→	Dec 2025	Director of Insight Communication & Engagement	Performance & Finance Committee
1 - People of Swansea Bay live healthier, equitable prosperous lives	100	**A lack of a robust approach to partnerships & collaboration** If the health board does not have effective structures, processes and working relationships with its external partners, there is a risk that areas of work dependent upon collaboration with partners may not deliver what is required in a timely way, impacting on the delivery of health board priorities.	May 2024	12	12	→	Dec 2025	Executive Director of Planning & Partnerships	Population Health Committee
2 - Care is high quality, safe, efficient, and delivers the best possible outcomes for people	4 (739)	**Healthcare Acquired Infection** Risk of patients acquiring infection as a result of contact with the health care system, resulting in avoidable harm, impact on service capacity, and failure to achieve national infection reduction goals.	Apr 2019	20	20	→	Dec 2025	Executive Medical Director	Quality & Safety Committee
2 - Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships	94 (3516)	**CAMHS failure to meet required standards of performance** The CAMHS service is unable to meet the required level of performance due to workforce deficits in the team across all staff groups including medics, psychological therapies and nursing.	Oct 2023	20	12	→	Dec 2025	Chief Operating Officer	Performance & Finance Committee
2 - Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships	80 (1832)	**Transfer of Clinically Optimised Patients** Risk that we fail to significantly reduce the number of Clinically Optimised Patients in hospital beds. A deficit in the availability of appropriate community / domiciliary care results in unacceptable delays in discharging patients from acute hospital beds. As a result, patients can decompensate and never gain the independence that could have been available from an early	May 2021	20	20	→	Dec 2025	Chief Operating Officer	Quality & Safety Committee

Strategic Objective	Risk Ref	Description of risk identified	Date Opened	Inherent Score	Current Score	Trend	Last Reviewed	Director Lead	Scrutiny Committee
		discharge.							
2 - Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships	61 (1587)	**Paediatric Dental GA Service – Parkway** Safety risk of general anaesthetic procedures performed on children outside of an acute hospital setting. Repatriation of service to acute site delayed which means the health board continues to commission services for delivery outside of national guidance attracting reputational risk. There is also an associated risk in that the diagnosing clinician does not deliver the care to the patient resulting in increased risk of need for multiple GAs.	Apr 2019	15	16	→	Dec 2025	Chief Operating Officer	Quality & Safety Committee
2 - Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships	66 (1834)	**Access to Cancer Services (SACT)** The demand & complexity of planned treatment regime for cancer patients requiring chemotherapy currently exceed the available chair capacity, risking unacceptable delays in access to SACT treatment in Chemotherapy Day Unit with impact on targets and patient outcomes.	Nov 2019	25	20	→	Dec 2025	Executive Medical Director	Quality & Safety Committee
2 - Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships	69 (1418)	**Adolescents are being admitted to adult mental health wards** Risk related to adolescent patients being admitted to Adult MH inpatient wards – Inappropriate settings potentially resulting in 'Safeguarding Issues'. The WG has requested that Health Boards identify Secondary Care inpatient 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.	Feb 2020	20	20	→	Dec 2025	Chief Operating Officer	Quality & Safety Committee
3 - Care is delivered in safe and appropriate settings	64 (2159)	**Health and Safety Infrastructure** Insufficient resource and capacity of the health, safety and fire function to maintain legal and regulatory compliance.	Sep 2019	20	20	→	Dec 2025	Executive Director of Finance & Performance	Quality & Safety Committee

Strategic Objective	Risk Ref	Description of risk identified	Date Opened	Inherent Score	Current Score	Trend	Last Reviewed	Director Lead	Scrutiny Committee
3 - The delivery of care is supported by innovative digital solutions	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.	Apr 2019	20	16	→	Dec 2025	Director of Digital	Digital, Data Research & Innovation Committee
3 The delivery of care is supported by innovative digital solutions	60 (2003)	**Cyber Security (In Committee Risk)** The level of cyber security incidents is at an unprecedented level and health is a known target.	Jul 2019	20	20	→	Dec 2025	Director of Digital	Digital, Data Research & Innovation Committee
3 - The delivery of care is supported by innovative digital solutions	104	**Failure to meet Tier 1 targets in Clinical Coding Completeness** There is a risk that clinical notes for inpatient episodes will not be coded in a timely way.	May 2025	12	20	→	Dec 2025	Director of Digital	Digital Data & Innovation Committee
3 - The delivery of care is supported by innovative digital solutions	105	**Significant increased cost for the replacement Pathology System LIMS** If the new Laboratory Information Management (LIMS) system is not live before 31st December 2025 then there will be significant more cost across NHS Wales which could impact the Health Board's financial plans in 2025/26 and 2026/27. Costs would have to be covered to avoid pathology losing access to the current LIMS system resulting in the inability of pathology to deliver diagnostic results and blood transfusion services across all Health Board services including emergency, acute, primary and community services	May 2025	25	20	→	Dec 2025	Director of Digital	Digital Data & Innovation Committee
3 - The delivery of care is supported by innovative digital solutions	108	**WCCIS/Connecting care - Provision of an Integrated Health Record for MH&LD and PCT NEW RISK** If the Connecting Care programme fails to deliver a digital solution that meets the operational, clinical, and reporting needs of Mental Health & Learning Disabilities (MH&LD) and Community & Therapies services, Then wider MH&LD, Community and Therapies teams will lack access to timely, accurate, and shared information across care	Dec 2025	20	16	New risk	Dec 2025	Director of Digital	Digital Data & Innovation Committee

Strategic Objective	Risk Ref	Description of risk identified	Date Opened	Inherent Score	Current Score	Trend	Last Reviewed	Director Lead	Scrutiny Committee
		settings, resulting in fragmented service delivery, limited availability of high-quality data for performance monitoring and informed decision making, increased duplication of effort, and elevated clinical and governance risks. This includes the potential for further Regulation 28 reports, as previous Prevention of Future Deaths (PFD) notices have explicitly cited the absence of an integrated electronic system as a contributing factor to avoidable harm. Without a fit-for-purpose solution, the Health Board may be unable to fulfil the actions required under Regulation 28, particularly around effective information sharing and risk management across agencies.							
4 - The health board is a great place to work where staff feel valued and work together towards a common goal	3 (843)	**Recruitment of Consultant Medical and Dental Staff** Due to national shortages, there is a risk that that the health board will be unable to recruit consultant medical & dental staff into particular hard to fill roles which may result in difficulties fulfilling rotas on all sites, and adverse impact upon patient safety, service provision, quality and financial matters.	Apr 2019	20	16	→	Dec 2025	Executive Director of Workforce & OD	Workforce & OD Committee
4 - The health board is a great place to work where staff feel valued and work together towards a common goal	89 (3071)	**Healthcare Nursing Staff Levels (HMPS)** There is a risk that the men in HMP Swansea will not receive the appropriate standard of care. This is due to the fact that the nursing establishment within the prison no longer fully meets the changed demographics and numbers of men being detained.	Nov 2022	20	20	→	Dec 2025	Executive Director of Nursing & Patient Experience	Quality & Safety Committee
4 - The health board is a great place to work where all staff feel valued and work together towards a common goal	101	**Industrial Action (Healthcare Support Workers)** CLOSED (In Committee Risk) Due to inconsistencies in the bandings of healthcare support workers across the UK and NHS Wales at a band two and three level, action is being taken in partnership with Unison and the RCN to address inequalities against the context of limited financial resource availability. [Full description In Committee]	Jul 2024	20	12	Closed	Dec 2025	Executive Director of Workforce & OD	Workforce & OD Committee

Strategic Objective	Risk Ref	Description of risk identified	Date Opened	Inherent Score	Current Score	Trend	Last Reviewed	Director Lead	Scrutiny Committee
5 - The health board is a resilient, sustainable and responsible organisation	43 (1514)	**DoLS** Due to a lack of Best Interest Assessor resource, there is a risk of failure to complete and authorise the assessments associated with Deprivation of Liberty/Liberty Protection Safeguards within the legally required timescales, exposing the health board to potential legal challenge and reputational damage.	Apr 2019	16	16	→	Dec 2025	Executive Director of Nursing & Patient Experience	Quality & Safety Committee
5 - The health board is a resilient, sustainable and responsible organisation	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.	Apr 2019	15	15	→	Dec 2025	Executive Director of Nursing & Patient Experience	Health Board (Welsh Language Group)
5 - The health board is a resilient, sustainable and responsible organisation	85 (2561)	**Non-Compliance with ALN Act** There is a risk of the Health Board not fulfilling the statutory requirements of the Additional Learning Needs and Education Tribunal (Wales) Act 2018 (the ALN Act) within the timescales that are required under the ALN Act, resulting in non-compliance with these duties.	May 2022	25	20	→	Dec 2025	Executive Director of Allied Health Professions & Health Sciences	Quality & Safety Committee
5 - The health board is a resilient, sustainable and responsible organisation	90 (2796)	**Subject Access Request Risk** Due to insufficient resources and inconsistent processes across Swansea Bay University Health Board, there is a risk that Subject Access Requests (SARs) will not be fulfilled in compliance with UK-GDPR Article 15, resulting in potential breaches of personal data which could cause distress and lead to a loss of public and government confidence in the Health Board's trustworthiness and legal standing.	Jan 2023	16	20	→	Dec 2025	Director of Digital	Digital, Data Research & Innovation Committee
5 - The health board is a resilient, financially sustainable and responsible organisation	92 (3444)	**Finance: Forecast Deficit Risk** Forecast deficit is not met due to insufficient progress on run rate reduction, and the saving targets required across all areas are not achieved.	Jun 2023	20	25	→	Dec 2025	Executive Director of Finance & Performance	Performance & Finance Committee

Strategic Objective	Risk Ref	Description of risk identified	Date Opened	Inherent Score	Current Score	Trend	Last Reviewed	Director Lead	Scrutiny Committee
5 - The health board is a resilient, financially sustainable and responsible organisation	93 (3448)	**Finance: Reduced capital funds** **Reduced from 20** Reduced discretionary capital funds and reduced National NHS funds requiring a restricted Capital Plan for 2024/25.	Jun 2024	20	12	↓	Dec 2025	Executive Director of Finance & Performance	Performance & Finance Committee
5 - The health board is a resilient, sustainable and responsible organisation	96	**Failure to Develop an Approvable IMTP (statutory compliance)** If we fail to have an approvable Integrated Medium-Term Plan (IMTP) for 2026/27 then we will not meet our statutory duty to break even and may lose public confidence.	Oct 2025	20	20	→	Dec 2025	Executive Director of Planning & Partnerships	Performance & Finance Committee
5 - The health board is a resilient, sustainable and responsible organisation	106	**Emissions Reduction** If we do not identify funding and implement appropriate actions effectively and in a timely way, there is a risk that we will not deliver the emissions reduction targets of 16% by 2025 and 34% by 2030 as determined in the NHS Wales Decarbonisation Strategic Delivery Plan (DSDP 2021). This could result in failure to achieve Health Board targets, undermine achievement of national targets, and expose the Health Board to potential reputational damage in the eyes of Welsh Government and the wider public.	Oct 2025	20	20	→	Dec 2025	Executive Director of Planning & Partnerships	Performance & Finance Committee
5 - The health board is a resilient, sustainable and responsible organisation	107	**EPRR & Recovery** If the health board lacks adequate and effective emergency preparedness, planning, response and recovery at both corporate and operational levels, there is a risk that it may not be able to respond and recover promptly, efficiently, or effectively to a major incident, business continuity, or critical incident. This could lead to: Negative impacts on patient care delivery in both acute and non-acute settings; Potential harm or injury to patients and/or staff; Non-compliance with statutory obligations under the Civil Contingencies Act 2004; Legal actions and financial penalties; Reputational damage and diminished public trust.	Oct 2025	25	20	→	Dec 2025	Executive Director of Planning & Partnerships	Population Health Committee

Datix ID Number: 843 Date Opened: April 2019	Date Last Reviewed: December 2025	HBR Ref Number: 3 Risk Target Date: 31/03/2026	Current Risk Rating 4 x 4 = 16
Objective: The health board is a great place to work where all staff feel valued and work together towards a common goal	**SRR Ref:** 4.1	**Director Lead:** Tina Ricketts, Director of Workforce and OD **Assuring Committee:** Workforce & OD Committee	

Risk: Recruitment of consultant medical & dental staff in hard to fill roles.
Due to national shortages, there is a risk that that the health board will be unable to recruit consultant medical & dental staff into particular hard-to-fill roles which may result in difficulties fulfilling rotas on all sites, and adverse impact upon patient safety, service provision, quality and financial matters.

Risk Rating
(consequence x likelihood):
Inherent: 5 x 4 = 20
Current: 4 x 4 = 16
Target: 4 x 3 = 12

Rationale for current score:
National shortages of numbers in some areas can lead to:
- Inability to recruit sufficient numbers of trainees to fulfil rotas on all sites
- Inability to attract non training grades to complete rotas
- Inability to fill Consultant grade posts in some specialties with adverse effects on patient safety and employer relations. Inability to recruit sufficient registered nursing staff.

Risk score has been reviewed and reflects current position across services as a whole. Services with particular difficulties are listed under the Assurance section. Where risk at service level is significant and/or interdependencies could lead to service collapse, these will be escalated separately.

Rationale for target score:
This remains a challenge and is also a national problem.

Controls (What is currently in place to manage 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 Health Board Workforce & OD Committee will seek assurance of medical workforce plans to maintain services.
- Engagement of the Deanery about recruitment position.
- Weekly workforce delivery meetings with Executive Medical Director to review progress against critical medical and clinical posts
- Working with specialist agency and head-hunters to improve chances to fill hard to recruit posts
- Working with a marketing agency to develop a branding and attraction campaign for the health board.
- Consideration of the RPO (Recruitment Process Outsourcing) model.
- Implemented the CESR (Certificate of Eligibility for Specialist Registration) framework to grow our own consultants
- Revised Consultant Development Programme, sponsored by the Medical Director.

Further Actions (What more are we going to do to address the risk?)

Action	Lead	Deadline
Medical training initiatives pursued in a number of specialties to ease junior doctor recruitment	Service Group Medical Directors	31/03/2026
The Medical Workforce Group continues to monitor recruitment and junior doctor's rotas.	Executive Medical Director	31/03/2026
Continue to recruit internationally where appropriate.	Director W&OD	31/03/2026
Continue to work with head-hunters	Director W&OD	31/03/2026

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 situation monitored through W&OD Committee • Regular communication with Deanery • Ongoing and targeted recruitment campaigns • Monitoring by Service Group teams and specialty based local workforce boards • Monthly workforce planning and deployment taskforce meetings with service groups • Weekly workforce delivery meetings with CEO as above • Areas currently experiencing recruitment difficulties are: mental health, oncology, anaesthetics, acute care physicians, care of the elderly, pathology and haematology.	Locum cover Adequate supply of doctors who can work in this country Ability to flexibly deploy doctors in training. Dedicated work between workforce and finance to review and confirm budgeted medical workforce establishment by service group to confirm SIP and vacancy factor.
Additional Comments / Progress Notes 28/10/2025: The Health Board is considering introducing a Medacs Bank which will include a Recruitment Process Outsourcing (RPO) offer which could help with some hard to fill consultant roles.	

Datix ID Number: 739 Date Opened: Apr 2019	Date Last Reviewed: December 2025	HBR Ref Number: 4 Risk Target Date: 31/03/2026	Current Risk Rating 4 x 5 = 20
Objective: Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships	**SRR Ref:** 2.4	**Director Lead:** Richard Evans, Executive Medical Director **Assuring Committee:** Quality & Safety Committee	

Risk: Healthcare Acquired Infection (HCAI)
Risk of patients acquiring infection as a result of contact with the health care system, resulting in avoidable harm, impact on service capacity, and failure to achieve Tier 1 national infection reduction goals.

Risk Rating
(consequence x likelihood):
Inherent: 4 x 5 = 20
Current: 4 x 5 = 20
Target: 4 x 3 =12

Rationale for current score:
Health Board incidence of key Tier 1 infections per 100,000 population above All Wales rates, indicating Health Board's population at greater risk of infection. High occupancy rates & frequent ward moves associated with increased risk of infection transmission. Lack of decant facilities compromises environment deep cleaning & decontamination and planned preventative maintenance programmes.

Rationale for target score:
Improved governance structures for IPC and antimicrobial stewardship will drive improved local ownership and embed responsibility for these priorities for all levels of staff. Adequately maintained & clean environments facilitate good IPC & minimise infection risks. Reduced occupancy & frequency of patient moves mitigate against infection transmission. Compliant ventilation systems and water safety minimise infection risks. Access to timely data on infections, training, antimicrobial stewardship, cleaning at ward/unit/practice level enables Service Groups to identify areas for focused QI programmes, drive improvement, & effectively measure outcomes.

Controls (What is currently in place to manage the risk?)

- Policies, procedures, protocols and guidelines supplement the National Infection Control Manual.
- Infection Prevention & Control (IPC) related training provided programmes.
- Surveillance of infections, with early identification of increased incidence, and instigation of controls.
- Antimicrobial stewardship programmes and systems of monitoring and feedback.
- Provision of cleaning service to meet National Standards of Cleanliness. IPCT meet regularly with the Domestic service teams and the service groups to prioritise the provision of enhanced cleaning hours to areas with a high incidence of infection/outbreaks.
- Engineering controls for water safety, ventilation, and decontamination.
- Infection Prevention Improvement Plans 2025/26 for HB and Service Groups were approved by the Health Board's Infection Prevention & Control Strategic Group on 29/04/2025. Progress is reported at Service Group Infection Control Committees, Health Board Infection Prevention & Control Group, Quality & Safety Group, Quality & Safety Committee, and Management Board. These include trajectories to meet national targets and report performance against them.

Further Actions (What more are we going to do to address the risk?)

Action	Lead	Deadline
Revised: Achieve 80% compliance with IPC mandatory training (Levels 1 & 2) in all staff groups.	Service Group Directors	31/03/2026
Achieve reduction in Tier 1 infections to meet de-escalation criteria for intervention targets	Service Group Directors	31/03/2026

• The Health Board has been escalated to Targeted Intervention for its position relating to healthcare associated infection (HCAI). Governance processes for HCAI have been revised to provide strengthened scrutiny and assurance.			

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
• Clear Corporate and Service Group IPC Assurance Framework in place. • Infection Prevention Improvement Plans for HB and Service Groups with progress reported at SG Infection Control Committees, HB Infection Prevention & Control Group, Quality & Safety Group and at Management Board. These include trajectories to meet national targets and report performance against them. This is also reported to Quality & Safety Committee. • Ongoing monitoring of infection control rates. • QI projects across the organisation Quality Improvement Project focusing on antimicrobial stewardship within MHSG _AMU; including an MDT AMS ward round reviewing choice of antibiotics and improve the outcome to switch from IV to oral administration route. • IPC, antimicrobial, decontamination and cleaning audit programmes. • Annual completion of IPC Level 2 mandatory training for all HB staff. • Compliance and validation systems for water safety, ventilation systems and decontamination. • Revised and strengthened governance structure for HCAI, including monthly meetings of Executive HCAI Scrutiny Group. • Service group Medical Director led HCAI case review meetings take place: to determine if the infection episodes were avoidable, and to identify where improvements can be made to achieve better patient outcomes.	• High occupancy rates & frequent ward moves associated with increased risk of infection transmission. Additional beds introduced to wards as a result of the "UEC Test of Change" pilot, reducing the space between beds. • Lack of single room availability, leading to delays in isolating patients with infections and increasing risks to patient contacts. • Increased numbers of clinically optimised patients remaining in hospital leads to increased length of stay, increased risk of over-occupancy and over-crowding, with consequence of increasing risks of acquisition of infection. • General infrastructure of the aging hospital estate compromises the ability to clean and decontaminate effectively. • Antimicrobial prescribing, relating particularly to total volume of antibiotics, with the SBUHB having second highest total volume of antibiotics prescribed in primary care in Wales. • Lack of decant facilities compromises environment deep cleaning & decontamination and planned preventative maintenance programmes. • Varying levels of IPC responsibility embedded across all disciplines and groups, with variable medical engagement at all levels in infection prevention-related Quality Improvements programmes. • Not all staff groups have achieved IPC Level 1& 2 training compliance.

Additional Comments / Progress Notes

17/12/2025: The HB received WHC 2025 039 Antimicrobial Stewardship and Infection Prevention and Control Improvement Goals for 2025-27 will be incorporated into the HB Improvement goals for 2026/27.

HCAI position: Tier One Target Organism Progress to end of Nov 2025.

• *C. difficile* – 10 hospital onset cases (target 6).
* Combined (hospital onset and community onset) cumulative total – 155 cases.
• *Staph. aureus* – 4 hospital onset cases (target 3).
* Combined cumulative total - 83 cases.
• *E. coli* - 5 hospital onset cases (target 4).
* Combined cumulative total - 193 cases.
• *Klebsiella* spp. - 3 hospital onset cases (target 4).
* Combined cumulative total – 77 cases.
• *Pseudomonas aeruginosa* (Not included within targeted interventions) * Combined cumulative total – 18 cases.

IPC training compliance target >80% is being maintained. ESR reporting compliance levels as of Nov 30th, 2025: Level 1 = 90.34%, Level 2 = 85.19%

Several QI projects are taking place across the Service Groups to reduce HCAI's including a project to reduce urinary catheter associated infections, ward rounds to improve Antimicrobial Stewardship (AMS) and IV to oral switch (IVPOS) and additional projects are being proposed within the *C. difficile* collaborative.

Datix ID Number: 1043 Date Opened: Apr 2019	Date Last Reviewed: December 2025	HBR Ref Number: 36 Risk Target Date: TBC	Current Risk Rating 4 x 4 = 16
Objective: Care is delivered in partnership with our communities in safe and appropriate settings, supported by innovative digital solutions, research, development and innovation	**SRR Ref:** 3.4	**Director Lead:** Matt John, Director of Digital **Assuring Committee:** Digital, Research & Innovation Committee **For information:** Quality & Safety 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. There is an increased fire risk where medical records are stored outside of the medical record libraries.

Risk Rating
(consequence x likelihood):
Inherent: 4 x 5 = 20
Current: 4 x 4 = 16
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. Increased risk of fire where records are stored outside of the medical record libraries.
L - we know this happens from incidents raised

Rationale for target score:
C - The increased development and adoption of the digital record will reduce the need for the paper health record being available at the point of care.
L - The increased development and adoption of the digital record, the introduction of RFID and the approach to management of the paper record identified in the Business case process should reduce the amount of paper required to be stored and managed.

Controls (What is currently in place to manage the risk?)

- There is a plan in place to increase the functionality of the electronic record to document patient care. The delivery of the plan is overseen by the Digital Leadership Group and progress provided to Management Board. (Supported by individual project boards as appropriate).
- Records managed by the Medical Records libraries are RFID-tagged (Radio Frequency Identification) and location tracked.
- Medical Record libraries are regularly risk assessed for fire by health and safety.
- Alternative offsite storage arrangements have been identified.
- All records must be documented on the Information Asset Register (IAR).

Further Actions (What more are we going to do to address the risk?)

Action	Lead	Deadline
Allow for new process to stabilise and evaluate benefits of new centralised unit.	Head of Health Records & Clinical Coding	28/02/2026

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 and storage of records
- Health Records performance reports 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 and electronic sources
- Monitoring complaints and incident reporting.
- Electronic record is being implemented in accordance with the plan e.g. implementation of WNCR

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

Investment required supporting the delivery and operational costs of the Digital strategy.
Reliance on DHCW (Digital Health & Care Wales) 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.

(Welsh Nursing Care Record), ETR (Electronic Test Requesting), HEPMA (Hospital Electronic Prescribing and Medicines Administration)	Process for ensuring clinical adoption of electronic ways of working and cessation of adding information to the paper record that is already available electronically needs to be agreed and enforced by the Health Board. Impact of the infected Blood Inquiry on the health board's ability to destroy notes and the change in the records code of practice is being reviewed by the Director of Digital.
Additional Notes 22/12/2025 – Reviewed – no further amendments.	

Datix ID Number: 1514 Date Opened: Apr 2019	Date Last Reviewed: December 2025	HBR Ref Number: 43 Risk Target Date: TBC	Current Risk Rating 4 x 4 = 16
Objective: The health board is a resilient, sustainable and responsible organisation	**SRR Ref:** N/A	**Director Lead:** Elizabeth Rix, Executive Director of Nursing **Assuring Committee:** Quality & Safety Committee **For Information:** Mental Health Legislation Committee	

Risk: Deprivation of Liberty Safeguards

Due to a limited resources within the MCA/DoLS (Mental Capacity Act/Deprivation of Liberty Safeguards) service (lack of Best Interest Assessor resource and signatory approval) there is a risk of failure to complete and authorise the assessments associated with Deprivation of Liberty within the legally required timescales, exposing the health board to potential legal challenge and reputational damage.

Risk Rating
(consequence x likelihood):
Inherent: 4 x 4 = 16
Current: 4 x 4 = 16
Target: 3 x 2 = 6

Rationale for current score:
Multiple breaches in statutory duty
Breaches confirmed as expected at least as frequently as weekly, but not daily.
No claims received to date.

Rationale for target score:
Consequences of DoLS breaches for the Health Board will not change. With controls in place, over time likelihood should decrease.
Risk target date indicates date of review following mitigating actions

Controls (What is currently in place to manage the risk?)

- Duty system in place. Duty BIA (Best Interest Assessors) scrutinise referrals and liaise with managing authority to ensure safeguards are in place to mitigate risks.
- Four signatory authorisers in place.
- Monthly Performance & Assurance Meeting
- Monthly Legislative Assurance Meeting with Group Nurse Director and Finance.

Further Actions (What more are we going to do to address the risk?)

Action	Lead	Deadline

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

Monthly Legislative Assurance Meeting with Group Nurse Director and Finance.
Quarterly reports to Mental Health & Legislative Committee on MCA/DoLS compliance.

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

Current resources

- 3 substantive BIA (3 wte)
- 6 external BIA (£250 per assessment)
- 4 (band 8) signatories
- Specialist Practitioner Band 7 vacancy – out to advert.

Additional 4 WTE BIAs required to meet service demands.
Substantive BIA's role includes additional duties compared to external BIA whose only role is to complete form 3a of the DoLS process. In addition to form 3a completion, substantive BIA also undertake the following to meet service demand (Daily Duty Rota to scrutinise referrals; Facilitate Level 3 MCA/DoLS Training; Capacity Assessments;

	Advice and support to Managing Bodies; Support during Best Interest Meetings)
Additional Comments / Progress Notes 20/11/2025: Breach data at the end of October reported at 3. Band 7 Specialist Practitioner appointed and going through recruitment checks. Risk score remains at 16. To review monthly. 17/12/2025: Due to breaches remaining low for last 3 months the risk is currently under review and will be discussed at the next service group RMG in January.	

Datix ID Number: 1763 **Date Opened: Apr 2019**	**Date Last Reviewed: December 2025**	**HBR Ref Number: 52** **Risk Target Date: TBC**	**Current Risk Rating** **4 x 3 = 12**
Objective: People of Swansea Bay live healthier, fairer and more prosperous lives	**SRR Ref:** 1.1	**Director Lead:** Richard Thomas, Director of Communications and Engagement **Assuring Committee:** Performance & Finance Committee	

Risk: Impact Assessment Requirements

The Health Board does not have sufficient skills & resource in place to undertake integrated equality impact assessments in line with strategic service change and policy development.

Risk Rating
(consequence x likelihood):
Inherent: 4 x 4 = 16
Current: 4 x 3 = 12
Target: 4 x 2 = 8

Rationale for current score:

- Current lack of required skills / staff to deliver requirements.
- Risk lowered to 12 because new Integrated Impact Assessment process developed and being tested across a range of issues.

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.

Controls (What is currently in place to manage the risk?)

- Robust policies and processes to be in place for Impact Assessment going forward.
- EIA responsibilities incorporated into wider Impact Assessments.
- Development of Strategic Equality Group across organisation to support processes.

Further Actions (What more are we going to do to address the risk?)

Action	Lead	Deadline
Roll out Impact Assessment process across organisation. Training and integration with planning processes across the organisation will be required.	Assistant Director of Insight, Charity & Engagement & DICE	31/01/2026

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

Advice on Equality Impact Assessment and then wider Impact Assessments available across organisation supported by robust policies and procedures, overseen by Strategic Equality Group.

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

Participation from across organisation in Strategic Equality Group.

Additional Comments / Progress Notes

29/10/2025: Actions in relation to new structure not taken forward at this stage – further discussions required with Chief Executive and Director of W&OD as part of roll out of Organised for Success. Roll out of IIA (Integrated Impact Assessment) training delayed as a result of staff absence within DICE but targeted support being provided to high profile changes where IIAs are required e.g. Gorseinon.

Datix ID Number: 1762 Date Opened: Apr 2019	Date Last Reviewed: December 2025	HBR Ref Number: 53 Risk Target Date: 31/03/2026 (Review point)	Current Risk Rating 5 x 3 = 15
Objective: The health board is a resilient, sustainable and responsible organisation	**SRR Ref:** N/A	**Director Lead**: Elizabeth Rix, Executive Director of Nursing **Assuring Committee:** Health Board (Welsh Language Group)	

Risk: Welsh Language Standards
Failure to fully comply with all the requirements of the Welsh Language Standards, as they apply to the University Health Board.

Risk Rating
(consequence x likelihood):
Inherent: 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.
There has been an increase of 512% in the demand for translation services since May 2024, this is an increasing trend. Capacity within the current team is based on previous activity, meaning our reliance on external translators and associated costs has increased.

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. Risk Target Date refreshed to indicate a review point following completion of actions planned for 2025/26.

Controls (What is currently in place to manage the risk?)

- An independent baseline assessment of the Health Board's position against the Standards has been undertaken. This is in addition to the Health Board's own self-assessment.
- Work to implement the recommendations in the above baseline assessment was completed in 2023.
- An online staff Welsh Language Skills Survey has been launched. This resulted in a response rate of 15%
- We have a record of staff Welsh language skills for 58% of our staff and continue to work to improve this.
- Close constructive working relationships are in place with the Welsh Language Commissioner's Office
- Strong networks are in place amongst Welsh Language Officers (WLO) 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.
- Plan to provide clinical consultations through the medium of Welsh launched in 2024 (Standard 110 and Standard 110a) – this is progressing well within some areas, though more focussed work is required in stroke services, care of the elderly and children and young people's services.

Further Actions (What more are we going to do to address the risk?)

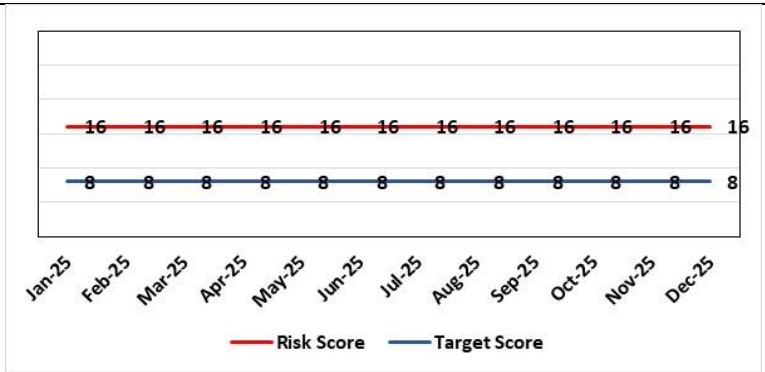
Action	Lead	Deadline
Review demand for translation services to ascertain whether activity level return to their baseline level	Welsh Language Officer	31/03/2026

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
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. 5. Reporting to QSG 6. Outcome of compliance spot checks 7. Welsh Language Delivery Group has been re-established and met in September 2025; a quarterly programme of meetings has been established.	Formal and regular reporting to the Board will recommence with the production of the next annual report. Incorporation of relevant Welsh Language Standards into ward assurance processes. Welsh Language Delivery Group to be re-established, following nomination of chair.
Additional Comments / Progress Notes	
13/10/25: A paper is being presented to Management Board in October proposing that recording of language skills on ESR is mandated from January 1st 2026 – this will improve the Health Board position in relation to Standard 96.	

Datix ID Number: 1587 Date Opened: Apr 2019	Date Last Reviewed: December 2025	HBR Ref Number: 61 Risk Target Date: TBC	Current Risk Rating 4 X 4 = 16
Objective: Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships	**SRR Ref:** 2.4	**Director Lead:** Deb Lewis, Chief Operating Officer **Assuring Committee:** Quality & Safety Committee	

Risk: Paediatric dental GA (General Anaesthetics)/Sedation services provided under contract from Parkway Clinic, Swansea. Medical Safety risk as general anaesthetics are performed on children outside of an acute hospital setting. Repatriation of service to acute site delayed due to theatre capacity which means the health board continues to commission services for delivery outside of national guidance (WHC 2018-09) attracting reputational risk. There is also an associated risk in that the diagnosing clinician does not deliver the care to the patient resulting in increased risk of need for multiple General Anaesthetics.

Risk Rating
(consequence x likelihood):
Inherent: 5 x 3 = 15
Current: 4 x 4 = 16
Target: 4 x 2 = 8



Rationale for current score:
There is no immediate access to crash team/ICU facilities in in Parkway Clinic – the client group are undergoing GA (general anaesthetic)/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 general anaesthetics service [provided by Parkway Clinic] to a hospital site being treated as a priority.

Controls (What is currently in place to manage 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 general anaesthetics.
Multi-drug sedation ceased from Sep 2018 in line with WHC 2018 009
Revised SLA (Service Level Agreement)/Service Specification
HIW (Healthcare Inspectorate Wales) Inspection Visit Documentation provided to Health Board
All extended general anaesthetics cases require approval from paediatric specialist prior to treatment.

Further Actions (What more are we going to do to address the risk?)

Action	Lead	Deadline

Assurances (How do we know if the things we are doing are having an impact?)
RMC (Referral Management Centre) 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.

Gaps in assurance (What additional assurances should we seek?)
Deputy Chief Operating Officer-led Task & Finish Group is no longer in place – it will need to be re-established to progress transfer when theatre capacity is agreed.
Pressures on the Princess of Wales special care dental general anaesthetics list and this service is considered alongside any plans for the Parkway contract.

Additional Comments / Progress Notes

06/05/2025: Health Board Management Board agreed that current contract with provider will be extended for 2+1 years whilst the Health Board explores capital bid for regional service as part of wider Paediatrics Day Case Unit
20/11/2025: This risk remains as at last update (04/08/2025).

Datix ID Number: 2159 Date Opened: September 2019	Date Last Reviewed: December 2025	HBR Ref Number: 64 Risk Target Date: 31/03/2026	Current Risk Rating 4 X 5 = 20
Objective: Care is delivered in partnership with our communities in safe and appropriate settings, supported by innovative digital solutions, research, development and innovation	**SRR Ref:** 3.2	**Director Lead:** Darren Griffiths, Director of Finance & Performance **Assuring Committee:** Quality & Safety Committee	

Risk: Health & Safety (H&S) Infrastructure

Insufficient resource and capacity of the health, safety and fire function within SBUHB to maintain legal and regulatory compliance for the workforce and for the sites across SBUHB.

Risk Rating
(consequence x likelihood):
Inherent: 5 x 4 = 20
Current: 4 x 5 = 20
Target: 4 x 3 = 12

Rationale for current score:
The Health Board received 12 Health & Safety Executive (HSE) improvement notices during 2019-20 covering various Health & Safety legal breaches covering a range of areas. There is the potential for future multiple notices for not meeting legal requirements based on current available resources. Due to retirement resources in the team has reduced and the risk level increased to 20.

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 and demonstrate that suitable resources are in place to undertake the roles and responsibilities of the department, also to undertake suitable and sufficient training, provide corporate overview/audit to ensure practices are being employed in the workplace.

Controls (What is currently in place to manage the risk?)

- Assistant Director of Health and Safety in post to support strengthening and develop the H&S function to support the organisation. Business case submitted for additional resources.
- Health and Safety Operational Group and the Health and Safety Committee monitor compliance. Refreshed the Fire Safety Group with additional controls in place.
- Fire risk assessments (FRA) are being prioritised to reduce the number of FRA overdue and to bring up to date. However, due to leavers and recruitment, resource levels have fluctuated along with compliance levels that are continually monitored.
- Fire training in place and fire wardens in place
- Fire risk assessment schedule in place for the next 12 months concentrating on sleeping risk areas to maintain 100% compliance in these areas, and other non-sleeping risk areas are regularly reviewed, with the frequency of these moved to 18-monthly or 2-yearly, dependent upon the overall risk of the premises.

Further Actions (What more are we going to do to address the risk?)

Action	Lead	Deadline
Having completed staffing structure review, next action is to work through Health Board governance processes to ensure affordability and to agree a risk-based, phased approach to implement any agreed structure going forward.	Assistant Director of Capital and H&S	31/03/2026

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

- Monitoring through the appropriate group/committees (H&S committee) to receive assurance and or identify gaps for key compliance and adherence to applicable legislation.

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

Health and safety, capital and estates now sit under the umbrella of Finance and is currently going through a restructure, with the H&S structure also included in this and will

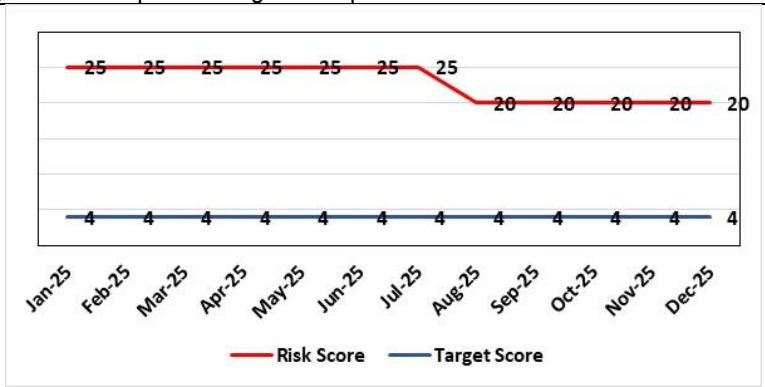
• Site visits/tours to identify compliance and gaps in compliances.	be phased in, with a target date of 31/03/2026 for the proposed new structure to be in place. Compared to other Health Boards SBUHB does not have the same level of structures and is unable to undertake audits/inspections or provide the level of support to service groups ie cover to provide appropriate levels of training, support and auditing in all areas (Manual Handling; Violence & Aggression/Case Management; Health & Safety' Fire Safety and Fit Testing).
Additional Comments / Progress Notes 27/08/2025: Successful conclusion to interviews [Head of H&S post], with an agreed commencement date 01/11/2025. No change in overall risk rating, with risks monitored and prioritised within current resources. 27/10/2025: Overall risks are monitored and prioritised covering Manual Handling, Violence & Aggression, Health & Safety and Fire with mitigations and action plans developed to address prioritised risks within current resources i.e. On-going discussions with Fire and Rescue to address issues raised by Mid & West Wales Fire & Rescue Service (MWWFRS), with identified mitigations planned to address 'Your Next Patient' challenges. 24/11/2025: Risk remains at 20, with no changes in current resources within health & safety team. We continue working with MWWFRS to mitigate the challenges of 'Your Next Patient' on each of the wards, with a target date of end of November 2025.	

Datix ID Number: 1834 Date Opened: November 2019	Date Last Reviewed: December 2025	HBR Ref Number: 66 Risk Target Date: 28/02/2026	Current Risk Rating 5 X 4 = 20
Objective: Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships	**SRR Ref:** 2.3	**Director Lead**: Richard Evans, Executive Medical Director **Assuring Committee:** Quality & Safety Committee	

Risk: Access to SACT (Systemic Anti-Cancer Therapy)

The demand & complexity of planned treatment regime for cancer patients requiring chemotherapy currently exceed the available chair capacity, risking unacceptable delays in access to SACT treatment in Chemotherapy Day Unit with impact on targets and patient outcomes.

Risk Rating
(consequence x likelihood):
Inherent: 5 x 5 = 25
Current: 5 x 4 = 20
Target: 2 x 2 = 4



Rationale for current score:
Demand for SACT continues to exceed current service capacity.
Ongoing workforce challenges persist within the Chemotherapy Day Unit (CDU) and Pharmacy Technical Services (PTS), impacting service delivery.
Patient waiting times remain elevated, with a continued number of breaches against SACT Key Performance Indicators (KPIs).
The introduction of new cancer diagnoses and NICE-approved treatments necessitates the implementation of additional SACT regimens, further straining resources.
Approval has been granted for additional treatment chairs, and initial recruitment to posts successful. Training of staff is essential prerequisite before this expansion can be operationalised. It is likely to take until Feb 2026 to fully train.
Improved performance from Q4 24/25 to Q1 25/26.

Rationale for target score:
Reduced delays in treatment will reduce risk of harm.

Controls (What is currently in place to manage the risk?)

- Review of scheduling by staff to ensure all chairs used appropriately.
- A daily scrutinizing process in progress to micro-manage individual cases, deferrals etc.
- Changes made to prescribing & authorising processes to improve workflow for PTS reducing potential delays to supply and administration of treatment.
- Responsibility for checking bisphosphonate prescriptions in CDU moved to nursing staff to free up Pharmacy capacity allowing them to focus on key clinical tasks within Pharmacy.
- Joint project with Nuclear Medicine to streamline pathways and prioritise SACT patients appropriately halved the average time waiting for MUGA/EDTA tests required before starting SACT.
- Increased homecare capacity
- Adopted principles from UK SACT board publication: General Principles to Support Systemic anti-Cancer Therapy Aseptic Pressures September 2023

Further Actions (What more are we going to do to address the risk?)

Action	Lead	Deadline
Recruiting to posts (dependency on recruitment process changes)	Divisional Manager (Cancer)	28/02/2026
Training of new staff (full competency)	SACT Training Team / Pharmacy	28/02/2026

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

Gaps in assurance (What additional assurances should we seek?)
Workforce requirements have and continue to be mapped to identify the additional

- To support increased demand, additional funding has been secured to expand the nursing establishment, ensuring appropriate staffing levels during the unit's core operating hours.
- Posts are currently out to advert or in the recruitment process. Once successful appointments are made and training is completed, improvements in performance are expected to be reflected in service delivery metrics.
- Waiting times are tracked against the new SACT metrics, which are based on treatment intent rather than average waiting times, providing a more outcome-focused measure. These metrics are reported through our Cancer Performance Report to Welsh Government, the Management Board, and internally via governance structures within NPTSSG, where Oncology services are hosted.
- Patient experience continues to be monitored through the Friends and Family Test and the Welsh Cancer Patient Experience Survey, in line with our Putting Things Right (PTR) procedures.
- The SBU Capacity Task and Finish Group meets monthly to analyse demand and capacity gaps. Common delay themes are identified and reviewed monthly, with a quarterly report presented to the SACT Consultant Meeting and the Divisional Business Meeting to inform service planning.
- Current breach trends are primarily linked to CDU capacity constraints and SACT booking delays, as evidenced in quarterly reporting. Work is ongoing to explore new models of care in addition to the approved posts to address these issues.

Priority & wait		Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
P1	Treatments started	2	1	3	0	0	1
	</=2 days	50%	100%	67%	0%	0%	100%
	3-14 days	50%	0%	33%	0%	0%	0%
	15-21 days	0%	0%	0%	0%	0%	0%
	>21 days	0%	0%	0%	0%	0%	0%
P2	Treatments started	40	44	37	49	46	43
	</=2 days	0%	0%	30%	0%	0%	0
	3-14 days	35%	23%	27%	29%	28%	26%
	15-21 days	18%	20%	49%	55%	39%	40%
	>21 days	48%	57%	22%	16%	33%	35%
P3	Treatments started	13	7	9	9	10	8
	</=2 days	0%	0%	0%	0%	0%	0%
	3-14 days	8%	0%	22%	0%	30%	0%
	15-21 days	31%	43%	44%	56%	50%	25%
	>21 days	62%	57%	33%	44%	20%	75%

Welsh SACT performance metrics – P2 to start within 14 days. P3 to start within 21 days

capacity needed to meet both current and projected future demand for SACT services. While initial funding has been secured to support the first phase of this work, it does not guarantee the sustainability of future capacity. This marks the beginning of a phased approach to workforce planning and service development

Additional Comments / Progress Notes
16/12/2025 Performance remains steady and improved on this time last year Performance might dip due to Christmas break but measures in place to mitigate against risk Risk score discussed regularly – no change at present Some issues remain with backfill of pharmacy posts, timeline for completion of training may need to be reassessed. Nursing posts to be determined (band 3/4) but will require less training so should not have same impact on ability to increase capacity.

Datix ID Number: 1418 Date Opened: February 2020	Date Last Reviewed: December 2025	HBR Ref Number: 69 Risk Target Date: See Target Rationale	Current Risk Rating 5 X 4 = 20
Objective: Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships	**SRR Ref:** 2.7	**Director Lead**: Deb Lewis, Chief Operating Officer **Supporting Director:** Elizabeth Rix, Executive Director of Nursing **Assuring Committee:** Quality & Safety Committee	

Risk: Issues related to adolescent patient admission to adult mental health inpatient wards

Risk of inappropriate settings resulting in 'Safeguarding Issues'. The Welsh Government has requested that Health Boards 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.

Risk Rating
(consequence x likelihood):
Inherent: 2 x 3 = 6
Current:5 x 4 = 20
Target: 2 x 3 = 6

Rationale for current score:
Every health board is required to have an admission facility for adolescent Mental Health patients. Whilst ward F has been identified as the single point of access in SBU and provides access to a bed for adolescent admissions if available at the time of request it is a mixed sex adult ward. Therefore, the facilities are less than ideal for young patients in crisis.

Rationale for target score:
The longer-term aim for the Health Board remains to create an admission facility for adolescent Mental Health patients but this will not be possible until the new Adult Inpatient Unit is built.

Controls (What is currently in place to manage the risk?)

Safeguarding Training for Staff, Joint protocol with Cwm Taf LHB [CAMHS] currently subject to review, Local SBUHB policy on providing care to young people in this environment. This includes the requirement for all such patients on admission to be subject to Level 3 Safe and Supportive observations.
Only Adolescents within 16-18 age range are admitted to the adult ward.
The health board works with CAMHS to make sure that the length of stay is as short as possible.

Further Actions (What more are we going to do to address the risk?)

Action	Lead	Deadline
Next service group review of effectiveness of current controls.	Head of Nursing (Mental Health) & Clinical Directors	01/02/2026

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

Individual Rooms with en Suite Facilities, Joint working with CAMHS, monitoring of staff training, Monitoring of admissions by the MH&LD SG Legislation Committee of the Health Board. The ongoing issues with the risks presented by the use of this has recently been raised at an all-Wales level with Welsh Government and a formal review is anticipated. The Service Group continues to flag the risk particularly in light of Ward F being identified as the SPOA for AMH in the Health Board which has resulted in an increase in acuity and a greater concentration of individuals who are experiencing the early crisis of admission - this has served to increase the already identified risks for young people in the environment.

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

Additional Comments / Progress Notes

18/11/2025: No change. Admissions have been infrequent.
17/12/2025: No change to the current arrangements and controls. Requirement for adult inpatient new build to accommodate appropriate facilities. Currently being reviewed under the MH

Transformation Programme. There has been a marked reduction in admissions of young people to adult inpatient wards since 2024. Score has been reinstated to 20 on SDG Risk in line with All Wales position and given the critical clinical risks should an admission be required.

Datix ID Number: 1832 Date Opened: May 2021	Date Last Reviewed: December 2025	HBR Ref Number: 80 Risk Target Date: 31/12/2025	Current Risk Rating 4 x 5 = 20
Objective: Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships	**SRR Ref:** 2.1	**Director Lead:** Deb Lewis, Chief Operating Officer **Assuring Committee:** Quality & Safety Committee	

Risk: Transfer of Clinically Optimised Patients

Risk that we fail to significantly reduce the number of Clinically Optimised Patients in hospital beds. A deficit in the availability of appropriate community / domiciliary care results in unacceptable delays in discharging patients from acute hospital beds. As a result, patients can decompensate and never gain the independence that could have been available from an early discharge. Lack of access to same day domiciliary care/emergency placements in the community hinders ability to avoid admission and associated harms.

Risk Rating
(consequence x likelihood):
Inherent: 4 x 5 = 20
Current: 4 x 5 = 20
Target: 4 x 2 = 8

Rationale for current score:

- Sustained levels of clinically optimised patients (COPs) leading to overcrowding within ED, use of inappropriate or overuse of decant capacity in ED and delays in accessing medical bed capacity, clearly emerged as themes.
- Constraints in relation to all patient flows out of Morriston to a more appropriate clinical setting, identified and included in an expanded risk.
- Delay in discharge for clinically optimised patients can result in deterioration of their condition.
- Increase in demand for Pathway 1.

Rationale for target score:

Targeted reduction of Clinically Optimised patients remains a priority for the HB in order to minimise risk of avoidable harm to patients within the HB and in the wider community.

Controls (What is currently in place to manage the risk?)

- One of the measures under targeted intervention is to see a reduction in pathway of care delays, which specifically supports the reduction in the number of clinically optimised patients.
- Review is undertaken on a patient-by-patient basis – with explicit action agreed in order to progress transfer to appropriate clinical setting.
- Critical constricts in relation to access/time delays for social workers and assessment for package of care and social placement
- Weekly escalation meetings are held with health and social service colleagues to ensure the requirements of the patients are reviewed and patients are pulled through the system where possible.
- Planned transfer of 30 COP patients (Pathway 3) from Morriston to Singleton 5th Jan 26 to enable closure of the AMU surge area reliant on a temporary workforce model.

Further Actions (What more are we going to do to address the risk?)

Action	Lead	Deadline
Work programme and governance structure agreed by local partnership (health board & local authorities) to work up sustainable D2RA model.	Associate Director UEC	31/03/2026
Formal agreement through Communities and Older Persons Board to proceed to OCP for health employees to deliver the D2RA hub and recruitment into Swansea LA, with a limited offer from NPT LA.	Service Group Director (PCT)	31/01/2026

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

- Patient level dashboard allows breakdown by delay type
- Regular (weekly) COP reviews and escalations

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

Capacity and demand exercise required to inform reshaping of community services

• Shared vision with NPT & Swansea LA CEOs agreed and governance structure with Executive Directors for sign off • POCD reporting into the UEC and Communities and Older Persons Boards.	

Additional Comments / Progress Notes

12/05/2025: Action previously completed: The Care Action Committee (CAC) focus on reducing the impact of clinically optimised patients within acute hospitals. The Health Board engaged with the work from the CAC and currently developing the Winter Plan for 24/25, of which reducing COPs will be a key focus. This work is being taken forward by the Associate SGD PCTS to ensure cross-boundary support.
Integrated Discharge hub now established from within existing resources following a successful test of change. Positive turnaround of patients from front door services reducing admission demand and long-term care demand. Roll-out of true Discharge to Recover then Assess (D2RA) principles/ activity planned in conjunction with Local Authority partners to improve timeliness of all discharges (which will positively impact COP position)
17/07/2025: Action complete: Reintroduce D2RA Principles across the Health Board with external consultancy support
16/10/2025: See HBR1 for update on related actions ('Test of Change' and advanced D2RA work; discharge improvement sprint (focusing on COP wards) to free up bed capacity/ improve flow across Morriston site; refresh of the Optimal Hospital Flow Framework at Board Rounds via sustainable ward-level discharge coaching and support.) Exploring a revised model of COP management health board wide.
19/11/2025: POCD are being reviewed by Deloitte. CW has agreed with DL that there will not be an OCP because there are no substantive posts in the IDH.
18/12/2025: Process mapping, capacity and demand of Pathway 2 supported by Deloitte in progress. Audit of Pathway 2 bed utilisation being undertaken 18/12/25 – planned workshop Jan 26 to consolidate findings and agree work programme to re-engineer Pathway 2 bed pool.

Datix ID Number: 2561 Date Opened: May 2022	Date Last Reviewed: December 2025	HBR Ref Number: 85 Risk Target Date: 31/07/2026	Current Risk Rating 4 x 5 = 20
Objective: The health board is a resilient, sustainable and responsible organisation	**SRR Ref:** N/A	**Director Lead:** Christine Morrell, Director of Therapies & Health Sciences **Assuring Committee**: Quality & Safety Committee	

Risk: Non-Compliance with ALN Act

There is a risk of the Health Board not fulfilling the statutory requirements of the Additional Learning Needs and Education Tribunal (Wales) Act 2018 (the ALN Act) within the timescales that are required under the ALN Act, resulting in non-compliance with these duties.

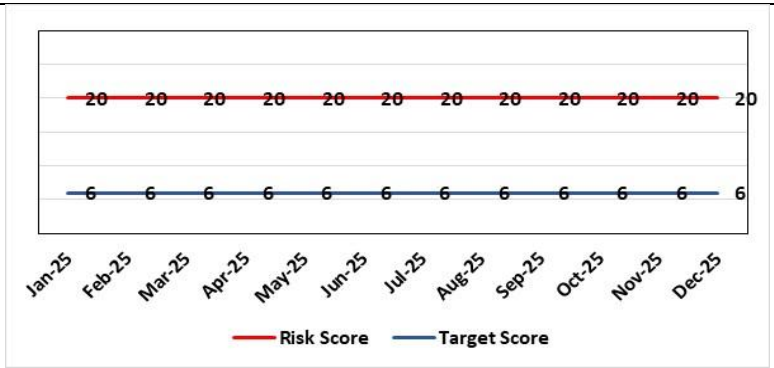
The Health Board has a digital infrastructure that provides data regarding its compliance with its statutory duties under Sections 65 and 20 of the ALN Act. These duties relate to the timely provision of information to support Education planning and decision-making (Section 65), and to timely decision-making about relevant Health provision followed by delivery of this provision where it is found to be required (Section 20). Data for 2025 shows there are breaches against both duties with a high level of frequency (as at July 2025, breaches are generally occurring on an approximately daily basis). Data is not currently reliably captured with regard to the Health Board fulfilling its duty to secure (deliver) additional learning provision where this is identified following a Section 20 referral, so assurance regarding this duty is limited.

In addition to the above:

- The Health Board is currently unable to provide assurance with its duty to notify Education of pre-school children with probable ALN under Section 64 of the legislation. This risk is caused by process and data quality issues.
- The Health Board has not established a process by which it fulfils its legal duties for post-16 learners in partnership with local Further Education Institutes. There is a need to establish this process.

Potential consequences of the risk of the Health Board not fulfilling the statutory requirements of the ALN Act within the timescales required are: non-compliance with statutory duties; parent / carer and young peoples' dissatisfaction leading to complaints and legal challenge; reputational impact; and children failing to access the multi-agency support that they need with their learning needs, leading to poor outcomes.

Risk Rating (consequence x likelihood): Inherent: 5 x 5 = 25 Current: 4 x 5 = 20 Target: 2 x 3 = 6		**Rationale for current score:** 2025 compliance data shows that the Health Board is breaching multiple statutory duties (duties under both Sections 65 and 20 of the ALN Act) with a high level of frequency (approximately daily). The Health Board is currently unable to provide assurance regarding compliance with its legal duties under Section 64 of the Act, The risk consequence is major (multiple breaches of a statutory duty - 4) and the likelihood is expected (breaches occurring approximately daily - 5), hence the current risk score of 20.



Rationale for target score:
As the ALN Act is new legislation, there remains some ongoing likelihood of risk events during the initial phases of implementation, though with lessened consequences as a result of mitigating actions.

Controls (What is currently in place to manage the risk?)

- Designated Educational Clinical Lead Officer (DECLO) is in post, providing a single point for direction and co-ordination of the Health Board's activity under the ALN Act. The post is a statutory requirement.
- Operational processes through which the Health Board fulfils its statutory duties under the ALN Act are in place.
- Health Board ALN Steering Group has been established, with ALN Operational Group working under the governance of this,
- There is close and ongoing collaborative working with Local Authority Education partners, including their involvement in the ALN Steering and Operational Groups as noted above.
- Activity is planned to develop a clear understanding of the causes of the current risk and to identify the actions required to mitigate the risk. This activity will be progressed within the relevant Service Groups' ALN governance structures with oversight of the ALN Steering Group.

Further Actions (What more are we going to do to address the risk?)

Action	Lead	Deadline
Revise processes through which the Health Board fulfils its duty under Section 64 of the ALN Act and ensure that accurate and reliable data is available.	DECLO	28/02/2026
Establish process through which Health Board fulfils its legal duties with local college partners	DECLO	31/03/2026
Ensure ALN performance metrics are embedded in all relevant Service Groups' governance structures, with strengthened accountability arrangements	DECLO	31/03/2026

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

- The Health Board has a digital infrastructure to monitor compliance
- There is regular reporting on compliance with the ALN Act that is now data-informed through the Patient Safety and Compliance Group.
- The Health Board has an ALN Steering Group, chaired by the Deputy Director for Allied Health Professions and Health Sciences, ensuring oversight at a senior level within all impacted operational and corporate areas. The Health Board also has an ALN Operational Group, chaired by the DECLO, to co-ordinate activity required to address the risk. The Operational Group has an ALN workplan and reports are made to the Steering Group regarding progress

Gaps in assurance (What additional assurances should we seek?

Additional Comments / Progress Notes

22/12/2026: Activity is ongoing to strengthen governance and accountability arrangements for ALN Act compliance through operational Service Groups. Service Group updates will be provided to the ALN Steering Group, chaired by the EDAHPHS, in January 2026. The previous action regarding securing longer-term business and project management support has been removed as

this is not directly linked to ALN Act compliance. There has been some delay in progressing work involving local colleges and adult Health Board services, and consequently the deadline for one action has been adjusted,

Datix ID Number: 3071 Date Opened: November 2022	Date Last Reviewed: December 2025	HBR Ref Number: 89 Target Risk Date: TBC	Current Risk Rating 4 x 5 = 20
Objective: The health board is a great place to work where all staff feel valued and work together towards a common goal	**SRR Ref:** 4.1	**Director Lead:** Elizabeth Rix, Executive Director of Nursing **Supporting Director:** Deb Lewis, Chief Operating Officer **Assuring Committee:** Quality & Safety Committee	

Risk: Healthcare Nursing Staff Levels at HMP Swansea

There is a risk that the men in HMP Swansea will not receive the appropriate standard of care. This is because the nursing establishment within the prison no longer fully meets the changed demographics and numbers of men being detained. The maximum operational capacity of the Prison can reach circa 480 men. The Health Board investment into the Prison is based on delivering services to 250 men. This was also highlighted as a risk in the June 2022 HIW governance review. In addition, there is no head room built into the Prison nursing establishment, so periods of sickness, leave and study render the roster short.

Risk Rating
(consequence x likelihood):
Inherent: 4 x 5 = 20
Current: 4 x 5 = 20
Target: 2 x 2 = 4

Rationale for current score:
Consequence major – unable to fully deliver on the recommendations of HIW due to low healthcare staffing numbers, further impacted during periods of sickness or absence as no headroom. Recommendations also raised in Prison & Probation Ombudsman reports. Likelihood expected – suboptimal care provided on a daily basis.

Rationale for target score:
Consequence minor – With sufficient staffing numbers the prison will be able to deliver on HIW recommendations and fully implement the actions in the Health Delivery Plan. Likelihood unlikely – With full establishment and headroom, suboptimal care is less likely.

Controls (What is currently in place to manage the risk?)

Daily communication with the Governor about the availability and priority of healthcare nursing staff.
Pharmacy technician role established – can administer drugs to support nursing establishment.
Agreed that Health Care Support Workers to be 2nd checkers for CD drugs and to support substance withdrawal monitoring (awaiting accreditation).
Bank and agency staff are used in a limited way, when skillset allows.
E-roster implemented and scrutinised with regular reporting to Service Group Patient Safety & Compliance Group.
Escalation for overtime and additional hours to fill shortfalls.

Further Actions (What more are we going to do to address the risk?)

Action	Lead	Deadline
Review of staffing in prison. Royal College of Psychiatrists Substance Misuse and Mental Health Baseline assessment completed – analysis of outcome and agreement of further action next. (Following financial deep dives)	Deputy Head of Nursing	31/01/2026

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

Prison feedback and complaint process
Progress reporting on action plans through Service Group PS&C Group, and Health Board Q&S structures (via Patient Safety & Compliance Group).

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

Implementation and reporting of clinical audits. Audit framework for HMP Swansea in development - Clinical Pathways/Audits and Health Promotion groups taking forward.

Additional Comments / Progress Notes

19/11/25 - 2 WTE band 6 appointed, 3.5 WTE band 5 posts submitted to TRAC for approval. Reduction in variable pay noted. HMP position paper was not presented at PCT operational board on 28/10/25,this report highlights a programme of work to address recommendations from the Healthcare Needs Assessment (HNA) 2024 and QHNSMH 2024 (Quality Network for Prison

Mental Health Services – Royal College of Psychiatrists) and Healthcare Inspectorate Wales (HIW) 2022 Inspection recommendations, await date to present. 30/12/25 – Approval for 3.5 WTE Band 5 agreed on 29/12/25, will now follow recruitment process. Continued scrutiny with rosters for use of variable pay, it is noted that this will improve once 3.5 WTE Band 5 are in post. DHON and NGD to meet early January 2026 to review workforce.

Datix ID Number: 2796 Date Opened: January 2023	Date Last Reviewed: December 2025	HBR Ref Number: 90 Target Risk Date: TBC	Current Risk Rating 4 x 5 = 20
Objective: The health board is a resilient, sustainable and responsible organisation	**SRR Ref:** N/A	**Director Lead:** Matt John, Director of Digital **Assuring Committee:** Digital, Research & Innovation Committee	

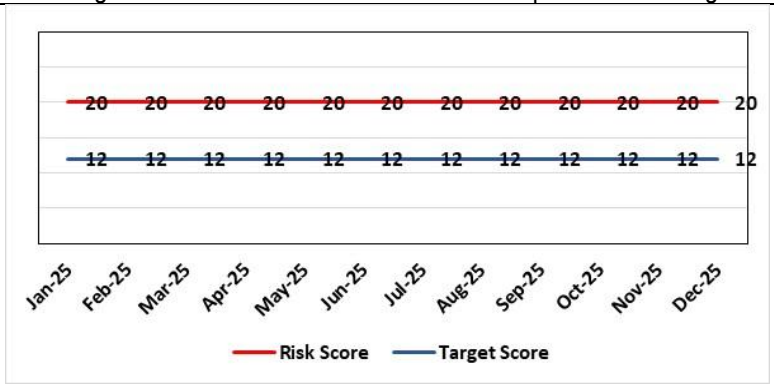
Risk: Subject Access Request Risk

Due to insufficient resources and inconsistent processes across Swansea Bay University Health Board, there is a risk that Subject Access Requests (SARs) will not be fulfilled in compliance with UK-GDPR Article 15, resulting in potential breaches of personal data which could cause distress and lead to a loss of public and government confidence in the Health Board's trustworthiness and legal standing.

Additional Potential Consequences:

- Regulatory Enforcement: ICO (Information Commissioner's Office) may impose fines up to 4% of annual turnover for serious breaches. While the ICO has not historically issued fines for SAR breaches, this may change, especially as enforcement activity increases. A recent reprimand issued by the ICO to another NHS Trust, signals heightened regulatory scrutiny.
- Operational Disruption: Staff diverted from priority tasks to manage SARs, affecting service delivery
- Legal Exposure: Increased risk of litigation & claims from individuals with compromised data rights.

Risk Rating
(consequence x likelihood):
Inherent: 4 x 4 = 16
Current: 4 x 5 = 20
Target: 4 x 3 = 12



Rationale for current score:

C – This is assessed to be Major (score 4) under the Governance & Assurance risk domain of health board policy. Given the heightened external scrutiny of Swansea Bay University Health Board's Maternity and Mental Health services, failure to comply with SAR requirements or mis-sharing of sensitive information in these areas could result in multiple complaints, loss of public confidence, negative media coverage, and/or criticism by Welsh government.

L- The probability of one of these potential consequences occurring is currently considered to score 5 (expected – greater than 50% chance) due to the sustained and growing backlog of SARs, particularly in the Maternity and Children and Young People (CYP) services, along with 2024/25 statistics showing 65% of SARs are released without full clinical approval. These areas are experiencing a surge in requests following media coverage, with further increases expected. The complexity and sensitivity of these cases, combined with limited resources and inconsistent processes, make delays and errors expected. While the risk of an ICO fine remains low, the frequency of breaches, solicitor correspondence, complaints, ICO involvement and claims for financial compensation is already high and likely to escalate.

Rationale for target score:

C – As above

L – Additional resources would allow the organisation to make significant improvements to the process by which SARs are managed. Being able to adequately comply with legal requirements reduces the likelihood of enforcement action and fines from the ICO, as well as minimising the risk of reputational damage.

<table>
<tr><th>Controls (What is currently in place to manage the risk?)</th><th colspan="3">Further Actions (What more are we going to do to address the risk?)</th></tr>
<tr><td rowspan="2">• Approved SAR Policy: Provides a formal framework for consistent SAR handling.
• Dedicated SAR Lead (Band 7 IG Manager): Ensures operational oversight and coordination.
• Defined Governance Roles: SIRO, Caldicott Guardian, and DPO roles are in place and active.
• Legal and Risk Advice: Accessed for complex SARs to ensure lawful and appropriate handling.
• Escalation to Information Governance & Cyber Assurance Group (IGCAG): Enables timely intervention and oversight of emerging issues
• SAR Working Group monitoring: Tracks delivery of actions and feeds into governance structures.</td><td>Action</td><td>Lead</td><td>Deadline</td></tr>
<tr><td>Implement detailed Action Plan in line with the timescales outlined within the Plan</td><td>Data Protection Officer/Head of Health Records</td><td>31/03/2026</td></tr>
<tr><td>Assurances (How do we know if the things we are doing are having an impact?)
• Bi-monthly reporting to DDRI: Provides regular oversight and visibility at committee level.
• IGCAG oversight: Chaired by the SIRO and attended by key governance leads.
• Escalation reports to Management Board and DDRI: Ensures senior leadership awareness.
• Internal audit findings: Highlighted resource gaps and informed improvement planning.</td><td colspan="3">Gaps in assurance (What additional assurances should we seek?)
Internal audit report identified the requirement to invest in resources to address gap in assurance.</td></tr>
<tr><td colspan="4">Additional Comments
Background and Context:
The Health Board faces a sustained increase in both the volume and complexity of SARs, driven by technological advancements, expanded data availability, and evolving communication practices (e.g. use of WhatsApp and non-corporate email channels). This surge has outpaced existing capacity, including that of professional and expert staff, with many requests exceeding statutory response times and lacking adequate redaction or clinical review. The fragmented nature of record-keeping—spanning paper files, multiple systems, and sensitive content— and inconsistent handling procedures across departments further complicates timely and compliant disclosures.
During the 24/25 financial year, the acute SAR team processed 8,652 requests for data. This excludes other areas of SBUHB who manage their own SAR. Each SAR application may involve multiple requests for Health Care Professionals (HCPs) to approval the release of information. The 8,652 applications resulted in 9,102 requests to HCPs to approve, with an additional 4561 released without specific approval based on an ‘open consent’ given previously. Of the requests to approve, 48% (4,366) did not reply within 7 days and therefore this data was released without approval. Therefore only 35% of all SAR requests are released with full HCP oversight. The acute SAR team note that of the 8,652 requests into them, 124 were unable to be completed within the 28-day mandatory timescale. Of these 124, 104 were relating to Children and Young People (CYP) and 18 related to complex email enquiries. Whilst these figures may not appear significant in comparison to the total annual requests received, it is important to recognise that the time required to address these CYP and complex emails is considerable and places an excessive pressure on the organisation, e.g. A large email search may result in 10,000-15,000 emails, all requiring oversight and review, often taking weeks to complete for each request.
During 2024/25, SBU received 10 SAR complaints from the public, an additional 3 SAR complaints from the ICO, and reported 1 SAR breach to the ICO.
Progress Notes
04/12/2025: Met with Caldicott Guardian on 17/11/25 to discuss a number of actions on the Action Plan. Some actions requiring CG input have subsequently been marked as complete.</td></tr>
</table>

Datix ID Number: 3444 Date Opened: June 2023	Date Last Reviewed: December 2025	HBR Ref Number: 92 Risk Target Date: 31/03/2026	Current Risk Rating 5 x 5 = 25
Objective: The health board is a resilient, sustainable and responsible organisation	**SRR Ref:** 5.1	**Director Lead:** Darren Griffiths, Director of Finance and Performance **Assuring Committee:** Performance & Finance Committee	

Risk: Forecast Deficit

Forecast deficit is not met due to (1) insufficient progress on run rate reduction, (2) the saving targets required across all areas are not achieved.

Risk Rating
(consequence x likelihood):
Inherent: 5 x 4 = 20
Current: 5 x 5 = 25
Target: 5 x 1 = 5

Rationale for current score:

- Delivery of the deficit plan is predicated on a combination of savings and run rate reductions
- Consequence is significant as failure to deliver the plan could impact service delivery if cost reduction required later in the year
- A deficit plan is a failure to meet a statutory duty

Rationale for target score:

- The consequence will not change given the important of financial delivery and its relationship with the delivery of the Health Board recovery and sustainability plan
- Reducing likelihood to 1 supports a confidence that the deficit plan will be delivered.

Controls (What is currently in place to manage the risk?)

The Health Board is doing the following:

- Accountability Letters and Budgetary Management Framework were issued to all Directors in April 2025, which set the expectation and budget for 2025/26.
- Introduced in Q3 of 2024/25 the Health Board has put in place further oversight via the Recovery & Sustainability Board, which reported directly to PFC and is chaired by the CEO. This Board is held bi-weekly.
- Supporting the R&S Board is the R&S Team, which for 2025/26 has dedicated resource to lead the programmes of work agreed for 2025/26, of which the Board has agreed on 5 key areas.
- Budgetary Management approach 2025/26 requires all Services Groups to produce a Financial Strategy by end May 2025.
- Continued transparent exchange of position with NHS Executive & Welsh Government, with both weekly and monthly meetings with the NHS Executive.
- Standard Day 5 Finance Reports on Variable Pay, Savings Performance and Flash report published via SharePoint site.
- Variable Pay Cap agreed by the organisation to deliver £32m of savings as set out in the Financial Framework dated 30th June 2025 as well as further enhancements of controls agreed through Q2, Q3 via Recovery & Sustainability Board.
- Strengthening of the Recovery & Sustainability governance and controls aligned to the initial recommendations from work by Deloitte (external partner).

Further Actions (What more are we going to do to address the risk?)

Action	Lead	Deadline
Extension to commissioning of external support (Deloitte), in collaboration with Welsh Government, which commenced on 14th July 2025. Provide further support for core areas of financial delivery for 2025/26 and establishment of a sustainable position into 2026/27.	Director of Finance & Performance	28/02/2026
Assessment of the action to address the gap to deliver £58.7m was provided to both Performance & Finance Committee and at a special meeting of the Board in mid-December. Following the agreed actions the Finance Team will provide updates on progress against these as part of the core monthly reporting for the remainder of 2025/26.	Director of Finance & Performance	31/03/2026

• The Health Board has developed with its strategic external partner (Deloitte) a clear plan to deliver the £55.4m savings required for 2025/26.			
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: • WG Monthly Monitoring Returns and letter signed by CEO and DOF • Monthly financial performance meetings • Monthly performance meetings (New 2025/26) • Performance & Finance Committee • Independent Member briefings • Recovery & Sustainability Board • Routine reporting to Board of most recent monthly position and financial forecasts • Weekly meetings with the NHS Executive • Monthly TI Meetings with NHS Executive • Face to Face meetings with Director Finance for NHS Wales	**Gaps in assurance (What additional assurances should we seek?)**		
Additional Comments / Progress Notes 21/10/2025: First formal feedback from our external strategic partner has been held jointly with the Health Board and Welsh Government, aligned to the deliverables of the contract. Feedback was initially in draft, and work is ongoing to finalise the reports. 03/11/2025: Service Group Directors and Finance Business partners were required to provide robust forecast for 2025/26 and recurrent impact, including savings delivery for Check & Challenge meeting with Director of Finance & Performance on 4 November. This work was put in place to support the wider assessment of the Health Board's forecast to 31st March 2026. Work has been completed and the gap to deliver £58.7m assessed and presented to Performance & Finance Committee at end November.			

Datix ID Number: 3448 Date Opened: June 2024	Risk score reduced from 20 Date Last Reviewed: December 2025	HBR Ref Number: 93 Risk Target Date: 31/03/2026	Current Risk Rating 4 x 3 = 12
Objective: The health board is a resilient, sustainable and responsible organisation	**SRR Ref:** 5.1	**Director Lead:** Darren Griffiths, Director of Finance and Performance **Assuring Committee:** Performance & Finance Committee	

Risk: Reduced Capital Funds

Reduced National NHS funds available for major capital schemes requiring a restricted Capital Plan for 2025/26.

Risk Rating
(consequence x likelihood):
Inherent: 5 x 4 = 20
Current: 4 x 3 = 12
Target: 5 x 1 = 5

Rationale for current score:

- The Health Board has been advised that its discretionary capital allocation for 2025/26 is £13.875m.
- The funding available within the Capital Resource Limit (CRL) will not meet the demands for capital investment. Discretionary capital is deployed to replace ageing medical devices & equipment; to address backlog maintenance of premises; and to support small scale, non-National service improvements with capital investments
- The outcome of the national capital prioritisation exercise means some major capital scheme business cases are on hold. A number of high-risk priority schemes will require funding support from WG, including interim measures for ED and Acute Adult Mental Health In-patients services.
- All assumed income to achieve a balanced plan has now been received from Welsh Government.
- Slippage funding of £4.8m received from Welsh Government in November.
- Additional funding bids £4.4m submitted to Welsh Government 11th December.
- Potential consequences of this risk are the inability to achieve the ambitions set out within health board plans; the potential failure of ageing equipment leading to service disruption; the exposure to potential environmental health & safety risks.
- Following the receipt of additional funding which reduces the immediate in-year pressure on the medical equipment and digital replacement programmes, and with all income risks removed, the risk rating is lowered from 20 to 12.

Rationale for target score:

The target score expresses the aspiration of the health board for addressing this risk. The target date indicated above reflects the point which the current actions are anticipated to reduce the risk, though knowledge of the actual funding available is required to reduce it further and this is not available until some months into the financial year.

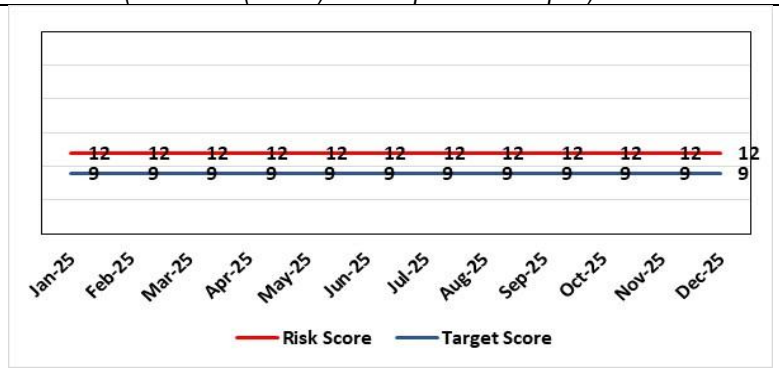
<table>
<tr><th colspan="2">Controls (What is currently in place to manage the risk?)</th><th colspan="3">Further Actions (What more are we going to do to address the risk?)</th></tr>
<tr><td rowspan="3">The Health Board is doing the following:
• Regular dialogue with Welsh Government regarding capital requirements.
• Clear communication and reporting of the capital position, the risks and limitations.
• Close management of all schemes to ensure slippage is understood along with the impact on service.
• Clear prioritisation of any new requirements recognising the current constraints</td><td>Action</td><td>Lead</td><td>Deadline</td></tr>
<tr><td>Routine review and flexing of plan as spending is committed through the year. Routine monitoring processes will identify any potential slippage and will deploy this on risk-based basis.</td><td>Director of Finance & Performance</td><td>Monthly through the financial year as plan is dynamic</td></tr>
<tr><td>Examine the specific prioritisation and phasing of capital investment to meet health board objectives through the Capital & Estates Taskforce.</td><td>Director of Finance & Performance</td><td>Bi-Monthly</td></tr>
<tr><td></td><td>Maintenance of risks through the Capitalisation Prioritisation Group should additional WG funding become available later in the year.</td><td>Assistant Director of Finance (Strategy & Planning)</td><td>On-going</td></tr>
<tr><td colspan="2">Assurances (How do we know if the things we are doing are having an impact?)
The Health Board capital position is reviewed and monitored through:
• Quarterly capital prioritisation group
• Performance & Finance Committee quarterly finance report
• Capital & Estates Taskforce
• Capital & Estates Board
• Capital Management Group
• Monthly Monitoring Returns to Welsh Government.</td><td colspan="3">Gaps in assurance (What additional assurances should we seek?)
Reporting on impact of constraints to the capital programme on service delivery.</td></tr>
<tr><td colspan="5">Additional Comments / Progress Notes
16/10/25: There are new constraints on the national funding position which is putting pressure on the local in-year capital plan. Decisions made on fixing the in-year CRL position on 31st October with WG will need to take account of the new unfunded local pressures.
23/11/25: Risk remains at 20 following Performance & Finance Committee meeting 28/10/25. CRLs fixed with WG 30/10/25. Additional £4.780m in-year funding bids submitted to WG 6/11/25.
17/12/25: Slippage funding of £4.8m received from Welsh Government in November. Following the receipt of additional funding which reduces the immediate in-year pressure on the medical equipment and digital replacement programmes, and with all income risks removed, the risk rating is lowered from 20 to 12.</td></tr>
</table>

Datix ID Number: 3516 Date Opened: October 2023	Date Last Reviewed: December 2025	HBR Ref Number: 94 Risk Target Date: TBC	Current Risk Rating 4 x 3 = 12
Objective: Care is high quality, safe, efficient, and delivers the best possible outcomes for people in partnerships	**SRR Ref:** 2.7	**Director Lead:** Deb Lewis, Chief Operating Officer **Assuring Committee:** Performance & Finance Committee **For information:** Quality & Safety Committee	

Risk: CAMHS failure to meet required standards of performance

The CAMHS service is unable to meet the required level of performance due to workforce deficits in the team across all staff groups including medics, psychological therapies and nursing. Data quality review has been completed and new processes are in place to ensure it is accurate.

Links to other CAMHS risk register entries: (Ref: 3373 (ADHD)/ 3346 open / 3350 open)

Risk Rating (consequence x likelihood): Inherent: 4 x 5 = 20 Current: 4 x 3 = 12 Target: 3 x 3 = 9		**Rationale for current score:** Marked improvement in the performance against the Mental health Measure for CAMHS. Data validation for new patients complete. Current risk score 12 in view of improved performance however this reflects the fragility in the workforce to deliver sustained performance. Work is still ongoing within CAMHs to maintain and improves the situation. **Rationale for target score:** The rationale for the target score is linked to successful recruitment and more timely access to services for children and young persons which will reduce risk.

Controls (What is currently in place to manage the risk?)	**Further Actions (What more are we going to do to address the risk?)**		
	Action	**Lead**	**Deadline**
Ongoing recruitment into nursing and medical staff groups. Psychology and Therapies are fully recruited. Use of temporary agency workforce in nursing at premium pay rates to sustain current levels of performance Recent appointment into psychological therapies lead posts. -Exploring fixed term appt of Band 5 psychological therapies support staff to improve performance.	Continued efforts at recruitment. Recovery Plan in place.	Associate Service Director	31/01/2026

Assurances (How do we know if the things we are doing are having an impact?)	**Gaps in assurance (What additional assurances should we seek?)**
As above with controls. -Monthly CAMHS Directorate meeting in place where performance and workforce are scrutinised -Reporting into Weekly Business Team and MH & LD management board. - Mental Health Division Quarterly Performance Review -Reporting into SBU Performance & Finance Committee and IQPD (Integrated Quality & Performance Delivery) meeting with Welsh Government	

Additional Comments / Progress Notes

11/12/2025

CAMHS 1a: remains generally consistent.

CAMHS Part 1B:

Recruitment to vacancies has been successful, however additional vacancies and maternity leave weakens the capacity pool to almost pre-recruitment levels

Despite this, the recovery plan roll out is underway, which includes changes to the delivery of the initial therapeutic offer for 1:1 intervention, which enables young people to commence support more quickly. This has resulted in 3 months of small, but consistent improvement in the Part 1B performance irrespective of staffing challenges, which is now at 66% (Submitted for Nov 2025) Weekly meetings continue over booking and utilisation of capacity and using our staffing resource as flexibly as possible

Datix ID Number: 3571 Date Opened: October 2023	Date Last Reviewed: December 2025	HBR Ref Number: 96 Target Date: 31/03/2026	Current Risk Rating 4 x 5 = 20
Objective: The health board is a resilient, financially sustainable and responsible organisation	**SRR Ref:** 5.1	**Director Lead:** Marie Davies, Executive Director of Planning & Partnerships **Assuring Committee**: Performance & Finance Committee	

Risk: Failure to Develop an Approvable IMTP (statutory compliance)

If we fail to have an approvable Integrated Medium-Term Plan (IMTP) for 2026/27 then we will not meet our statutory duty to break even and may lose public confidence.

Risk Rating
(consequence x likelihood):
Initial: 4 x 5 = 20
Current: 4 x 5 = 20
Target: 4 x 2 = 8

Rationale for current score:
The Health Board does not have a WG approved IMTP and has been placed in enhanced monitoring for Finance, Strategy and Planning following the inability of the Health Board to submit a balanced IMTP since March 2023. Given the All-Wales financial context, the Health Board was not able to submit an IMTP in March 2025. It has instead developed an Annual Plan 25/26 set in a three-year context.

Rationale for target score:
The target remains to develop a financially balanced IMTP so that we meet our statutory duties.

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

- As per the Welsh Government de-escalation criteria for Strategy and Planning, work has commenced to update and realign the Health Board's strategy and clinical services strategic plan.
- As per the Welsh Government de-escalation criteria for Strategy and Planning, work has been undertaken to assess the Health Board against the planning maturity matrix and develop an action plan in response. This will be reported via the Board Planning & Partnerships formal report.
- The Recovery and Sustainability Board monitors delivery of agreed actions in relation to the financial position.
- The Annual Plan Oversight Group has been superseded by the Integrated Planning and Performance Review Meeting which takes on a quarterly basis and is chaired by the CEO with the purpose of providing formal management oversight to the delivery of the Annual Plan, and to act as a forum for future planning discussions.
- Plan development will continue to be subject to robust challenge and scrutiny through regular briefings to Independent Members, Performance and Finance Committee (now meeting twice a month, once informally and once formally) and with detailed oversight from the Board itself.

Mitigating actions (What more should we do?)

Action	Lead	Deadline
Refresh Clinical Services Strategic Plan	Executive Director of Planning & Partnerships/ Medical Director	31/03/2026
Recovery and Sustainability Board to continue to focus on savings delivery and now shift to a more sustainable approaches in the longer term. A new monthly performance review regime and Executive Team members to oversee thematic savings workstreams and support Service Groups to meet targets.	Executive Director of Finance and Performance	31/03/2026

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

Progress against the delivery of the plan will be scrutinised through strengthened governance supported by a new performance management and accountability framework.

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

Additional Comments / Progress Notes

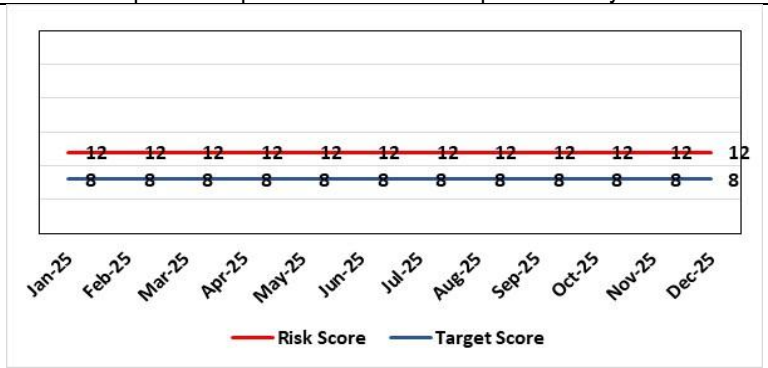
17/12/2025: Register entry reviewed & updated.

Datix ID Number: TBC Date Opened: May 2024	Date Last Reviewed: December 2025	HBR Ref Number: 100 Target Risk Date: 28/02/2026	Current Risk Rating 4 x 3 = 12
Objective: People of Swansea Bay live healthier, fairer and more prosperous lives	**SRR Ref:** 1.1	**Director Lead:** Marie Davies, Executive Director of Planning & Partnerships **Assuring Committee:** Population Health Committee	

Risk: A lack of a robust approach to partnerships & collaboration

If the health board does not have effective structures, processes and working relationships with its external partners at the Public Services Board (PSB) and/or Regional Partnerships Board (RPB), there is a risk that areas of work dependent upon collaboration with partners may not deliver what is required in a timely way, impacting on the delivery of health board priorities.

Risk Rating
(consequence x likelihood):
Inherent: 4 x 3 = 12
Current: 4 x 3 = 12
Target: 4 x 2 = 8



Rationale for current score:
Currently the likelihood of non-delivery of partnership priorities that meet expectations is possible.

Rationale for target score:
The occurrence of non-delivery of partnership priorities will reduce with an improved partnership approach within the Health Board, although given the complex nature of partnership working it is unlikely to completely eradicate the risk.

Controls (What is currently in place to manage the risk?)

- Senior Health Board leadership is now embedded across the West Glamorgan Regional Partnerships Board (WGRPB) governance to improve visibility and decision making, and the internal Strategic Partnerships Group the Population Health Committee – both established in 2023, provide oversight for external partnerships.
- Collaborative Partnerships Framework has been agreed by SBUHB Management Board, setting out a Health Board approach to Partnerships.
- The Annual Plan 2025/26 outlines clear priorities for working with PSB and RPB Board and governance and leadership arrangements have been strengthened to support delivery
- The Director of Planning & Partnerships and the Chief Operating Officer meet weekly with Directors of Social Services and are continuing to align work programmes and develop trusted relationships. Two key areas of work that are being integrated/closely aligned are: 6 Goals programme to be integrated into RPB governance and RPB Emotional Wellbeing & Mental Health programme will be aligned through governance and reporting structures.
- A Partnerships Tracker has been developed and presented to the Audit Committee. The Partnerships Tracker will provide greater oversight of the health board's statutory duties and requirements, and a report will go to Audit Committee three times a year.

Further Actions (What more are we going to do to address the risk?)

SB)	Lead	Deadline

Assurances (How do we know if the things we are doing are having an impact?)
Strategic Partnerships Group (SPG) in place and provides oversight of partnership discussions,

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

including the WGRPB and the Public Service Boards (PSB). Regular updates and assurance are provided to Health Board via the Director of Planning and Partnerships Management Board report. Collaborative Framework and the Partnerships Tracker are both tools developed to support the Health Board become a better partner with greater oversight.	

Additional Comments / Progress Notes

17/12/2025:

• Children & Young People – The establishment of the Women, Children & Young People's Care Programme Board will provide increased visibility and strategic leadership in these key priority areas. A workshop in December was co-chaired by the Executive Director of Nursing and the Chief Operating Officer and the first meeting is scheduled for February 2026.

• Partnerships governance – The Partnerships Tracker is now agreed and the first report will be submitted to audit committee in January 2026. The ongoing review and maintenance of the tracker will be the responsibility of the planning & partnerships team.

The risk level will be re-assessed following the establishment of the SBUHB Women, Children & Young People's Programme Board and Plan for Children & Young People (target risk date field updated to reflect this).

Datix ID Number: 443 Date Opened: May 2025	Date Last Reviewed: December 2025	HBR Ref Number: 104 Risk Target Date: 31/03/2027	Current Risk Rating 4 x 5 = 20
Objective: Care is delivered in partnership with our communities in safe and appropriate settings, supported by innovative digital solutions, research, development and innovation	**SRR Ref:** 3.4	**Director Lead:** Matt John, Director of Digital **Assuring Committee:** Digital Data & Innovation Committee **For information:** Quality & Safety Committee	

Risk: Failure to meet Tier 1 targets in Clinical Coding Completeness

Because: The volume of new inpatient episodes exceeds the available clinical coding staff capacity; There are difficulties recruiting and retaining a sufficient number of trained clinical coding staff to address the gap, and clinical information is not always of sufficient quality or completeness electronically (such as DALs) to support swift coding.

There is a risk that: Clinical notes for inpatient episodes will not be coded in a timely way.

Resulting in: The non-achievement of the Tier 1 Welsh Government target (which is that 95% of inpatient activity should be coded within 30-days of discharge); Insufficient coded data to support effective service planning for population health needs; Inadequate data being available for mortality review/quality and safety purposes, with increased risk of failure to spot variance that are negatively impacting levels of patient care and potentially causing avoidable deaths; Negative impact on accuracy of analysis to understand how resources are being allocated and used at Health Board level and national level (programme budgeting); Delays in claiming casemix sensitive contract lines with JCC, Hywel Da and Cwm Taff (circa 70m per annum value in total) due to lack of coding data.

Risk Rating
(consequence x likelihood):
Inherent: 3 x 4 = 12
Current: 4 x 5 = 20
Target: 4 x 3 =12

Rationale for current score:

C - Insufficient coding data will negatively impact service planning for population health needs and inadequate data being available for mortality review/quality and safety purposes. This could result in failures at spotting patterns of variance that are negatively impacting levels of patient care and potentially causing avoidable deaths.

Clinically coded activity is also used to understand how resources are being allocated and used at Health Board level and national level (programme budgeting), and therefore a reduction in coding completeness will impact on the accuracy of this analysis. It is also used to claim casemix sensitive contract lines with JCC, Hywel Da and Cwm Taff of circa 70m per annum with lack of coding data impacting on the timeliness in making these claims.

L - Tier 1 target is currently not being met on a regular basis.

		Rationale for target score: C - Insufficient coding data will negatively impact service planning for population health needs and inadequate data being available for mortality review/quality and safety purposes. This could result in failures at spotting patterns of variance that are negatively impacting levels of patient care and potentially causing avoidable deaths. Clinically coded activity is also used to understand how resources are being allocated and used at Health Board level and national level (programme budgeting), and therefore a reduction in coding completeness will impact on the accuracy of this analysis. It is also used to claim casemix sensitive contract lines with JCC, Hywel Da and Cwm Taff of circa 70m per annum with lack of coding data impacting on the timeliness in making these claims. L – Increase in what can be coded electronically, unit centralisation, greater staff retention and the development of an auto-coding model will lead to increased capacity and a reduction in likelihood for targets not being met.

Controls (What is currently in place to manage the risk?)	**Further Actions (What more are we going to do to address the risk?)**		
	Action	**Lead**	**Deadline**
• A three-year coding modernisation plan has been approved by executive board on 26th February 2025. This plan will see the implementation of an auto-coding solution and a re-banding of the clinical coding department within existing budgets to attain Tier 1 targets by 27/28. • The coding management team assess the staffing complement on a daily basis to ensure resources are deployed in the most efficient and effective manner, in line with demand and clinical coding priorities. • There is a comprehensive training programme in place for new Trainee Coders. • The Clinical Coding Departments raise incidents when clinical information is missing from the patient's health records and prevents the activity being coded in a timely manner. These incidents are highlighted at the Directorate Business Meetings held on a monthly basis as part of the Clinical Coding Key Performance Indicators. • Clinical coding staff performance continues to be monitored and discussed during the monthly Clinical Coding Managers Meetings, which are chaired by the Head of Health Records & Clinical Coding, and an update is also reported and presented on the Health Board Performance Scorecard. • An App has been developed by Digital Intelligence that shows any relevant data relating to a patient episode from different systems including Signal, TOMs, EPOA and DAL in one place. This will reduce the number of systems a clinical coder needs to log into.	Auto-coding Model in production with Neurology Day-Case Episodes	Head of Digital Intelligence Programmes	30/12/2025
	Auto-coding model in production for two specialties	Head of Digital Intelligence Programmes	28/02/2026
	Additional working from home days to be added for staff due to increase in electronic coding opportunities.	Head of Health Records & Clinical Coding	31/12/2025

Assurances (How do we know if the things we are doing are having an impact?)	Gaps in assurance (What additional assurances should we seek?)
• Attainment of the Tier 1 Health Board target for clinical coding completeness which relies on the timely availability and quality of the paper record and electronic sources. Coding 95% of in-patient activity within 30 days of discharge is a tier 1 Welsh Government target that is currently not being achieved regularly within SBU – with an average of circa 74% for 24/25. Performance is reported to Digital Business Meeting every 3 months, and to Digital, Data, Research & Innovations Committee via a Coding Paper. • Episodes are coded from paper and electronic sources; the ability to code from electronic sources improves the timeliness & accuracy; approximately 52,000 episodes of 150,000 episodes are coded from electronic sources currently. This is reported to Digital Business Meeting every 3 months, and to Digital, Data, Research & Innovations Committee via a Coding Paper. • An Audit has been carried out by NHS Wales Assurance and Audit Services of the Coding Department was completed in June 2024 with a result of limited assurance. In response a twelve-point action plan was developed of which one action remains which is the escalation of the coding risk to the Health Board Risk register.	• Investment required supporting the delivery and operational costs of the Digital strategy. • Replacing qualified coders who have left the department with trainees reduces productivity - the only mitigation against this is an auto-coding product to increase productivity and re-banding across coding department to put staff at same bandings as NHS England and help staff retention – the investment required for this is yet to be funded. • The Quality of Discharge Summary provision and standard of clinical information available at the point of coding requires improvement to assist with prompt and accurate coding. There continues to be missing clinical information at the point of coding, preventing accurate and timely coding. • Incomplete DALs.

Additional Comments / Progress Notes

Supplementary Notes:

- Coding 95% of in-patient activity within 30 days of discharge is a tier 1 Welsh Government target that is currently not being achieved regularly within SBU – with an average of circa 74% for 24/25.
- Contract coders and overtime have been used to achieve that 75% average which has stopped due to the current financial situation of the Health Board.
- Retaining and recruiting qualified coding staff is a big challenge due to higher bandings in England and the availability of digitised record to allow home working.
- 6 WTE qualified coders have been lost to English Health Boards or DHCW in the last 3 years due to higher bandings with a further 2WTE retiring. This has resulted in circa 44% of the current coding WTE being trainees/unqualified. Currently, there are 5 qualified coder vacancies (June 2025).

Progress Notes:

08/12/2025 – Auto-Coding Model date has been amended to December - currently in final testing ahead of potential go-live week commencing 8th December.

Datix ID Number: 3114 Date Opened: May 2025	Date Last Reviewed: December 2025	HBR Ref Number: 105 Target Date: TBC	Current Risk Rating: 4 x 4 = 16
Objective: Care is delivered in partnership with our communities in safe and appropriate settings, supported by innovative digital solutions, research, development and innovation	**SRR Ref:** 3.3	**Director Lead:** Matt John, Director of Digital **Supporting Director:** Chris Morrell, EDAHPHS **Assuring Committee:** Digital, Data & Innovation Committee **For information:** Quality & Safety Committee	

Risk: Significant increased cost for the replacement Pathology System LIMS

If the new Laboratory Information Management (LIMS) system is not live before 31st March 2026 then there will be significant additional cost across NHS Wales which could impact the Health Board's financial plans in 2025/26 and 2026/27. Costs would have to be covered to avoid pathology losing access to the current LIMS system resulting in the inability of pathology to deliver diagnostic results and blood transfusion services across all Health Board services including emergency, acute, primary and community services.

Risk Rating
(consequence x likelihood):
Inherent: 5 x 5 = 25
Current: 4 x 4 = 16
Target: 4 x 1 = 5

Rationale for current score:
Consequence – Additional costs could be in region of approximately £1m for the Health Board depending on the length of delay
Likelihood – probable (10-50% chance currently) – due to being off-track on project and lack of confirmed back-up plan.

Rationale for target score:
Consequence as above
Likelihood will be negligible if effective system / mitigations put in place in time

Controls (What is currently in place to manage the risk?)

Configuring and testing the new LIMS system with the aim of go-live with all disciplines before 31st March 2026

SBUHB Pathology services are working in collaboration with other Health Boards and Trusts to share configuration and testing as part of a national programme. The project has agreed a go-live of Cellular Pathology in November. However, national replanning is still underway for other disciplines (Microbiology, Andrology, Blood Sciences and Blood Transfusion) to secure go-live dates before 31st March 2026 when funding for the national programme ends. The two months allocated by the national programme for User Acceptance Testing has been extended to over 12 months as the number of defects in the system remains high. There remain significant defects to be addressed by the supplier, most notably for Blood Sciences with over 400 defects – over 300 of which must either be resolved or worked around before go-live.

Pursuing only a 'Minimal Viable Product' to avoid scope-creep

SBUHB Pathology Services are only seeking to pursue a safe replacement system, known as a 'Minimal Viable Product'. This is to eliminate the possibility of testing timescales being extended.

Further Actions (What more are we going to do to address the risk?)

Action	Lead	Deadline
Determine what additional local costs may be attracted due to extending the project from 31st December 2025 until 31st March 2026 and how these could be funded.	SBUHB Project Team	31/12/2025
Continue to work in collaboration with other NHS Wales organisations to challenge supplier delivery and secure go-live dates before 31st March 2026.	SBUHB Project Team	31/03/2026
Determine what additional local costs may be attracted due to extending the project into financial year 26/27.	Head of Digital Planning	31/03/2026

Other Health Boards and Trusts report they are following the same approach. **Challenging the supplier and Digital Health and Care Wales for their technical delivery** The supplier is responsible for addressing any defects identified during testing. Digital Health and Care Wales (DHCW) are responsible for delivering some of the technical integrations (in addition to co-ordinating the national programme). The SBUHB Project Team, through the programme governance, challenge the supplier and DHCW to deliver on their commitments.			
Assurances (How do we know if the things we are doing are having an impact?) **National Programme Board** SBUHB, together with all Health Boards, Trusts and the supplier belong to the national LIMS Programme Board. The Programme Board receives updates on Digital Health and Care Wales progress towards procuring extended licenses, or a replacement of, the current remote access software. The Programme Board receives updates on testing activities, including metrics showing the number of outstanding system issues. It is chaired by the Executive Director of Allied Health Professions and Health Science for Aneurin Bevan University Health Board. **SBUHB Project Team** A Project Manager is in place to manage the SBUHB Project Team on daily basis. **Operational Delivery Network LIMS 2.0 Sub-Group** SBUHB work in regional partnership with Hywel Dda University Health Board (HDUHB) and hold a joint, monthly Operational Delivery Network LIMS 2.0 Sub-Group, which receives reports from the SBUHB and HDUHB Project Managers, along with Programme Managers from the supplier and Digital Health and Care Wales. This group is jointly chaired by the SBUHB Clinical Lead for Laboratory Medicine and HDUHB Head of Pathology Service, who are also Senior Responsible Officers for the SBUHB and HDUHB projects. **Morriston Management Board** The SBUHB project regularly reports progress to the Morriston Management Board. **Digital, Data, Research and Innovation Committee** The SBUHB project regularly reports progress to the Digital, Data, Research and Innovation Committee.	**Gaps in assurance (What additional assurances should we seek?)** **Meeting the costs of extending the project and access to the current LIMS** A national mitigation plan was previously proposed that would enable go-lives of all SBUHB pathology disciplines by 31st December 2025. The national programme has since reported they have extended the programme until 31st March 2026. Welsh Government have confirmed they will cover the £1.6m cost of the mitigation plan that would fund the programme until 31st December 2025. Digital Health and Care Wales are seeking to cover a further £0.87m of national costs not previously included in the mitigation plan, that would fund national components of the programme until 31st March 2026. The SBUHB project needs to determine what additional local costs may be attracted due to extending the project from 31st December 2025 until 31st March 2026 and how these could be funded. **Resource Constraints** All available staff are committed to the programme, with no external resources readily available. This has contributed to the programme's red RAG status.		

Additional Comments / Progress Notes

User Acceptance Testing sign-off

User Acceptance Testing across Wales was originally expected to take place across the two months of September and October 2024. However, a significant number of issues in the system, coupled with partial delivery of integrations between the LIMS and national systems managed by Digital Health and Care Wales, were identified early in the process. Maintaining the availability of Pathology staff to undertake testing across an extended duration, alongside maintaining service delivery, has also been challenging.

User Acceptance Testing has been extended to, depending on the pathology discipline, around twelve months. Go-lives have not been delayed by the same amount and the decreased duration between the end of User Acceptance Testing and go-live puts additional pressure on the project:

	Previously	Currently
Duration of User Acceptance Testing	2 months	12 months
Duration between User Acceptance Testing sign-off and go-live	3 months	1 month

Business Continuity

The Health Board's current Business Continuity Plan to address a failure in digital pathology systems is to revert back to paper based reporting, which is unsustainable and would only be effective over a very short-term period (days).

Blood Transfusion services in other part of Wales

SBUHB Blood Transfusion are the only Blood Transfusion service in Wales that have successfully migrated onto the current LIMS system. Other Blood Transfusion services use other legacy systems and will potentially be impacted after the 15th December 2025 in other ways (e.g. by having to extend support for their existing legacy systems).

Pathology resource for testing

Testing is reliant on the knowledge and skills of Health Board staff whose availability is limited, having to manage testing alongside normal service delivery. With a national shortage of Biomedical Scientists, there is no readily available external resource to support this process.

11/11/2025 – The pathology Operational Delivery Network LIMS sub-group chair has written to the LIMS national programme chair to request that the Backup Plan and the costs estimated within it be revisited given the increasing likelihood that go lives will take place in the new financial year.
09/12/2025 - Costs shared with 9th December 2025 Programme Board show a cost after 31st March 2026 of £3.3m per quarter, with £0.4m of those costs apportioned to SBUHB.

Datix ID Number: TBC **Date Opened: October 2025**	**Date Last Reviewed: December 2025**	**HBR Ref Number: 106** **Target Date: TBC**	**Current Risk Rating:** **4 x 5 = 20**
Objective: The health board is a resilient, sustainable and responsible organisation	**SRR Ref:** N/A	**Director Lead:** Marie Davies, Director of Planning & Partnerships **Assuring Committee:** Performance & Finance Committee	

Risk: Emissions Reduction

If we do not identify funding and implement appropriate actions effectively and in a timely way, there is a risk that we will not deliver the emissions reduction targets of 16% by 2025 and 34% by 2030 as determined in the NHS Wales Decarbonisation Strategic Delivery Plan (DSDP 2021). This could result in failure to achieve Health Board targets, undermine achievement of national targets, and expose the Health Board to potential reputational damage in the eyes of Welsh Government and the wider public.

Risk Rating (consequence x likelihood): Inherent: 4 x 5 = 20 Current: 4 x 5 = 20 Target: 4 x 3 = 12		**Rationale for current score:** Consequence: 4 – based on Governance and Assurance domain outcome of: Low performance rating (low confidence of external stakeholders and Welsh Government connected to potential delay slippage/delay in delivery of targets) Likelihood: 5 – We are expecting to miss first targets. **Rationale for target score:** Likelihood: 3 - Reduced likelihood of low performance rating through actions taken and engagement with stakeholders nationally.

Controls (What is currently in place to manage the risk?)	**Further Actions (What more are we going to do to address the risk?)**		

• Board leadership is provided by the Executive Director of Planning and Partnerships. There is a supporting governance structure in place.
• There is a Climate Action Plan (CAP) 2024-26.
• A Climate Action Plan Implementation Group manages the delivery of improvement actions, reporting to the Swansea Bay Steering Group prior to Management Board.
• Measures required to achieve emissions reduction objectives are integrated into other strategies and plans, including: Estates Strategy; IMTP; Quality Strategy; Sustainable Travel Strategy; Healthy & Sustainable Catering Strategy; Value Based Healthcare, People Strategy; Population Health Strategy
• Climate change & decarbonisation is a component part of the prioritisation for Capital Projects across NHS Wales organisations.
• Health Board takes part of the wider Welsh Government Health and Social Care Climate Emergency Programme governance through membership and participation on:
  ○ Buildings, Estates, Land Use Planning Programme Board
  ○ Transport and Procurement Programme Board
  ○ Approach to Healthcare Programme Board
	NHS Wales Shared Services Partnership led: Working with suppliers on carbon reduction plans. NWSSP require any contract over £5 million have a Carbon Reduction Plan, that can then provide a more accurate emissions factor supporting calculation. Furthermore, there is a Health Board responsibility not to over purchase items and ensure stock is utilised prior to reorder to remove any waste/expiry of dates.	Director of Planning & Partnerships
		(SRO, but action led by NWSSP)
			Ongoing

	Appropriate lead within the CAP will meet with potential funders and partners, and ongoing sourcing of funding / collaboration opportunities identified.	Director of Planning & Partnerships	Ongoing
	A Revised national DSDP is	Director of Planning &	31/03/2026

○ Adaptation Programme Board ○ Community of Experts ○ Adaptation Accelerator Programme ○ DSDP Refresh Working Group • The Health Board has contracted three 'Sustainability Clinical Leads' including an ED (Emergency Department) Consultant, a Consultant Anaesthetist, and NAU (Neurology Ambulatory Unit) Manager. They are driving sustainable healthcare work in the health board including Green ED, Greener Theatres, Green Group and other initiatives as well as wider NHS Wales and Royal College networks. • Participation on the Public Services Boards in Swansea and Neath Port Talbot sharing best practice and investigating opportunities for collaboration.	expected to be published in September 2025. The Health Board will be able to re-assess its position and alignment with refresh of the CAP which is being undertaken concurrently.	Partnerships	
Assurances (How do we know if the things we are doing are having an impact?	**Gaps in assurance (What additional assurances should we seek?)**		
• Annual carbon emissions data: This is reported to Welsh government annually, based on a financial year. There are three emissions measures reported. The Health Board has some success in meeting the target for Scope 1 and 2 emissions, but the scope 3 emissions are off target. *See Additional Comments at foot of this template for definition of measures and performance figures*. • CAP Delivery Plan & RAID (Risks Actions Issues & Decisions) log: Implementation of the CAP is reviewed and updated monthly and received at Climate Action Plan Implementation group. CAP actions are on track. • DSDP Delivery Plan & RAID log: Implementation of the DSDP is reviewed and updated monthly and received at Climate Action Plan Implementation group. DSDP elements are amber/red due to external constraints, particularly around funding. • DCR reporting and benchmarking: Bi-annual reporting (Q1/2 and Q3/4) on DSDP-only actions is benchmarked against other NHS Wales Organisations, comparing progress, risks, and issues. This is not currently comparable due to differences in interpretation of the RAG system. • Benchmarking: An annual review is undertaken within SBU against progress in the wider health sector and other relevant developments in sustainability and climate related work. This highlights that the Health Board is aware of work, but it can be hard to replicate. This will be partially addressed through the established Sustainable Healthcare Working, led by the Deputy Medical Director. • Annual CAP reporting: Progress report and assurance to Welsh Government around local Health Board actions as detailed in the CAP being undertaken in addition to those in the DSDP. • NWSSP internal audit review: Audit conducted for period Sep-23 to Apr-24 reported Limited assurance due to Welsh Government not having any dedicated funding stream. This risk has been	• Source of emissions: The Health Board has made significant reductions on the emissions from the Estates with the RE:Fit programme and development of the solar farm powering Morriston Hospital. However, most Health Board emissions are indirect, predominantly from the Supply Chain, and harder to reduce. • Funding stream: The SBU Climate Action Plan (CAP) has been developed to be achievable cost neutrally. However, the NHS Wales Decarbonisation Strategic Delivery Plan (DSDP), published in 2021, was developed by the Carbon Trust and directly targets emissions from buildings. However, suitable resource to implement the actions was not provided by Welsh Government or NHS Wales to support delivery of the plan. There is an expectation that additional funding be absorbed into Health Board financial plans. This is not feasible, recognising decarbonising buildings costs more than £60 million. • Funding stream: The SBU Climate Action Plan (CAP) has been developed to be achievable cost neutrally. However, the NHS Wales Decarbonisation Strategic Delivery Plan (DSDP), published in 2021, was developed by the Carbon Trust and directly targets emissions from buildings. However, suitable resource to implement the actions was not provided by Welsh Government or NHS Wales to support delivery of the plan. There is an expectation that additional funding be absorbed into Health Board financial plans. This is not feasible, recognising decarbonising buildings costs more than £60 million.		

continuously reflected in the DCR reporting process to WG. In addition, periodic updates are provided internally to the Head of Compliance which informs reporting to Audit Committee.	

Additional Comments: Targets Explained:

Public Sector Emissions Reporting:

Annual carbon emissions reporting to Welsh Government calculating emissions associated with Health Board Activities (based on financial year).

• Scope 1: Direct emissions from owned or controlled sources including natural gas, fleet, fluorinated gases and anaesthetic gases

• Scope 2: Indirect emissions from the purchase and use of electricity

• Scope 3: All other indirect emissions that occur in the upstream and downstream activities of an organisation this includes supply chain, business travel, commuting, waste, water, and processes associated with electrical distribution and extracting fossil fuels.

Context: Climate Emergency was declared by Welsh Government in 2019, leading to the Net Zero Wales ambition for the Welsh public sector to collectively reach net zero by 2030. In response NHS Wales developed a 'Decarbonisation Strategic Delivery Plan (DSDP)' (published in 2021).

The Health Board has some success in meeting the target for Scope 1 and 2 emissions, largely driven by the development of the solar farm and Re:Fit energy efficiency programme managed by Estates. This is despite new categories being added since establishment of the baseline including kerosene, fluorinated gases and anaesthetic gases. A total of 76% of the Health Board's emissions are part of the supply chain – emissions reductions in this space will be dependent on suppliers actively working on reducing their own emissions and sharing this information with the Health Board. NWSSP is leading on this with all contracts over £5million requiring a carbon reduction plan. In 2023/24 this data (tier 2 / supplier specific) was available for 223 suppliers reducing total emissions by 35,954.54 tCO2e. Supply chain data was also removed where it would be reported by another NHS Wales organisation or wider Welsh Public Sector body.

Annual carbon emissions data is reported to Welsh government annually, based on a financial year. This calculates emissions associated with health board activities (and so reflects outcome of activities aimed at managing risks to delivery). Most recent performance (2023/24) against WG revised 2018/19 baseline is:

Scope		2018/19* (tCO_2e)	2023/24 (tCO_2e)
1	Direct emissions from owned or controlled sources incl. natural gas, gas oil, kerosene, fleet, fluorinated gases, anaesthetic gases	26,123.40	21,444.26
2	Indirect emissions from the purchase/use of electricity incl. grid electricity		
3	All other indirect emissions (up/downstream) incl. supply chain, commuting, business travel, water, waste, well to tank and transmission and distribution (grid)	110,063.30	120,499.95
Total		**136,186.70**	**141,944.21**

*Readjusted baseline from WG, based on the change in footprint: ABMU to SBU

Progress Notes

Datix ID Number: TBC Date Opened: October 2025	Date Last Reviewed: December 2025	HBR Ref Number: 107 Target Date: TBC	Current Risk Rating: 5 x 4 = 20
Objective: The health board is a resilient, sustainable and responsible organisation	**SRR Ref:** N/A	**Director Lead: Marie Davies, Director of Planning & Partnerships** **Assuring Committee: Performance & Finance Committee**	

Risk: Emergency Preparedness, Resilience and Response, (EPRR) and Recovery

If the health board lacks adequate and effective emergency preparedness, planning, response and recovery at both corporate and operational levels, there is a risk that it may not be able to respond and recover promptly, efficiently, or effectively to a major incident, business continuity, or critical incident. This could lead to: Negative impacts on patient care delivery in both acute and non-acute settings; Potential harm or injury to patients and/or staff; Non-compliance with statutory obligations under the Civil Contingencies Act 2004; Legal actions and financial penalties; Reputational damage and diminished public trust.

Risk Rating
(consequence x likelihood):
Inherent: 5 x 5 = 25
Current: 5 x 4 = 20
Target: 4 x 4 = 16

Rationale for current score:
The current score is aligned with the Wales Risk and Preparedness Register and reflects the Health Board's compliance with statutory obligations under the Civil Contingencies Act and NHS Wales EPRR standards. It also considers assurance processes in place, including regular audits, training compliance, and business continuity planning. These controls provide a robust framework for preparedness; however, residual risk remains due to external dependencies, inter-agency coordination challenges, supply chain vulnerabilities, and the evolving nature of threats such as cyber incidents, climate-related events, and public health emergencies.

Rationale for target score:
Achieving the target score will require enhanced compliance with EPRR training, strengthened governance, and fully embedded business continuity arrangements across all critical services. In addition, improved interoperability with partner agencies, robust assurance processes, and investment in risk mitigation measures, such as cyber security, supply chain resilience, utilities and climate adaptation, will further reduce organisational vulnerability. These actions will collectively support effective preparedness, coordinated response, and timely recovery in the event of major incidents or emergencies, aligning with national standards and statutory obligations. The target score also reflects a commitment to continuous improvement through regular exercising and testing of plans, lessons learned from incidents, and ongoing engagement with stakeholders to ensure resilience remains dynamic and responsive to emerging risks.

Controls (What is currently in place to manage the risk?)	Further Actions (What more are we going to do to address the risk?)		
• There is an Executive Director nominated as lead for Civil Contingences (the Director of Planning & Partnerships).	Amended: Training & Competency: • Ensure full compliance with EPRR training requirements for all relevant staff. • Refresher training and scenario-based	Executive Director of Planning and Partnerships	31/03/2026

• A comprehensive business continuity management (BCM) process is in place, allowing services to assess and manage risks across the five key business continuity (BC) areas (premises, people, service, utilities, and supplies) and implement suitable mitigations. The BC framework serves as a guide for departments to develop their own specific BC procedures. • An overarching Strategic BC Procedure outlines the management processes, escalation protocols, and response structures to ensure effective command, control, and coordination during a significant disruption. In addition, each Service Delivery Group has an overarching Tactical BC Procedure outlining the tactical management processes, escalation protocols and response structures for effective command and control and coordination. • A Emergency Preparedness, Resilience, and Response (EPRR) strategy and program is in place to oversee and ensure enhanced assessment, preparedness, prevention, response, and recovery strategies. These aim to ensure there is the capacity and capability to be resilient, prepared and for staff to have the right skills and to have the correct plans to safely and effectively respond and recover from emergencies. This has been shaped by consideration of lessons identified from previous emergency incidents and exercises; the management of shared risks; and the impacts outlined in the EPRR risk and preparedness register. • The organisation has fully established emergency preparedness, resilience, and response (EPRR) measures, with the EPRR work and training programs aligned to meet Civil Contingency statutory requirements. Oversight is provided by the EPRR Oversight Group. • A range of emergency response protocols, including a major incident procedure, has been developed. To support, there is a suite of emergency procedures at national and regional levels to address and mitigate national, regional, and local risks as effectively as possible. These risks are identified in the Health Board EPRR Risk and Preparedness register and aligned to National Risk Register, Wales Risk and Preparedness Register, Local Resilience Forum (LRF) Community Risk Register, and respective local authority risk registers. • The Health Board actively participates in the NHS Executive Health Emergency Planning Advisory group and its sub-groups, which provide a platform for discussing and advancing NHS emergency preparedness and planning policies. Additionally, the HB is involved in the Wales Resilience Partnership Group and South Wales Local Resilience Forum and contributes to various pan-Wales/regional groups. The Health Board works closely with local partners and is a member of both Neath Port Talbot and Swansea Local Authority risk groups. • The HB EPRR arrangements are aligned to the HB Strategic vision and objectives. EPRR not only helps the HB to comply with the legal requirements but also reinforces the delivery of high-quality, safe, and equitable services, as well as supports the long-term sustainability and resilience of the organisation.	learning for key roles, Amended: Business Continuity Management: • Embed and test business continuity plans across all critical services. • Ensure plans include critical resilience and alternative arrangements.	Executive Director of Planning and Partnerships	31/03/2026

• There is a holistic approach to building, strengthening, and maintaining the EPRR work programme with consideration to leadership and governance (and ensuring these are up to date to ensure clear accountability), training and workforce development, scenario planning and exercises, risk management, community engagement and continuous improvement, including the conduct of regular audits and assurance checks against NHS Wales EPRR standards. This allows delivery of care to be of high quality, efficient, resilient, and adaptable during times of crisis. • Exercising & Continuous Improvement: Scheduling regular internal training and exercises simulations; capturing lessons identified from incidents and exercises and integration into plans.			
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 EPRR Strategy Group is responsible for overseeing the strategy and implementation of the EPRR work plan. It operates under the coordination of the corporate Strategy Directorate, with the programme focused on achieving Civil Contingency responsibilities, conducting thorough risk assessments, and facilitating training, exercises, and lessons learned. A digital dashboard is in place to support the monitoring of the EPRR work programme. • The HB delivers various exercises to test the effectiveness of current arrangements and response procedures and key training programmes. A comprehensive HB training and exercise strategy is established, covering operational, tactical, and strategic response levels. • Local procedures (including Major Incident and Emergency Response procedures) are regularly reviewed to incorporate the latest UK and national guidance, as well as lessons identified from actual events. Following each live incident, a debrief is conducted, and the findings are documented in the SBUHB lessons identified register. • As part of the EPRR Work Programme and within the Digital Dashboard, the EPRR Strategy Group monitors and ensures that all business continuity procedures are kept up to date. Identified gaps in business continuity management are taken forward by the respective Service Delivery Group and cross cutting services EPRR • The EPRR Strategy Group oversees the HB EPRR risk register, which includes the necessary mitigations for consequence management. This informs the EPRR work programme and training and exercising strategy. • Risks associated with health included in the Wales Risk and Preparedness Register are included on the South Wales Local Resilience Forum Risk Register and the specific health risks are discussed in the Loal Resilience Health Group. This work informs multi-agency, regional resilience, and response arrangements. • The EPRR Strategy Group currently provides annual updates to the Management Board, with a summary to the Health Board. This includes presenting the Major Incident Procedures, which are	• EPRR is a corporate function and must be recognised as a vital, cross-cutting service to ensure EPRR considerations are integrated into all HB operations. Progress is being made in this area, but further work is needed. Service Delivery Groups must designate appropriate managerial resources to take on EPRR responsibilities within their respective services. These individuals should have the necessary seniority to make decisions and drive the required work programme forward. Additionally, EPRR mapping has been undertaken for the HB Strategic vision and objectives evidencing where HB-wide work programmes need to incorporate resilience, with EPRR clearly defined as a critical pillar in supporting these efforts. However, further clarity is needed regarding the specific gaps or challenges hindering the full integration and effectiveness of EPRR within these processes.		

reviewed each year, submitting the NHS Executive Annual Report for approval, and offering a comprehensive EPRR update. The update covers challenges, achievements, and other emergency response arrangements. • The six statutory duties shape the overarching EPRR work programme, with progress monitored through the Digital Dashboard and discussed at the EPRR Strategy Group. Indicator of achievement of 2025/26 objective is: As a Category 1 Responder organisation under the Civil Contingencies Act 2004, HB meets the six statutory duties. Assurance of this is provided through the NHS Executive Annual Report, which is signed by the HB CEO and presented to the Management Board. The report also includes an update on the delivery of the HB EPRR work programme. • Business Continuity audit report • Additionally, to support the HB EPRR Training and Exercising Strategy, HB takes every opportunity to participate in national and regional exercises. These exercises are then discussed in the various resilience forums, as mentioned earlier.	

Additional Comments / Progress Notes

06/11/2025: Management are looking to Increase general staff awareness of roles & responsibilities in the event of an emergency by mandating the NHS Wales "Introduction to Emergencies" e-learning within the health board.
27/11/2025: Rationales and actions updated.
05/12/2025: Controls and actions sections revised.

Datix ID Number: 4334 **Date opened: December 2025** NEW RISK	**Date last reviewed: December 2025**	**CRR Ref Number: 108** **Target Risk Date: 31/03/2029**	**Current Risk Rating** **4 x 4 = 16**
Objective: Care is delivered in safe and appropriate settings supported by innovative digital solutions	**SRR Ref: 3.4**	**Director Lead:** Director of Digital **Assuring Committee:** Digital, Data, Research and Innovation	

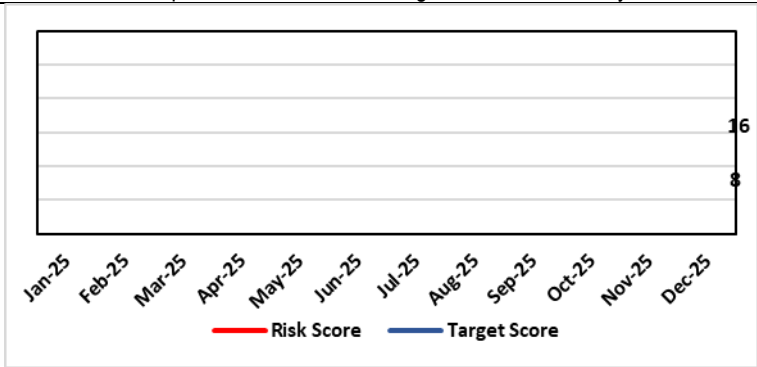
Risk: WCCIS/Connecting care - Provision of an Integrated Health Record for MH&LD and PCT

If the Connecting Care programme fails to deliver a digital solution that meets the operational, clinical, and reporting needs of Mental Health & Learning Disabilities (MH&LD) and Community & Therapies services,

Then wider MH&LD, Community and Therapies teams will lack access to timely, accurate, and shared information across care settings, resulting in fragmented service delivery, limited availability of high-quality data for performance monitoring and informed decision making, increased duplication of effort, and elevated clinical and governance risks. This includes the potential for further Regulation 28 reports, as previous Prevention of Future Deaths (PFD) notices have explicitly cited the absence of an integrated electronic system as a contributing factor to avoidable harm. Without a fit-for-purpose solution, the Health Board may be unable to fulfil the actions required under Regulation 28, particularly around effective information sharing and risk management across agencies.

Whilst the issue facing current users across integrated teams from the loss of WCCIS will be largely mitigated through the approved procurement of replacement solutions through the strategic partnership with the supplier, there remains to be 3,000 users across MH&LD and PCT who continue to provide services without an appropriate digital solution to support them. The provision of a solution is a core component of the SBU Digital Strategy. A recent independent review of Mental Health and Learning Disability services at SBUHB identified the lack of a single digital solution as a critical barrier to safe and effective care, highlighting that fragmented systems and manual processes are contributing to clinical risk, delayed interventions, and repeated Regulation 28 reports due to inadequate access to shared electronic records.

Risk Rating
(consequence x likelihood):
Initial: 4 x 5 = 20
Current: 4 x 4 = 16
Target: 4 x 2 = 8



Rationale for current score:

Likelihood – given the current trajectory of the national Connecting Care programme and its inability to provide a clear and timely roadmap for delivering a solution that meets the needs of Mental Health & Learning Disabilities (MH&LD) and Community & Therapies services. The removal of key components such as the Shared Care Record from the business case, the absence of a national Mental Health framework, and the lack of guaranteed funding all contribute to growing uncertainty. Local service groups have already escalated concerns through multiple risk registers, and the reliance on manual workarounds continues to expose wider teams to operational inefficiencies and clinical governance issues. Without urgent intervention or a credible alternative, the probability of service disruption and further Regulation 28 reports is increasingly likely.

Consequence – there would continue to be a significant impact on quality of care and capacity of the MH&LD and PCT teams. The organisation would fail to address the requirements of Regulation 28 reports and there would continue to be a lack of quality data to allow performance monitoring and informed decision making on service transformation. This has a wider impact on the health service provision across the health board, including secondary care.

Rationale for target score:

Likelihood – If the health board introduce a solution for the wider community and mental health teams, then it is unlikely the consequence associated with system failure or not replacing the new system will occur and some reduction in risk level may be possible (though not to target).

Consequence – the consequence of not having a digital solution to support integrated teams and the wider community and MHLD teams will remain the same.

<table>
<tr><th colspan="2">Controls (What are we currently doing about the risk?)</th><th colspan="3">Mitigating actions (What more should we do?)</th></tr>
<tr><td colspan="2" rowspan="4">• Local Program Board has been established and is responsible for producing the business case and delivery of the interim measure
• Regional Program Board is in place to ensure HB and councils are working together and align implementation of solutions
• DHCW National Program Board is in place to deliver national approach</td><td>Action</td><td>Lead</td><td>Deadline</td></tr>
<tr><td>Implement the new interim solution</td><td>Director of Digital</td><td>31/08/2026</td></tr>
<tr><td>Business case completed and approved for the expansion of the interim solution across all of paper based mental health teams</td><td>Director of Digital</td><td>Complete</td></tr>
<tr><td>Business case completed and approved for the provision of an Electronic Patient Record for the whole of Community and MH&LD</td><td>Director of Digital</td><td>31/03/2027</td></tr>
<tr><td colspan="2">Assurances (How do we know if the things we are doing are having an impact?)
• Digital leadership group will have oversight of the delivery of the actions of the Local Program Board and reports to Management Board
• Digital, Data, Research and Innovation Committee will have oversight of the overall plan and act as escalation route to Health Board if required.</td><td colspan="3">Gaps in assurance (What additional assurances should we seek?)
• The national approach has been delayed and is difficult to influence in terms of scope and timelines for delivery
• The route to obtaining national funding to support the Health Board is not clear.</td></tr>
<tr><td colspan="5">Additional Comments
The Welsh Community Care Information System (WCCIS) was developed to provide staff across health and social services with a single system and shared electronic record to enable delivery of more effective and efficient services. It is used by health board teams within mental health and community services, in addition to local authority social services teams, but the system will be discontinued from January 2026. SBUHB users are mainly operating within Integrated Teams and access the solution via the Swansea Council's contract with the system provider.
• A business case for an interim solution to address the immediate needs of the current SBUHB users of WCCIS (integrated teams) was presented to and approved by Management Board on 19th December 2024.
• The Health Board are continuing to support the National Program in the process for acquiring a longer-term solution
• The procurement of the interim solution was completed at the end of 2025/26 and project implementation has commenced.
• In September 2025 WG confirmed approval of funding to DHCW of the first year costs in the National OBC. Funding is only available in 2025/26 and a proportion of the funding is available to SBUHB to support the interim solution for integrated teams and next steps. There has been no formal commitment from WG of funding in future years.

Update:
11/11/2025 - Business case for expansion of interim solution has been completed. Procurement has been approved by Director of Finance and CEO. So the 3rd action can be marked as completed.
09/12/2025- The business case contract has been awarded for the implementation of RIO in mental health and learning disabilities for 20 teams who are currently based on paper. Work has commenced on the implementation which is due to complete by 31st March 2026.</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 (PROBABILITY) 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