Bundle Quality, Safety & Experience Assurance Committee 9 June 2020

2.2 COVID-19 Risk Report

Presenter: Andrew Carruthers, Jill Paterson, Dr Philip Kloer, Mandy Rayani

Item 2.2 QSEAC COVID Operational Risk Report June 2020

Appendix 1 Covid19 Directorate Risks May 2020

Appendix 2 Covid19 Service Risks May 2020

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ANSAWDD, DIOGELWCH A SICRHAU PROFIOD
QUALITY, SAFETY AND EXPERIENCE ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	09 June 2020
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Operational Risks incorporating COVID-19
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Executive Director of Operations Jill Paterson, Director of Primary Care, Community and Long Term Care Dr Philip Kloer, Executive Medical Director Deputy CEO Mandy Rayani, Executive Director of Nursing, Quality and Patient Experience
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Wilson, Board Secretary Charlotte Beare, Head of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

As requested at Quality, Safety and Experience Assurance Committee (QSEAC) on 7th April 2020 this report provides the new COVID-19 identified operational risks.

The Committee is asked to take assurance that operational risks are being reviewed and updated to reflect the impact of COVID-19.

Cefndir / Background

Management of Operational Risks

Following agreement at the Board on 16th April 2020 a directive was sent to Executive Directors (Corporate functions) and General Managers (Operations Directorates) to advise that understanding the risks facing the organisation was as, if not, more important, now as the organisation responds to a global pandemic. Whilst recognising the significant capacity pressures and challenges on services, the organisation still requires there to be a proportionate response to risk and that the 'business as usual' risks needed to reflect current internal and external environment factors, i.e. COVID-19.

The Assurance and Risk team contacted risk owners in May 2020 requesting that they review their existing operational risks on the Datix Risk Module. Risk owners were informed of the new COVID-19 theme added to Datix for selection on any existing or new risks as appropriate. For existing risks, risk owners were asked to review to ascertain which risks remained a priority to manage and mitigate during the COVID-19 pandemic, and which risks that do not present a significant risk during the COVID-19 pandemic to be archived (however they must ensure that existing controls are in place and remain effective otherwise risk could increase). Risk owners were also asked to consider new and emerging risks to their service as a result of the COVID-19 pandemic (including potential risks in respect of returning to normal business).

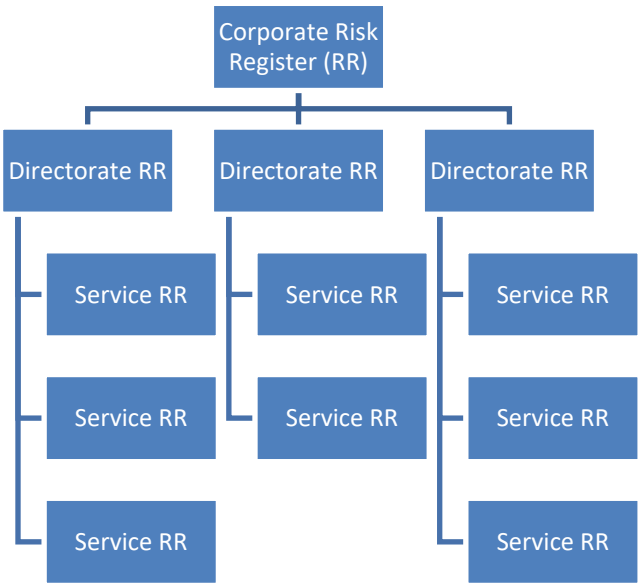
Asesiad / Assessment

Following the Board Meeting in April 2020, the Risk and Assurance Officers made contact with services and conveyed the outcome of the Board's expectation that management teams need to ensure their services are remain safe and the risk of harm to patients and staff is managed appropriately during COVID-19 through the effective management of their existing and new emerging risks to prevent harm, minimise loss and reduce damage. Whilst there was a positive response from the majority of services agreeing to undertake the work, not all areas have managed to do so to date.

As of 28th May 2020, there are 458 operational risks (excludes corporate risks) on the Datix Risk Module. 26 risks have COVID-19 selected as a theme, 6 of which are new risks that have emerged since COVID-19 started to affect services (risk no.850, 851, 852, 849, 857 and 858).

The number of risks within this report feels disproportionately low to the number of operational risks that might be expected to be affected by COVID-19, therefore this may not provide QSEAC with the appropriate assurance at this time. The Assurance and Risk team will continue to work with services to ensure risks are reviewed with a COVID-19 lens and reflect a more current position at future QSEAC meetings. However the responsibility to review and manage risks sits with risk owners within services who have to balance/prioritise this work with their other responsibilities.

The 26 risks in this report have been divided by Directorate (Appendix 1) and Service level (Appendix 2). The Directorate risk register includes any operational risks that affect the Directorate and its operational objectives. General Managers/Directors are responsible for approving the inclusion of operational risks and escalation of service level risks onto the Directorate Risk Register. The Service risk register includes any risks which affects a service or department. The Head of Service/Departmental Manager is responsible for approving the inclusion of operational risks on to Service/Department Risk Registers.



An extract from Datix of the 5 Directorate level risks can be found in the table below:

Risk Ref	Date Risk Identified	Title	Directorate	Current Risk Score	Target Risk Score
114	01/01/2016	Health Board wide, increased demand for CT and MRI & ultrasound services exceeding capacity and staff to deliver.	USC Pathways Pathology & Radiology	12	6
71	01/02/2011	Lack of effective communication between daytime practices and Out of Hours (OOH).	Central Operations	9 ↑ (from 6)	3
384	23/09/2017	Ability to fully comply with statutory and manufacturer guidelines for medical devices and equipment.	Central Operations	8 ↓ (from 12)	4
111	01/01/2016	Avoidable delay in diagnosis and treatment of patients lack of Consultant radiologists	USC Pathways Pathology & Radiology	6 ↓ (from 12)	6
857	22/05/2020	Inability to facilitate mandatory and statutory training due to COVID 19	Women & Children's	5 NEW	5

An extract from Datix of the 21 service level risks can be found in the table below:

Risk Ref	Date Risk Identified	Title	Directorate	Current Risk Score	Target Risk Score
572	01/04/2016	Inappropriate use of hospital beds due to a lack of capacity for timely assessments and delivery of packages of care in Ceredigion	3 Counties	16 →	8
720	15/04/2019	Avoidable harm to patients and staff due to staffing levels at Tregaron Hospital.	3 Counties	16 →	4
573	01/10/2016	GP practices serving notice that practice nurses will no longer treat and manage patients with leg ulcers in Ceredigion.	3 Counties	12 →	8
848	15/04/2020	Avoidable death due to unavailability of critical care medicines.	Primary, Community and Long Term Care (P,C,LTC)	12 NEW	8
574	01/12/2017	Community nursing will be unable to provide the level and quality of care to keep patients in the community in Ceredigion.	3 Counties	12 →	8
279	01/09/2016	HB wide: Inequality of care for children requiring access to Learning Disability Services.	Women & Children's	12 →	4
852	18/05/2020	COVID-19 – Domiciliary care / care home resilience	3 Counties	9 NEW	6
850	01/04/2020	Reporting, monitoring and escalation of patient safety issues during Covid-19	Nursing, Quality & Patient Experience (NQ&PE)	9 NEW	6

832	06/02/2020	Lack of clinical engagement in clinical effectiveness e.g. implementation of NICE guidance.	Medical Directorate (MD)	9 ➔	6
758	12/07/2019	Medical Device Regulation (MDR) and the In Vitro Diagnostic Medical Device Regulation (IVDR)	Central Operations	9 ➔	6
803	19/11/2019	Disruption to Out of Hours Service due to the failure of 111 IT systems.	Central Operations	9 ➔	6
851	18/05/2020	COVID-19 Risk of unknown harm to those who would ordinarily present to our services	3 Counties	9 NEW	6
664	09/11/2018	HB wide risk; Stability of 3rd sector to provide commissioned care particularly significant in Pembrokeshire.	Women & Children's	8 ➔	8
844	28/02/2020	Ability to specify the standards that guided care and management of patients	Medical Directorate (MD)	8 ➔	4
830	03/01/2020	Out of Hours service demand exceeds capacity.	Central Operations	8 ➔ (from 12)	4
294	24/04/2017	Non-compliance with Royal College of Nursing Standards; ratio of nursing to child or young person.	Women & Children's	6 ➔	6
278	20/02/2015	Non-compliance with Diabetes Peer Review Standards causing delayed and sub-optimal care of diabetic paediatric patients.	Women & Children's	6 ➔ (from 9)	6
392	01/12/2017	Lack of community paediatricians causing delayed assessment and review of community paediatric patients.	Women & Children's	6 ➔	6
858	22/05/2020	Reconfiguration of maternity services in HDdUHB.	Women & Children's	6 NEW	6
721	08/03/2019	Lack of resources to implement HB NICE policy.	Medical Directorate (MD)	6 ➔ (from 8)	4
849	07/05/2020	Security operations at COVID-19 sites	Estates & Facilities	5 NEW	5

Below is a list of new risks relating to COVID-19 that the Assurance and Risk team have been made aware of and have asked the services to consider for assessment on Datix.

- C4C Audits - No C4C (Credits for Cleaning) Audits were undertaken in April 2020 due to COVID-19. All other Audits will be resumed, targeting the very high risk areas first. Additional cleaning hours have been introduced due to COVID-19 across the acute hospitals which will help mitigate the risk. The supervisors have still received significant input into the ward/department areas but not undertaken the formal C4C audits due to risk of being in areas that hold potential COVID-19 patients.
- Oxygen infrastructure systems - The University Health Board's (UHB's) existing oxygen infrastructure systems are unable to produce the required oxygen capacity levels to support the needs of patients during pandemic conditions such as COVID-19, where significantly large volumes of patients require oxygen therapy at the same time via

ventilators or Continuous positive airway pressure (CPAP) machines. This will be a UHB wide overarching risk and a risk specifically for Glangwili General Hospital (GGH) and Bronglais General Hospital (BGH), as there are separate concerns at these sites.

- Workforce - The Workforce team have identified several potential risks in the areas listed below. These will be evaluated by the Director of Workforce and OD prior to being added to Datix:
  - Mass recruitment
  - Availability of workforce to meet future peaks/troughs in demand
  - Occupational Health (OH) checks for the new starters
  - Training capacity
  - Employee relations delays
  - Black, Asian and Minority Ethnicity (BAME) risk assessment

Argymhelliad / Recommendation

The Committee is asked to take assurance that operational risks are being reviewed and updated to reflect the impact of COVID-19, noting that work is continuing.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	5.1 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action. Contained in report
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
Nodau Gwella Ansawdd: Quality Improvement Goal(s):	All Quality Improvement Goals Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Underpinning risk on the Datix Risk Module from across the UHB's services reviewed by risk leads/owners
Rhestr Termau: Glossary of Terms:	Current Risk Score - Existing level of risk taking into account controls in place Target Risk Score - The ultimate level of risk that is desired by the organisation when planned controls (or actions) have been implemented Tolerable risk – this is the level of risk that the Board agreed for each domain in September 2018 – Risk Appetite Statement
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Sicrhau Profiod: Parties / Committees consulted prior to Quality, Safety and Experience Assurance Committee:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from report however impacts of each risk are outlined in risk description.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from report however impacts of each risk are outlined in risk description.
Gweithlu: Workforce:	No direct impacts from report however impacts of each risk are outlined in risk description.
Risg: Risk:	No direct impacts from report however impacts of each risk are outlined in risk description.

Cyfreithiol: **Legal:**	No direct impacts from report however proactive risk management including learning from incidents and events contributes towards reducing/eliminating recurrence of risk materialising and mitigates against any possible legal claim with a financial impact.
Enw Da: **Reputational:**	Poor management of risks can lead to loss of stakeholder confidence. Organisations are expected to have effective risk management systems in place and take steps to reduce/mitigate risks.
Gyfrinachedd: **Privacy:**	No direct impacts
Cydraddoldeb: **Equality:**	Has EqIA screening been undertaken? /No Has a full EqIA been undertaken? No

Risk Ref	Health and Care Standards	Directorate	Directorate lead	Management or service lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Risk Tolerance Score	Current Likelihood	Current Impact	Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Date Reviewed
114	Standard 3.1 Safe and Clinically Effective Care	USC: Radiology	Perry, Sarah	Evans, Amanda	1/1/2016	There is a risk of delay in diagnosis, not achieving 8 week diagnostic waits, increased inpatient Length of Stay (LOS) and inability to achieve cancer pathway targets. This is caused by increased demand for CT, MRI, Ultrasound and nuclear medicine which exceeds current capacity and staffing to deliver. Establishment of radiology staff and radiologists have not increased with demand. Inability to recruit to vacancies in both disciplines. This will lead to an impact/affect on delayed access to all imaging resulting in Negative impact on patient health and treatment plans. Increased stress and pressure for radiology staff. Risk location, Health Board wide.	Monthly monitoring of activity, demand. Patients / staff moved to available capacity . Weekly review of all patients on Cancer Pathway. Prioritisation of referrals based on clinical risk and discharge dependant investigations. Regular monitoring of waits. staff working additional hours to meet demand.	Safety - Patient, Staff or Public	6	4	3	12	The role of reporting radiographers has been increased.	Evans, Amanda	Completed	Eight trained reporting radiographers in post. No increase this year.	Operational Quality, Safety & Experience Sub Committee	2	3	6	5/15/2020
													Use of overtime and external reporting as required to meet demand. SBAR completed for 7 day working. On going SBAR - awaiting response.	Evans, Amanda	Completed	Costs identified for working week extension to 7 days not yet funded. Welsh Audit Office review of HDUHB radiology service completed July 16. Report published June 2017, indicates that radiographers and radiologists are more productive than the welsh average Preview copy highlights: Manpower and Demand as risks. Management response is being formulated. Currently reviewing templates and cross site working to improve efficiency.					
													Working with the Programme Management office on a demand optimisation project to reduce the amount of inappropriate requests.	Evans, Amanda	Completed	Process is in place and constantly monitored.					

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													Workforce and on call review to ensure right people, right place, right time.	Evans, Amanda	~~30/12/2019~~ 30/08/2020	Following initial analysis it has been decided to undertake a full workforce and service review which is underway to understand the correct levels and disciplines required to deliver the service. This is being undertaken with Programme Management Office support including HR, W&OD and Medical Recruitment.					
71		Central Operations: Out of Hours	Rees, Gareth	Davies, Nick	2/1/2011	There is a risk of avoidable detriment to the quality of care from a lack of effective communication between daytime practices and the Out of Hours service. This is specifically in relation to the inability to obtain timely Special Patient Notes (SPN). This is caused by insufficient clinical information specifically SPNs and inaccurate or incomplete information available to clinicians in the out of hours period. This will lead to an impact/affect on on patient experience. This could result in admission of patients who would otherwise be kept at home. Increased impact on Unscheduled Care. Calls to palliative care patients (or high-risk patients) could be more challenging owing to a lack of information from the day time practice. This can also result in a risk to staff safety due to lack of information. Risk location, Health Board wide.	Individual Health Records (IHR) improve access to clinical information. Roll out of new system access to 30%.	Quality/Complaints/Audit	8	3	3	9	Improve links with in hours practices, particularly around the provision of 'Special Notes' via WebAccess system.	Davies, Nick	~~18/10/2017~~ 01/04/2020 30/09/2020	IHR Systems are functional in all 3 Counties. SPN Web access software has been purchased. Rollout has commenced with the support of the Service Governance administrator. Rollout has been supported by the Deputy Medical Director of the Health Board who is securing resources to assist completion of this action.	Information Governance Sub Committee	1	3	3	5/21/2020
													IT system to be purchased to bridge the technological gap between Day Time Practice and the OOH service systems.	Davies, Nick	**Completed**	The new system has now been purchased and role out to day time practices has commenced.					
384		Central Operations: Clinical Engineering	Rees, Gareth	Hopkins, Mr Chris	9/23/2017	There is a risk of avoidable non-compliance with statutory and implied statutory standards where medical devices are concerned. This is caused by equipment not being maintained in accordance with manufacturers' instructions. This will lead to an impact/affect on overall treatment or suboptimal services with a potential impact of reputational harm and regulatory enforcement. Risk location, Health Board wide.	Medical and Non-Medical Devices Control Group has been reviewing performance. This group has now de-escalated and the risks are managed through relevant management structures and through the medical device group. HSE Action Plan is complete. Management information including regular reports provided for scrutiny to Medical Device Group. Identification of devices and categorisation and inventory refresh complete and new database procured and commissioned. System review processes operating to ensure	Statutory duty/inspections	8	2	4	8	Implement Medical Devices Action Plan (inc development of inventory, categorisation of incidents) - delivery is monitored by Medical Devices Control Group.	Rees, Gareth	**Completed**	Agreement on funding arrangements for remaining action outstanding. Discussions taking place with Director of Nursing, Quality and Patient Experience.	Quality, Safety & Experience Sub Committee	1	4	4	5/15/2020

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	Standard 2.9 Medic						missed inspections are not allowed to go unchecked. 5 tier risk stratification system developed for Health Board device holding which facilitates high risk devices targeted for first attention. Increased capital allocation has been realised. Strategic replacement plan for the Health Board's medical device holding now in place and servicing capital decision making. Improved ultrasound governance in place. Training Needs Analysis has been undertaken in conjunction with L&D Team. Servicing and inspection capacity restored to 2015 levels in clinical engineering. Broader control over all aspects of all aspects of medical device management to include radiology and estates now in place. Medical Device Policy now operational.						Operations Prioritisation System and Programme in place which feeds into annual capital planning process.	Rees, Gareth	Completed	Completed.	Operation				
													Review Medical Devices Assurance Group which reports to Operational QSE Sub-Committee to improve reporting of assurance.	Rayani, Mandy	Completed	This has been resolved and the Medical Devices Group now formally reports to Operational QSE Sub-Committee with escalation to QSEAC.					
													Review Medical Devices Assurance Group which reports to Operational QSE Sub-Committee to improve reporting of assurance.	Rayani, Mandy	Completed	This has been resolved and the Medical Devices group now formally reports to Operational QSE Sub-Committee with escalation to QSEAC.					
													Establish Information Governance requirements for medical devices.	Rees, Gareth	Completed	List of all equipment that holds PII or connects to the internet has now been forwarded to the IG team.					
													Complete a full 24 month schedule of Planned Preventative Maintenance work	Hopkins, Mr Chris	~~14/04/2021~~ This action will not conclude until April 2021	60% of inventory has now received a Planned Preventative Maintenance check.					
111	Standard 3.1 Safe and Clinically Effective Care	USC: Radiology	Perry, Sarah	Evans, Amanda	1/1/2016	There is a risk of avoidable delay in diagnosis and treatment of patients, leading to a poorer quality of care. Increases in diagnostic waiting time breaches and cancer pathway breaches. This is caused by unavailability of consultants in specialised areas (MSK Paeds and Interventional). This will lead to an impact/affect on the failure to treat patients, clinical deterioration and death. Lack of availability to cover MDT meetings. Increased costs for external reporting. Inpatients may have increased length of stay due to delay in reported studies being available. Increased turnaround time for reports. Financial impacts due to high cost of external reporting and agency staff Risk location, Health Board wide.	Arrangements in place for additional reporting by existing radiology team (In lieu of Locum). Unreported studies sent to third party tele-radiology company (Everlight). Recruitment campaign commenced to target radiologists with special interest. Radiologist money utilised to employ consultant radiographer in breast. Communication with both Swansea Bay and the National Imaging Academy for additional support with joint appointments and trainee radiologist placements. Continued communication with Swansea Bay around joint appointments. Reporting radiographers working to capacity , worklists redone to accomodate. Reporting radiographers trained for appropriate studies. Use of some locums and low cost agency to fill some gaps.	Safety - Patient, Staff or Public	6	2	3	6	Advertise for substantive and locum radiologists and recruit trainee reporting radiographers.	Evans, Amanda	Completed	8 reporting radiographers now trained and in post.	Operational Quality, Safety & Experience Sub Committee	2	3	6	5/15/2020
													Increase number of reporting Radiographers.	Evans, Amanda	Completed	Review to commence, with HR support, on efficiency of current staff and to evaluate the gaps. eview completed . identification of succession planning .. current staff able to fill the capacity . Robust governance identifiedand implemented					

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													Monitor delay in unreported studies. Unreported studies sent to third party tele-radiology company.	Evans, Amanda	Completed	Software installed to permit bulk upload of images to 3rd party reporting company. Routinely used across all sites.					
													work with the National Imaging Academy to recruit trainee radiologists	Evans, Amanda	Completed	Radiology Services Manager and Clinical Director in contact with deanery to improve traiing facilities Radiologist who is trainer working in conjunction with NAID Trainees to start 1st August					
													Job description approval	Evans, Amanda	Completed	Awaiting feedback from RCR Feedback recieved and Job description approved					
													Re launch the camapaign for substantive radiologists with the support of workforce	Evans, Amanda	Completed	Communications team about to launch new recruitment video in Arabic					
													Continual monitoring of radiology reporting lists to ensure no delays in turn arouund	Khan, Dr Liaquat	Completed	Working across all sites to maximise current levels of capacity					
													Review reporting radiographer capacity in light of recent retirements and vacancies of radiographers Recruit more reporting radiographers on Chest and Abdomen reporting as resilience in the system	Evans, Amanda	~~31/03/2020~~ 30/09/2020	Appendicular and Axial reporting current being evaluated. Visits to Homerton to review arrangements and ensure Hywel Dda has robust governance and peer support for reporting rads Reporting radiographers governance improved however chest and Abdo reporting is an issue due to training					

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													Review radiology referral pathways and levels of innapropriate tests	Evans, Amanda	~~31/03/2020~~ 30/09/2020	Radiology dashboard produced with assistance from programme management office. Demand optimisation work underway The COVID-19 pandemic and the restoration of services have impacted o the ability to drive this work . However as each service is restored pathways will be reviewed and improved					
857	Standard 2.1 Managing Risk and Promoting Health and Safety	Women & Children's: Midwifery/Maternity	Humphrey, Lisa	Jenkins, Mrs Julie	5/22/2020	There is a risk of of staff not being fully compliant with mandatory and statutory training requirements in line with national and local guidance as a result of COVID 19 pandemic. This is caused by COVID 19 pandemic and need for all personnel to adhere to social distancing (2 meters) and staff being unable to work due to shielding and not being patient facing(in administration roles) in line with National Government guidelines and advice. This will lead to an impact/affect on all staff not being compliant with mandatory training requirements In addition staff's skill set and competency my be affected resulting in non adherence to guidelines and policies and potentially poor patient outcome.	All staff encouraged to complete mandatory e-learning All staff were compliant with annual mandatory training up until end of March 2020 and all staff complete annually Exploring Webinar teaching for interpretation of fetal monitoring Weekly fetal monitoring workshops held via remote Zoom facility All Wales HOM currently reviewing with WAG and Welsh Risk Pool future plan for mandatory training requirements PROMPT reviewing current policies to incorporate COVID 19 guidelines	Safety - Patient, Staff or Public	6	1	5	5					Quality, Safety and Experience Assurance Committee	1	5	5	5/22/2020

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572	Standard 5.1 Timely Access	3 Counties: Ceredigion	Skitt, Peter	Hawkes, Jina	4/1/2016	There is a risk of delayed patient transfers resulting in further deconditioning of patients and hence avoidable harm. Increase of hospital patients being discharged directly to long term placements. This is caused by a lack of timely care packages and interim placements and a fragile domiciliary care provision within the Ceredigion and neighbouring counties. This will lead to an impact/affect on patients' loss of functional ability, delayed transfers of care, risk of hospital acquired infection and being able to maintain patients within their own home. Risk location, Ceredigion.	Delayed Transfers of Care monthly meetings embedded in practice as part of a formalised Welsh Government reporting. Robust processes in place with regards to Continuing Health Care requests which include Fast track arrangements. All Wales Escalation Guidance process in place which reports into the daily All Wales calls. Joint tendering process has been undertaken between Ceredigion County Council and the Health Board. Domiciliary Care contracts have been agreed and will be reviewed as part of an ongoing performance process. The Interim Placement Scheme was established as an alternative model of care when hospital beds were de-commissioned in Cardigan Hospital. The scheme 'block-purchased' beds in privately run nursing homes (maximum 6 weeks per patient) to enable timely assessment. The scheme worked successfully from 2015 until March 2018. In 2018-19 funding from the scheme was realigned to saving targets.	Safety - Patient, Staff or Public	8	4	4	16	Develop Community Resource Teams (North and South) which will include access to domiciliary care for a period of two weeks to enable a package of care to be sourced.	Hawkes, Jina	Completed	The South Ceredigion Community Resource Team (Nursing) is established with statistical evidence demonstrating good patient outcomes. The North Community Resource Team (Nursing) is partially established using Integrated Care Funding. This is short term until 2020.	Operational Quality, Safety & Experience Sub Committee	2	4	8	5/18/2020
													Develop a SBAR demonstrating the risk associated with funding of the interim care beds in relation to the TCS strategy	Hawkes, Jina	Completed	Data has been collated.					
													Engage with the Transformation Programme in order to develop a 24/7 service which can respond for a short term.	Hawkes, Jina	Completed	Work has commenced with Ceredigion County Council to develop a service spec and business case.					
													Utilise data to understand the scope and demand for a 24 / 7 response service	Hawkes, Jina	Completed	Work has commenced with Ceredigion County Council and HDUHB to scope the service.					
													Working with the LA, a service specification is being developed aligned with Programme 1 and Programme 3 of the Transitional Framework	Hawkes, Jina	Completed	Programme 3 draft submitted to Regional					
													Work with the Regional partnership to agree a scheme to fit within the Programme 1 and 3 Transitional Framework.	Hawkes, Jina	Completed	Local plans are being developed alongside Regional priorities					
													Prioritize the outcomes required for sustainable projects	Hawkes, Jina	Completed	The North Locality Programme Manager's has been appointed as well as the Ceredigion Regional Lead, both posts are regionally funded, however both posts have now been re-aligned to support COVID 19 activity.					
													Monitor and review capacity and waiting times on a regular basis	Hawkes, Jina	30/06/2020	Daily (Mon - Fri) COVID-19 Touch Point meetings have been established which have Social Care representation					

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720	Standard 3.1 Safe and Clinically Effective Care	3 Counties: Ceredigion	Skitt, Peter	Hawkes, Jina	4/15/2019	There is a risk of avoidable harm to patients and staff due to lack of staffing to meet patient acuity at Tregaron hospital. This is caused by sickness, retention and recruitment of staff. This will lead to an impact/affect on potential impact on patient care due to insufficient staffing levels to meet patient need. Risk location, Tregaron Hospital.	Trying to assure that appropriate patients are placed within Tregaron Hospital, whose needs can be met.	Safety - Patient, Staff or Public	6	4	4	16	Negate risks around gaps in rostas, ensure that appropriate patients are admitted in Tregaron (whose needs can be met).	Evans, Tracey -	Completed	Regular reviews and updates of situation	Operational Quality, Safety & Experience Sub Committee	1	4	4	5/18/2020
													Options paper to be taken forward in order to reduce the risk of patient harm in Tregaron hospital.	Evans, Tracey -	Completed	Options paper has been written					
													The CMT needs to review the contingency planning associated with staff shortages on both a short and medium term	Evans, Tracey -	Completed	All patients are screened prior to admission to ensure safe care can be delivered.					
													Risk needs to be escalated. Report to be written clearly demonstrating that all effort has been undertake to ensure safety regarding staff and patient care.	Evans, Tracey -	Completed	Contingency plan and options paper developed and submitted to Mandy Rayani. Beds have been reduced to 7					
													The staffing levels reflect the number and acuity of patients admitted in to Tregaron hospital.	Evans, Tracey -	Completed	Processes in place to ensure that the hospital is staffed appropriately.					
													Ongoing review of staffing levels and patient acuity.	Evans, Tracey -	Completed	Processes in place to ensure that the hospital is staffed appropriately to meet patient need.					
													Utilise the site to enable flow from the acute sites during the COVID-19 pandemic and therefore utilise additional capacity associated with the pandemic.	Evans, Tracey -	22/06/2020	Develop an SBAR to enable Tregaron to be used as a green step down / step up and re-hab facility to enable patient flow.					
573		3 Counties: Ceredigion	Skitt, Peter	Hawkes, Jina	10/1/2016	There is a risk of avoidable harm to existing patients and new referrals being directed onto district nurses' caseloads. This is caused by GP practices no longer providing treatment and management for ambulant patients with leg ulcers. This risk has been growing incrementally since 2014. This will lead to an impact/affect on an already overburdened district nursing resource which will draw out longer waits and potentially exacerbate existing conditions. In Jan 2017 there are 52 clinic sessions in operation to accommodate venous leg ulcers. GP practices intend to serve notice on venous, arterial and leg ulcers of mixed arteriology. This will impact on patient flow, delays in discharge, increased length of stay & increased exposure to hospital-acquired infection (HAI). Risk location, Health Board wide.	Counties have established leg ulcer clinics to accommodate ambulatory patients. These clinics are staffed by community nursing staff on a rotational basis. The Coronavirus pandemic has impacted upon the numbers of patients using the Leg Clubs.	Safety - Patient, Staff or Public	6	3	4	12	Explore opportunities associated with the Lindsey Leg Club model of delivery. Whilst this will not eliminate the risk, it may support control measures.	Hawkes, Jina	Completed	3 County Leg Ulcer Group has been established which continues to meet with Local Medical Council representatives A SBAR and Business Plan has been submitted to the Business Planning and Performance Assurance Committee (BPPAC) and HDUHB to provide a HDUHB Leg Ulcer service based on the preferred model. The first Ceredigion Lindsey Leg Club has been established.	Operational Quality, Safety & Experience Sub Committee	2	4	8	5/18/2020

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													Monitor and evaluate the Lindsey Leg Club activity and patient outcomes.	Hawkes, Jina	Completed	The first Ceredigion Lindsey Leg Club was established in December 2018. The Lindsey Leg Club approach has now been used successfully in Aberystwyth for some time and there are plans to roll out the same model in Lampeter					
													Monitor and evaluation, especially in relation to the sustainability of volunteers as they are fundamental to the approach.	Evans, Tracey -	Completed	The Lindsey Leg Club approach has now been used successfully in Aberystwyth for some time and there are plans to roll out the same model in Lampeter. Monitoring continues.					
													Open Lindsey Leg clubs in Lampeter and Cardigan	Evans, Tracey -	Completed	Lindsey Leg Clubs are now open in both Lampeter and Cardigan					
													Monitor the scheme in relation to patient attendance and sustainability of reliance on volunteers	Evans, Tracey -	Completed	Patient attendance appears to be greater than anticipated, with patient outcomes positive. The flow of both patients and volunteers is being recorded. Meeting with GPs is being arranged.					
													The Coronavirus pandemic has impacted upon the numbers of patients using the Leg Clubs as well as the capacity within the nursing service to support the clubs - continuous monitoring and reviewing is required.	Evans, Tracey -	30/06/2020	Daily (Mon - Fri) COVID-19 Touch Point meetings have been established where Leg Club activity is being reported.					
848	Standard 2.6 Medicines Management	P,C,LTC: Medicines Management	Pugh-Jones, Jenny	Rees, Stuart	4/15/2020	There is a risk of avoidable harm to patients due to potential unavailability of critical care medicines including haemophiltration fluids. This is caused by increased current demand and national shortages of medicines and also an All Wales Agreement allocating medicines to the highest need across Wales, this enables other Health Boards to draw on Hywel Dda stock of medicines. This will lead to an impact/affect on the Health Board's ability to provide and manage medicines for its intensive care patients across Hywel Dda, including those patients requiring ventilation and or renal replacement therapy. Risk location, Health Board wide.	All Wales agreement. Dashboard T20 stock levels controls of medicines - updated daily. Action Cards for movement of stock. Stock monitoring daily on all four sites. Input into HB Critical Care Functional Capacity Dashboard.	Safety - Patient, Staff or Public	6	3	4	12	Increase stock holding by approximately 25% to be undertaken by Site Leads.	Rees, Stuart	30/06/2020	Established monthly stock holding baseline, gradual increase ordering to achieve target of 25%.	Quality, Safety and Experience Assurance Committee	2	4	8	5/19/2020

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574		3 Counties: Ceredigion	Skitt, Peter	Hawkes, Jina	12/1/2017	There is a risk of avoidable harm by nursing services being unable to provide the level & quality of care to keep patients in the community as recommended by nurse staffing principles and supported by Welsh Government. This is caused by an inability to release staff to attend mandatory and essential training, the lack of clarity of the roles and responsibilities between health and social care in the delivery of specific tasks, insufficient numbers of nursing staff, delays in the recruitment process and an increased workload. This will lead to an impact/affect on care being compromised as nurses are not able to access the knowledge and skills required to deliver evidence based practice. Capacity will be reduced, timely response and may cause delays in discharge from the acute hospitals. Inability to meet tier 1 targets, increased complaints. Negative impact on the ability to meet patients nursing needs and ensure a safe quality service. Risk location, Health Board wide.	Regular review of service specification, resources and caseloads. Escalation policy. Use of bank and agency. The Coronavirus pandemic has resulted in reduced capacity within the service as a number of nurses are vulnerable to COVID-19 and are therefore unable to undertake face to face patient work.	Safety - Patient, Staff or Public	6	3	4	12	Update response for the 6-monthly monitoring of the response for the Chief Nursing Officer staffing principles for DN teams to be completed.	Evans, Tracey -	Completed	The second baseline of community staffing was completed in October 2018	Operational Quality, Safety & Experience Sub Committee	2	4	8	5/18/2020
													Create a second staffing principles for DN teams six monthly monitoring report for the Chief Nursing Officer	Evans, Tracey -	Completed	Awaiting feedback relating to the first draft report. Second draft completed 6/10/2018.					
													Create a third staffing principles for DN teams six monthly monitoring report for the Chief Nursing Officer (completed March 2019)	Evans, Tracey -	Completed	Third staffing principles for DN teams report has been produced.					
													Continue to create six monthly reports (March and September)	Evans, Tracey -	30/03/2020	Continue to monitor against principles and report on a six monthly basis. Report submitted Feb 2020.					
													Implement escalation policy. Regularly review the service.	Evans, Tracey -	30/06/2020	The escalation policy was implemented during March 2020, prioritising and limiting patient contacts. COVID-19 vulnerable staff are deployed to undertake telephone patient contact as well as administration duties. Daily (Mon - Fri) COVID-19 Touch Point meetings have been established where community nursing activity is being reported and when appropriate de-escalating actions are put into place.					

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279		Women & Children's: Community Children's Services	Humphrey, Lisa	Devonald-Morris, Margaret	9/1/2016	There is a risk of inequality of care for children and young people requiring access to Learning Disability (LD) services. This is caused by lack of health practitioners with the appropriate knowledge and skills to assess, monitor and review commissioned LD services for children and young people in residential care under 18 years of age. This will lead to an impact/affect on inequality in LD services across HDUHB is also a UK wide problem. Evidence shows that many physical, sensory and mental health needs of people with learning disabilities go unrecognised and unmet by services, with consequent negative impacts on their quality of life, life chances, life expectancy and experience of services(Strengthening the commitment, 2012). Risk location, Health Board wide.	Children's Disability Teams in Ceredigion and Carmarthenshire, and the Key working model undertaken by Action for Children in Pembrokeshire provide multiagency services. The young people who reside in residential settings are reviewed by Social Care, our Disability Team practitioners and for some the LAC nurse. The Service Delivery Manager or Senior Nurse for Community Services attends the 3 Complex Needs Panels where updates are provided regarding the residential placements. Learning Disability Continuing Health Care Adult commissioning team work with children's services regarding continuing care assessments.	Safety - Patient, Staff or Public	6	3	4	12	Develop a Health Board Learning Disability strategy for children and young people in partnership with the Learning Disability service.	Devonald-Morris, Margaret	Completed	Met with the Interim Director of Mental Health and Learning Disabilities on 22/08/18 who will set up the initial steering group to scope our current practice, practices across Wales, reviewing National and NICE guidelines to support the development of a Health Board strategy for children and young people. 02/10/19 meeting with LD and SCAMHS services.	Operational Quality, Safety & Experience Sub Committee	1	4	4	5/14/2020
													Clinical Lead, Service Delivery Manager and Senior Nurse to work with LD services in developing the strategy in line with 'Together for Children and Young People's service improvement programme.	Devonald-Morris, Margaret	Completed	Meeting coordinated by LD services to begin mapping and developing a LD strategy for Children and Young People. Following on from meeting, email communication on 23/01/20 from Head of Nursing Mental Health and Learning Disability stating that escalation to the Health Board's Vice Chair has been raised regarding the issue of the absence of a strategic Children's lead across a number of Directorates for learning Disability and Behaviours that challenge.					
													Engage with Learning disabilities regarding the Continuing Care assessment of children and young people.	Devonald-Morris, Margaret	Completed	The Learning Disability Nurse Assessor is supporting the children's nurse assessor relating to the assessment and funding requirements of children and young people who have a learning disability and behaviours that challenge.					

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													Clinical Lead, Service Delivery Manager/Senior Nurse Community, Head of Nursing for Mental Health and Learning Disabilities, and Head of Specialist Child and Adolescent Mental Health Service (SCAMHS) & Psychological Therapies to work together in developing a robust service delivery for Children and young People who have a Learning Disability including those who have behaviours that challenge.	Devonald-Morris, Margaret	~~30/04/2021~~	25/03/20, meeting postponed due to COVID-19 planning. 30/04/20, meeting with Head of SCAMHS and Lead Psychology, re: attached email communication detailing the outcome and actions.					
													Business Continuity Action Plans (BCAP) developed for both Disability teams in Carmarthenshire and Ceredigion as a result of Welsh Government directive in response to COVID-19.	Devonald-Morris, Margaret	30/06/2020	BCAP's submitted via email to Community Bronze Group on 08/04/20 and are attached to this risk. The key working service delivered by Action for children in Pembrokeshire have also restricted face to face visits, re: email communication on notepad.					
758	Standard 2.9 Medical Devices, Equipment and Diagnostic Systems	Central Operations: Clinical Engineering	Rees, Gareth	Hopkins, Mr Chris	7/12/2019	There is a risk of of not achieving compliance with the new legislation for Medical Device Regulations (MDR) and the In Vitro Diagnostic Medical Device Regulation(IVDR)which comes into force from May 2020. This is caused by the new regulations placing further legal obligations on the UHB will need to be met by 26 May 2020 for medical devices and 26 May 2022 for in vitro diagnostic devices. This will lead to an impact/affect on organisational reputation as the UHB will be non-compliant with legal requirements and general safety and performance requirements. Possible fines and prosecution. Risk location, Health Board wide.	An All Wales task and finish group is in place. An action plan is in place in order to address the requirements of the new MDR. ISO 13485 Registration required with BSI.	Statutory duty/inspections	6	3	3	9	Secure funding to implement the new regulations.	Hopkins, Mr Chris	**Completed**	Funding secured.	Operational Quality, Safety & Experience Sub Committee	2	3	6	5/15/2020
													Establish a local Task and Finish Group under the guidance of the Medical Device Governance and Assurance Group.	Oliver, Will	**Completed**	T&F Group established.					
													A recognised quality system ISO 13485 needs to be in place for HSDU and Clinical Engineering Departments.	Hopkins, Mr Chris	23/12/2019	HSDU have already achieved compliance and certification to ISO 13485. Clinical Engineering are working towards certification in November 2020. Certification now on hold until after the COVID-19 crisis.					

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852	Standard 6.1 Planning Care to Promote Independence	3 Counties: Ceredigion	Skitt, Peter	Skitt, Peter	5/18/2020	There is a risk of harm to patients due to a lack of resilience within domiciliary care / care homes during the Coronavirus pandemic This is caused by lack of staff capacity due to: staff being vulnerable to COVID-19, staff having to self-isolate whilst awaiting screening results; reluctance to take on additional clients without appropriate assurances in place. This will lead to an impact/affect on patient flow from hospital as well as increased demand on services to fill the gap. Risk location, Health Board wide.	Daily County meeting are established along with regular sit rep reporting. Local authority has deployed staff from alternative departments to support the sectors, however this may not be in place once services start to re-commence.	Safety - Patient, Staff or Public	6	3	3	9	Regular communications with Local Authority.	Hawkes, Jina	30/06/2020	Daily touch point meetings in place	Operational Quality, Safety & Experience Sub Committee	2	3	6	5/18/2020
803	Standard 3.2 Communicating Effectively	Central Operations: Out of Hours	Rees, Gareth	Davies, Nick	11/19/2019	There is a risk of disruption of the Out of Hours Service due to the failure of the out of hours and 111 IT systems. This is caused by a number of issues including failure of Hywel Dda, WAST IT system, CAS (111) system and Adastra (OOH) system. This will lead to an impact/affect on on data sharing and information processing which will directly affect patient care. Resulting in potential clinical risk to patients, to include care not being accessed. The need to revert to contingency processes to ensure patient referrals and sharing of confidential, or complex information impacts on information governance. Risk location, Health Board wide.	Action cards to support operational staff in the event of a IT outage are in wide circulation. Communication lines between WAST (111) and OOHs are established. Links to on-call local IT support are in place and access to Advanced helpdesk has been procured. Contingency developed, paper documentation is in place and manned fax lines are present in all OOH bases; a Safe Haven fax to coordinate OOH demand is held in WGH switchboard to receive demand from 111. Access to on-call service managerial support is in place.	Service/Business interruption/disruption	6	3	3	9	New IT solution (nationally based) is under development with proposed roll-out date of Q4 2021. This will be reviewed by the national programme team and the HB will be advised of progress as appropriate.	Davies, Nick	30/09/2021	Procurement stages complete and work to build new system has commenced. Ops managers and Clinical Leads are involved in the development of the system.	Capital, Estates and IM&T Sub Committee	2	3	6	5/21/2020
													Enquiry with IT to provide additional independent fax lines to improve contingency measures and efficiency and security of data sharing.	Davies, Nick	Completed	Currently agreed and installing an alternative solution for fax machines.					
													Provision of "incident boxes" to be allocated to all OOH bases for use in the event of system failure.	Davies, Nick	Completed	Allocated to members of Admin team to circulate and is in progress.					
													Transition to local installation of Adastra software via "SmartClient" in order to remove risks associated with Citrix environment.	Davies, Nick	Completed	No longer valid as an action as no longer an option to deliver.					
851	Standard 5.1 Timely Access	3 Counties: Ceredigion	Skitt, Peter	Skitt, Peter	5/18/2020	There is a risk of patients who would ordinarily present to our services, but are now delayed or prevented from initial or follow-up appointments. This is caused by the in-direct consequence of the coronavirus pandemic which has resulted in specialist nurses supporting other services, clinic sites operating as COVID sites and social distancing restrictions. This will lead to an impact/affect on patients may not receive timely assessments and interventions. Risk location, Health Board wide.	Community specialist nurses have prioritised their patients to maintain contact with those who are most vulnerable. Alternative communication channels are being utilised where appropriate. Emergency clinics are operational.	Safety - Patient, Staff or Public	6	3	3	9	Capacity in Cardigan Integrated Care centre to be maintained to enable emergency clinics when required	Evans, Tracey -	31/05/2020	Capacity in Cardigan ICC is currently available for emergency clinics	Operational Quality, Safety & Experience Sub Committee	2	3	6	5/18/2020
													Monitor the quantity of outpatient clinics operational in Ceredigion, currently operating 15% of pre-covid	Evans, Tracey -	30/09/2020	Processes are being put in place to monitor changes to the delivery of outpatient clinics					

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850	Standard 2.1 Managing Risk and Promoting Health and Safety	Nursing, Quality & Patient Experience	Passey, Sian	Steele, Cathie	4/1/2020	There is a risk of issuing affecting the quality of care and patient safety will not reported. This is caused by changes in wards and staffing during the Covid-19 pandemic. This will lead to an impact/affect on a positive patient safety culture. openness and transparency escalation and timely investigation of patient safety incidents. Risk location, .	Incident reporting procedure in place Corporate induction includes incident reporting Datix available for all staff Patient safety awareness briefings Concerns management during Covid-19 question and answer document circulated to managers by Director of Nursing Monitoring and scrutiny of incident reporting by the Quality Assurance and Safety Team. Assurance report QSEAC and extraordinary QSEAC (Covid)	Safety - Patient, Staff or Public	6	3	3	9					Operational Quality, Safety & Experience Sub Committee	2	3	6	5/15/2020
832	Standard 3.1 Safe and Clinically Effective Care	MD: Effective Clinical Practice	Evans, John	Davies, Lisa	2/6/2020	There is a risk of that NICE and other National Guidance is not effectively disseminated and implemented across the Health Board This is caused by a lack of clinical engagement in the Effective Clinical Practice agenda, and a failure to identify the appropriate clinical leads This will lead to an impact/affect on service developments to improve outcomes for patients, and delivery of safe and effective care. Risk location, Health Board wide.	AMD for Quality and Safety is in place; Clinical Director for Clinical Audit has been appointed.	Quality/Complaints/Audit	8	3	3	9	Appoint to clinical roles - Quality Improvement site leads (x4).	Ghosh, Dr Subhamay	~~29/05/2020~~ 31/07/2020	Advert has been developed and will go out imminently. Delayed by COVID-19. Advert has now been re-issued, therefore recruitment has re-commenced.	Operational Quality, Safety & Experience Sub Committee	2	3	6	5/26/2020
													Structures and systems are being developed to streamline the dissemination of NICE and other Guidance, in order to free up capacity to further support clinical engagement.	Davies, Lisa	~~28/08/2020~~ 30/09/2020	Review of systems and structures has commenced. Delayed due to COVID-19. Capacity has been redeployed to the management of COVID-19 guidance.					
													Progress the clinical engagement and communications workstreams identified within the project plan for clinical effectiveness.	Davies, Lisa	26/02/2021	A project plan for clinical effectiveness is in draft and work in the clinical engagement and communication workstreams is underway. Further development of these workstreams is subject to the review which is currently underway.					
664	Standard 3.1 Safe and Clinically Effective Care	Children's: Community Children's Services	Humphrey, Lisa	Devonald-Morris, Margaret	11/9/2018	There is a risk of unsustainable care delivery for children and young people who have continuing care packages delivered by only two 3rd sector providers. This is caused by only two providers, one covering Carmarthenshire and the other covers Ceredigion and Pembrokeshire. This will lead to an impact/affect on the provider covering Pembrokeshire has had issues with one package where family dynamics/expectations has been a contributing factor in retaining and recruiting care staff. This can lead to assessed need not being met and potential increase	Implemented impact assessments and contingency plans for all care packages HB wide. Children's Community Nursing Service working with Health & Safety and Social Care to address the family's dynamics and expectations. Use of HB core community staff and bank staff to cover packages of care to avoid admission to secondary care.	Safety - Patient, Staff or Public	8	2	4	8	Liaise with providers, Service Delivery Manager (SDM)/Senior Nurse (SN) Community, Children's Community Nurse Team Leader and Nurse Assessor to ensure the lease disruption to transfer of care delivery from one provider to another.	Devonald-Morris, Margaret	**Completed**	Children's Community Nursing Team Leader and Nurse Assessor to undertake weekly monitoring of care,identify gaps in service and implement action plan to address.	Operational Quality, Safety & Experience Sub Committee	2	4	8	2/14/2020

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	Stand	Women & C				admissions to secondary care and or use of Health Board Bank Staff. Risk location, Health Board wide, Pembrokeshire.							SDM/SN Community to work with Finance team to explore increase in nursing resource to develop 'in-house home care team' funded via the Continuing Care Budget.	Devonald-Morris, Margaret	~~31/07/2019~~ 31/03/2020	SDM/SN Community liaising with finance lead sharing SBAR development. Establishment for Continuing care packages identified on IMTP.	Operational Qua				
													Team Leader to plan monthly meetings with 3rd sector provider to develop action plans around recruitment and retention.	Devonald-Morris, Margaret	**Completed**	Meeting booked with 3rd sector provider, Health Board Procurement and Team Leader to review position.					
													Seek authorization from Bronze Command to maintain contract payment for Continuing Care package delivery in Carmarthen.	Devonald-Morris, Margaret	**Completed**	SBAR submitted to Bronze Command on 06/04/20, the Chair Person escalated to Gold Command, approval confirmed 0n 22/04/20.					
844	Standard 3.1 Safe and Clinically Effective Care	MD: Effective Clinical Practice	Evans, John	Davies, Lisa	2/28/2020	There is a risk of clinicians delivering care/treatment on behalf of the Health Board are unable to specify the standards that guided their care and management of the patient, or explain any deliberate and informed departure This is caused by by the failure of Directorates (as owning groups) to respond to existing processes for dissemination, assessment and recording around compliance with NICE/other Guidance, and decisions around departure from guidance or standards. This will lead to an impact/affect on considerations of the Ombudsman when preparing any report on investigations being undertaken into complaints about the care and treatment of patients in Hywel Dda University Health Board. Risk location, Health Board wide.	NICE Guidance is disseminated to owning groups and leads for onward cascade, according to NICE and Other National Guidance Implementation Policy. A system exists to capture dissemination of NICE Guidance and record the status, using a Status Feedback Form and Baseline Assessment if required.	Quality/Complaints/Audit	8	2	4	8	Review and further develop processes to disseminate, assess and record compliance with NICE/other Guidance.	Davies, Lisa	31/03/2021	Review has commenced	Operational Quality, Safety & Experience Sub Committee	1	4	4	5/26/2020
													Explore systems/software to support dissemination, assessment and recording compliance with NICE/other Guidance.	Davies, Lisa	31/12/2020	Systems are currently being identified and assessed, including AMaT and Datix Cloud IQ					
													Develop a risk-based work programme for a systematic review position regarding dissemination, assessment and recording around compliance with NICE/other Guidance, and decisions around departure from guidance or standards.	Davies, Lisa	30/09/2020	Approach is in development.					
													Review process for approval of COVID-19 related national and local guidance with a view to identifying lessons learned and implementing new ways of working.	Davies, Lisa	30/09/2020	Discussions have commenced to review scope to amend current processes.					

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830	Standard 2.1 Managing Risk and Promoting Health and Safety	Central Operations: Out of Hours	Rees, Gareth	Davies, Nick	1/3/2020	There is a risk of that patients requiring urgent primary care assessment and treatment during out of hours periods may not be seen within clinically acceptable time periods. This is caused by periodic staffing shortfalls within the GP out of hours service coupled with increased 111 generated demand along with ambulance service and ED escalation. This will lead to an impact/affect on clinical safety impacts arising from delayed or no care provision along with poor patient experience. This could result in significant harm to patients and the potential for increased complaints and possible litigation towards the HB. Risk location, Carmarthenshire, Ceredigion, Pembrokeshire.	Rota coordinators focus on maximising shift fill at all times. Remote working solutions have been identified and clinicians secured when available. Enhanced clinical support secured via the 111 clinical support hub - when available. Escalation plan shared with hospital managers, Executive team and 111 managers. Additional ED resources can be secured for potential increased ED attendance if required. Ability to increase pay in recognition of poor working conditions in an attempt to increase resilience. Advanced Paramedic Practitioners (APP) rotation utilising WAST Advanced Paramedic Practitioners to support with HB wide activity- when available.	Safety - Patient, Staff or Public	6	2	4	8	Recruit and deploy clinical shift lead GPs (where engagement can be secured) at times of highest demand to direct demand to available clinicians and to allocate available resources. This will require cross-border agreements where GPs operate from their particular base but cover calls across the HB footprint	Davies, Nick	Completed	Expressions of interest have been received. Clinical Lead, Deputy MD and 111 Clinical Advisor will all support with immediate pressures. Interviews to be arranged for remaining applicants	People, Planning & Performance Assurance Committee	1	4	4	5/21/2020
													Direction and challenge of current GP activity and cultural behaviour is required by Medical Directorate to ensure all GPs contribute fairly to HB wide demand (to include telephone advice and face to face consultation- including home visiting- regardless of geographical location.	Davies, Nick	Completed	Service leads and medical directors to meet and address issue and agree lines of communication					
													To hold a senior management/ service lead and 111 lead meeting to discuss current concern, understand risks and discuss potential solutions- to be chaired by Director of Operations	Davies, Nick	Completed	Meeting has been arranged for 28/01/2020 and invite circulated- responses awaited					
													Maximise clinician availability to support wider workforce pressure- while developing multi-disciplinary approach to service delivery. 2 month pilot utilising Acute Response Team (ART)staff on a bank basis to support OOH demand on a 3-county basis, ensuring access to patients (especially palliative care) is secures- without affecting capacity of existing ART caseload	Davies, Nick	Completed	Expressions of interest receieved and workforce approval gained- currently meeting with staff to ensure roles are appropriate and ascertain availability- rota to be prepared by 24/01/2020 with a view to initial deployment on 01/02/2020					
													Increase the deployment of WAST Advanced Paramedic Practitioners into the OOH rotation. Currently utilises skills of 2 WTE, looking to increase to 3 WTE.	Davies, Nick	~~30/06/2020~~ 31/12/2021	Delayed due to external educational requirements. Service leads are in discussion with WAST leads regarding the potential increase.					
													Recruitment of additional clinicians (to include GP and Advanced Nurse Practitioners)upon the receipt of potential applications.	Davies, Nick	Completed	Now have sufficient sessional GPs in place.					

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													Complete service redesign is needed and this work is being undertaken in collaboration with the Transformation Directorate.	Davies, Nick	31/12/2025	Working group established and workstreams assigned. Workforce planning will be complex and may require a complete statistical review of the service in collaboration with the Delivery Unit. It is envisaged that a plan will be devised within 12 months (July 2021- delayed due to COVID) but rollout likely to take several years when educational requirements etc are taken into account. This will be reviewed as the project plan develops and the workforce profile (and availability) is established.					
													SDM to assess the potential benefit of a Triage Nurse service- and possible implementation- to support with current service demand and delivery	Davies, Nick	~~29/05/2020~~ 31/12/2020	Benefit to nurse triage has been identified, SDM now to link with resourcing and with Nurse Directors to identify appropriate job descriptions, costings, business case and develop nurse hierarchy to enable securing of funding and then recruitment process to begin.Action has been delayed due to COVID planning and the current standing down of the TCS team.					
278		Women & Children's: Community Children's Services	Humphrey, Lisa	Devonald-Morris, Margaret	2/20/2015	There is a risk of delayed and sub-optimal care of paediatric diabetic patients as a result of current non-compliance with Diabetes Peer Review standards, including pschology support. This is caused by insufficient staff funding. Paediatric Dietetic time is managed by County teams. This will lead to an impact/affect on the timing of patient reviews and advice resulting in the subsequent risk of increased long-term diabetes-related morbidity and mortality, with deteriorating HbA1c. Risk location, Health Board wide.	Paediatric Diabetes nurse capacity combined across the Health Board to maximise availability of current resource to each county. 0.2WTE pschology support. Paediatric team prioritise patient access and reviews according to known clinical priority.	Safety - Patient, Staff or Public	6	2	3	6	Dietetic service to progress recruitment of additional Dietetic time via IMTP plans.	Devonald-Morris, Margaret	**Completed**	Instruction from Executive board to fund 0.6	rational Quality, Safety & Experience Sub Committee	2	3	6	5/14/2020
													Senior Nurse Community Paediatrics to undertake further assessment of Paediatric Diabetes Specialist Nurse(PDSN) Workforce.	Devonald-Morris, Margaret	~~01/12/2017~~ 31/03/2020	Directorate unable to further progress within available funding. Issue of 1.0 WTE highlighted via IMTP proposals.					

Risk Ref	Health and Care Standards	Directorate	Directorate lead	Management or service lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Risk Tolerance Score	Current Likelihood	Current Impact	Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Date Reviewed
													Identify appropriate funding to support PDSN bank staff. Develop a local management arrangement between paediatric ward staff and PDSN.	Devonald-Morris, Margaret	Completed	PDSN bank is being used to support nursing services. Local management arrangements in place and review for periods of leave. Recruited 0.8 WTE to 1.0 WTE post, commencement date end July 2018. 0.2 WTE vacancy currently funding bank hours. 0.8 WTE PDSN increased to 0.91WTE and 0.6 WTE increased to 0.69 WTE. PDSN bank not being used as current establishment filled.	Oper				
													Cover required for maternity leave from March 2020.	Devonald-Morris, Margaret	1/4/2020	Maternity leave cover being fully funded from vacant posts agreed - cost neutral. Waiting for Resourcing to authorise vacancy on TRAC to progress with appointing a suitable practitioner.					
													Due to COVID-19 a phased reduction in service as detailed on the attached Business Continuity Action Plans (BCAP), version 1 and version 2.	Devonald-Morris, Margaret	18/03/2020	BCAP reviewed and revised in response to the Welsh Government directive on social isolation and the revision to acute peadiatric service delivery. Submission of BCAP via email to the Community Bronze Group on 08/04/20.					
294		Women & Children's: Community Children's Services	Humphrey, Lisa	Devonald-Morris, Margaret	4/24/2017	There is a risk of delayed and sub-optimal care of paediatric patients requiring community nursing and a holistic approach to palliative care needs in line with NICE Guidance 61 End of Life care for infants. This is caused by non-compliance with Royal College of Nursing Standards re ratio of nursing to child, young people population. This will lead to an impact/affect on timely interventions and clinical outcomes for children and families, in addition to them coming to terms with end of life prognosis. Risk location, Health Board wide.	One Hywel Dda children's community nursing team in place. Traffic Light System in place to ensure a safe and sustainable Children's Community Nursing Service that has the flexibility to meet the holistic nursing needs of current caseload. All Wales Paediatric Advanced Care Plan and delivery action plan in place.	Quality/Complaints/Audit	8	2	3	6	Monitor existing caseload, referrals to be reviewed against the traffic light framework to ensure a safe, sustainable service delivery.	Devonald-Morris, Margaret	Completed	Ongoing appraisal of case load and referrals monitored.	Operational Quality, Safety & Experience Sub Committee	2	3	6	5/14/2020
													Ensure investment for service delivery is included in the Delivery Action Plans.	Devonald-Morris, Margaret	Completed	No investment to date. Investment for 2020-2022 included in IMTP.					
													Develop a paediatric action & delivery plan in line with NICE guidance self assessment.	Devonald-Morris, Margaret	Completed	Action & Delivery Plan completed, to present at the next Q&S meeting.					

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													Develop an additional SBAR which includes nursing and medical staffing as an action from the Paediatric Task and finish Group.	Devonald-Morris, Margaret	Completed	SBAR completed and presented to Paediatric Task and finish group.					
													Team review of case management, working practices, and the acuity across each patch to ensure quality and safety, and equitable distribution of staff.	Lewis, Ms Teresa	Completed	perceived increased demand on the Carmarthenshire area. Following case load review, redistribution of staff across Carmarthenshire and Pembrokeshire.					
													As a result of COVID 19, re: attached Business Continuity Action Plan, Covid-19 Continency guidance version 4, SBAR on-call 01/04/20 and SBAR on-call V3 01/05/20 submitted via email to Human Resource Bronze meeting.	Devonald-Morris, Margaret	30/06/2020	08/04/20: Business Continuity Action Plan, Covid-19 Continency guidance version 4, SBAR on-call 01/04/20 submitted on 08/04/20 via email to the Bonze command Community Group. SBAR on-call 01/04/20 agreed in principle but when submitted to Gold command request was put on hold until assurance had been received from HR. 13/05/20 Microsoft Team meeting with the Children's Community Nursing staff to review current practices in light of COVID-19.					
392		Women & Children's: Community Children's Services	Humphrey, Lisa	Devonald-Morris, Margaret	12/1/2017	There is a risk of delayed assessment and review of community paediatric patients. This is caused by long standing vacancies within Consultant Community Paediatric Team and is compounded by vacancies within supporting middle grade team. This will lead to an impact/affect on on timeliness of care and follow up review for patients. Risk location, Health Board wide.	Recruitment continues and employment of NHS locum staff. Community paediatric referrals are triaged and prioritised. Existing job plans regularly reviewed.	Safety - Patient, Staff or Public	6	2	3	6	Combined medical and nursing SBAR to be developed as an action of the paediatric task and finish group.	Devonald-Morris, Margaret	Completed	SBAR completed reviewed at Pediatric Task and Finish.	Operational Quality, Safety & Experience Sub Committee	3	2	6	2/14/2020
													Development of an 'action plan' to address the issues identified following the Demand and Capacity Review.	Devonald-Morris, Margaret	~~31/12/2018~~ 31/03/2020	Action Plan completed, further work is ongoing to address the issues.					
													Active validation of waiting list for new and follow-up appointments.	Devonald-Morris, Margaret	Completed	On-going validation as part of normal process.					

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													Review of service delivery in response to Welsh Government directive on COVID 19 and the revision of acute paediatric services. Business Continuity Action Plans (BCAP) completed and sent via email on 08/04/20 to the Bronze Community Group and included the following services, ADHD, Epilepsy, Antipsychotic Medication, adoption, Genetics, Paediatric Outreach Oncology service .	Devonald-Morris, Margaret	30/06/2020	14/05/20: attached BCAP to this risk for ADHD, Epilepsy, Antipsychotic Medication, adoption, Genetics, Paediatric Outreach Oncology service					
858	Standard 2.1 Managing Risk and Promoting Health and Safety	Women & Children's: Midwifery/Maternity	Humphrey, Lisa	Jenkins, Mrs Julie	5/22/2020	There is a risk of to service users and staff as a result of departments needing to be reconfigured due to COVID 19. This is caused by the COVID 19 pandemic, resulting in Ante Natal Clinic(ANC), DAU, Triage, Antenatal ward and MLU have been relocated and community maternity services have been streamlined in line with RCOG guidelines and Antenatal Screening Wales Guidelines. Resulting in virtual consultations and streamlined antenatal and postnatal care. This will lead to an impact/affect on service users and staff, lack of face to face services may increase incidents and mis-diagnosis, claims and complaints. Risk location, Health Board wide.	Pathway formatted in line with RCOG guidelines, ASW guidelines and NHS Wales collaborative Maintenance of essential maternity services through COVID 19 Pandemic. Signage in place to direct service users to appropriate areas. Working document in place to guide staff in clinical RED/ GREEN. areas. Dedicated theatres for COVID 19 patients. Telephone consultations for antenatal/postnatal care. Guideline for Home birth delivery working in partnership with WAST. Postnatal contraceptive pathway implemented POP pill available on discharge from hospital. Working in partnership with Newborn Blood Spot Screening to ensure compliance. Maintaining inter hospital transfers as and when required.	Service/Business interruption/disruption	6	3	2	6					Quality, Safety & Experience Sub Committee Operational Quality	3	2	6	5/22/2020
721	Standard 2.1 Managing Risk and Promoting Healthy Effective Care	Clinical Practice	Evans, John	Davies, Lisa	3/8/2019	There is a risk of NICE guidance not being disseminated to appropriate staff in a timely manner. This is caused by resources being limited to a staff of 0.4 WTE Band 7 and 0.4 WTE band 5.	Review of NICE policy initiated. Clinical Effectiveness Co-ordinator recruited, increased to 1 w.t.e. NICE Support Officer 1 w.t.e.	Complaints/Audit	8	3	2	6	Directorate lead to identify further resources and with Co-ordinator to identify new ways of working.	Eden, Ingaret	Completed	New action.	Quality, Safety & Experience Sub Committee	2	2	4	5/26/2020

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	Standard 3.1 Safe and Clinical	MD: Effective				This will lead to an impact/affect on the possibility that services will not be fully aware of their responsibilities in relation to NICE guidance. The Health Board is expected to ensure that provision is made to enable healthcare staff to implement NICE guidance as expected by the Welsh Government. Risk location, Health Board wide.	Review of system for dissemination and collection of baseline information.	Quality/(					Complete review of NICE Policy, processes and systems.	Davies, Lisa	~~06/08/2020~~ 31/09/2020	Review underway, commenced January 2020. Review was paused as capacity has been redeployed to the management of COVID-19 guidance. However, this will recommence pending confirmed approach for maintenance of COVID-19 processes for clinical guidance and release of capacity.	Operational Quality, Safety & Experience				
													Explore feasibility of procuring a system for central management and dissemination of NICE and other National Guidelines	Davies, Lisa	~~06/08/2020~~ 30/09/2020	An option has been demo'd and discussions ongoing with other Health Boards. Delayed due to COVID-19. Capacity has been redeployed to the management of COVID-19 guidance.					
849	Standard 2.1 Managing Risk and Promoting Health and Safety	Estates & Facilities	Harrison, Tim	Harrison, Tim	5/7/2020	There is a risk of to patient and staff safety at Covid 19 field hospitals sites. This is caused by the introduction of field hospitals resulting in high value equipment left unused and unattended for long periods of time exposing it to malicious loss. The operational phase of the field hospitals could potentially see site visits with attempts to gain unlawful access to red zones. This will lead to an impact/affect on staff being at increased likelihood of exposure to violence and aggression through visitors trying to access unlawful areas. Potential compromise of red zones exposes facility to interrupted operations and the community to higher risks of the Covid 19 pathogen. Theft of equipment could be catastrophic in that standards such as emergency generators are required and if failure occurs on site during treatment of ventilated patient this could result in death.	Security operatives are employed at all Covid 19 field sites in order to protect buildings and assets in the preparatory phase, escalating to protect site integrity , persons, property and operations during a live phase , followed with a step down phase to protect assets and buildings until removed and transferred out of control of the health board.	Safety - Patient, Staff or Public	6	1	5	5					Health and Safety Committee	1	5	5	5/7/2020