2.1.2 Operational Risks incorporating COVID-19

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

Item 2.1.2 Operational Risks Incorporating COVID-19

Appendix 1 Directorate Level COVID-19 Risk Register
Appendix 2 Service Level COVID-19 Risk Register
This is the second report to the Quality, Safety and Experience Assurance Committee (QSEAC) that details the operational risks identified with a COVID-19 theme on the Datix Risk Module.

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

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 the 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

At the time of writing this report, the Health Board is developing its delivery plan in response to the Welsh Government Quarter 2 Operating Framework. Appendix A of the Quarter 2 Operating Framework ‘Maintaining Essential Health Services during the COVID 19 Pandemic – summary of services deemed essential’ outlines the role that Board Quality and Safety Committees have in terms of gaining assurance that harm is minimised from the reduction in non-COVID-19 activity. It states that this should be done by triangulating timely information from different sources such as quantitative data, quality impact assessments, audit, harm reviews and risk profiles. These need to take into account clinical, operational and population risks and controls such as infection control and prevention interventions and processes. An open and transparent process to monitor and identify risks to delivery is necessary to identify where alternative solutions or ways of working may need to be determined.

It is anticipated that risks to delivery of the agreed plan will be identified and assessed on the Datix Risk Module, and monitored through the Bronze level groups, with assurance on delivery of the plan being provided to the People, Planning and Performance Assurance Committee. Significant risks to delivery should be escalated by the relevant Director to the Corporate Risk Register.

As of 23rd June 2020, there are 459 open operational risks (excludes 25 corporate risks) on the Datix Risk Module. 35 risks have COVID-19 selected as a theme, up by 9 from the previous meeting (one new risk (ref 859) and 8 existing risks that have been aligned to the COVID-19 theme – denoted by * on tables below).

The number of risks within this report still 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 identify, review and manage risks sits with risk owners within services who have to balance/prioritise this work with their other responsibilities.

The 35 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 6 **Directorate level** risks can be found in the table below:

<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Date Risk Identified</th>
<th>Title</th>
<th>Directorate</th>
<th>Current Risk Score</th>
<th>Target Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>114</td>
<td>01/01/2016</td>
<td>Health Board wide, increased demand for CT and MRI &amp; ultrasound services exceeding capacity and staff to deliver.</td>
<td>USC Pathways Pathology &amp; Radiology</td>
<td>12 ➔</td>
<td>6</td>
</tr>
<tr>
<td>71</td>
<td>01/02/2011</td>
<td>Lack of effective communication between daytime practices and Out of Hours (OOH).</td>
<td>Central Operations</td>
<td>9 ➔</td>
<td>3</td>
</tr>
<tr>
<td>551*</td>
<td>22/12/2017</td>
<td>Health Board risk relating to Waste Management - Generation, handling, storage and segregation.</td>
<td>Estates &amp; Facilities</td>
<td>8 (From 12) ➔</td>
<td>6</td>
</tr>
<tr>
<td>384</td>
<td>23/09/2017</td>
<td>Ability to fully comply with statutory and manufacturer guidelines for medical devices and equipment.</td>
<td>Central Operations</td>
<td>8 ➔</td>
<td>4</td>
</tr>
<tr>
<td>111</td>
<td>01/01/2016</td>
<td>Avoidable delay in diagnosis and treatment of patients lack of Consultant radiologists</td>
<td>USC Pathways Pathology &amp; Radiology</td>
<td>6 ➔</td>
<td>6</td>
</tr>
<tr>
<td>857</td>
<td>22/05/2020</td>
<td>Inability to facilitate mandatory and statutory training due to COVID 19</td>
<td>Women &amp; Children's</td>
<td>5 ➔</td>
<td>5</td>
</tr>
</tbody>
</table>

An extract from Datix of the 29 **service level** risks can be found in the table below:

<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Date Risk Identified</th>
<th>Title</th>
<th>Directorate</th>
<th>Current Risk Score</th>
<th>Target Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>846*</td>
<td>10/03/2020</td>
<td>A patient, member of staff or the public receiving a meal containing an allergen that they are allergic to</td>
<td>Estates &amp; Facilities</td>
<td>20 ➔</td>
<td>5</td>
</tr>
<tr>
<td>572</td>
<td>01/04/2016</td>
<td>Inappropriate use of hospital beds due to a lack of capacity for timely</td>
<td>3 Counties</td>
<td>16 ➔</td>
<td>8</td>
</tr>
<tr>
<td>No.</td>
<td>Date</td>
<td>Description</td>
<td>Location</td>
<td>Score</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>------------</td>
<td>------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>859</td>
<td>30/03/2020</td>
<td>COVID-19 Pandemic Community, Nursing Accommodation</td>
<td>3 Counties</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>720</td>
<td>15/04/2019</td>
<td>Avoidable harm to patients and staff due to staffing levels at Tregaron Hospital</td>
<td>3 Counties</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>574</td>
<td>01/12/2017</td>
<td>Community nursing will be unable to provide the level and quality of care to keep patients in the community in Ceredigion.</td>
<td>3 Counties</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>573</td>
<td>01/10/2016</td>
<td>GP practices serving notice that practice nurses will no longer treat and manage patients with leg ulcers in Ceredigion.</td>
<td>3 Counties</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>848</td>
<td>15/04/2020</td>
<td>Avoidable death due to unavailability of critical care medicines.</td>
<td>Primary, Community and Long Term Care (P,C,LTC)</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>751*</td>
<td>25/01/2019</td>
<td>Potential for failure of Storz Camera Systems in GGH Theatres.</td>
<td>Scheduled Care</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>752*</td>
<td>25/01/2019</td>
<td>Potential for failure of the Storz camera systems in BGH.</td>
<td>Scheduled Care</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>753*</td>
<td>25/01/2019</td>
<td>Potential for the failure of the Storz camera system in main theatre in PPH.</td>
<td>Scheduled Care</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>754*</td>
<td>25/01/2019</td>
<td>Potential for the failure of the Storz camera system in WGH theatre 1.</td>
<td>Scheduled Care</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>492*</td>
<td>13/06/2017</td>
<td>Damage to Meurig Ward Flooring – Bronglais General Hospital</td>
<td>Estates &amp; Facilities</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>279</td>
<td>01/09/2016</td>
<td>HB wide: Inequality of care for children requiring access to Learning Disability Services.</td>
<td>Women &amp; Children's</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>758</td>
<td>12/07/2019</td>
<td>Medical Device Regulation (MDR) and the In Vitro Diagnostic Medical Device Regulation (IVDR)</td>
<td>Central Operations</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>850</td>
<td>01/04/2020</td>
<td>Reporting, monitoring and escalation of patient safety issues during Covid-19</td>
<td>Nursing, Quality &amp; Patient Experience (NQ&amp;PE)</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>832</td>
<td>06/02/2020</td>
<td>Lack of clinical engagement in clinical effectiveness e.g. implementation of NICE guidance.</td>
<td>Medical Directorate (MD)</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>852</td>
<td>18/05/2020</td>
<td>COVID-19 – Domiciliary care / care home resilience</td>
<td>3 Counties</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>803</td>
<td>19/11/2019</td>
<td>Disruption to Out of Hours Service due to the failure of 111 IT systems.</td>
<td>Central Operations</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>851</td>
<td>18/05/2020</td>
<td>COVID-19 Risk of unknown harm to those who would ordinarily present to our services</td>
<td>3 Counties</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>664</td>
<td>09/11/2018</td>
<td>HB wide risk; Stability of 3rd sector to provide commissioned care particularly significant in Pembrokeshire.</td>
<td>Women &amp; Children's</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>844</td>
<td>28/02/2020</td>
<td>Ability to specify the standards that guided care and management of patients</td>
<td>Medical Directorate (MD)</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>830</td>
<td>03/01/2020</td>
<td>Out of Hours service demand exceeds capacity</td>
<td>Central Operations</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Date</td>
<td>Description</td>
<td>Department</td>
<td>Score</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>392</td>
<td>01/12/2017</td>
<td>Lack of community paediatricians causing delayed assessment and review of community paediatric patients.</td>
<td>Women &amp; Children's</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>858</td>
<td>22/05/2020</td>
<td>Reconfiguration of maternity services in HDdUHB.</td>
<td>Women &amp; Children's</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>294</td>
<td>24/04/2017</td>
<td>Non-compliance with Royal College of Nursing Standards; ratio of nursing to child or young person.</td>
<td>Women &amp; Children's</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>151*</td>
<td>23/05/2016</td>
<td>Non-compliance with Royal College of Nursing Standards; ratio of nursing to child or young person.</td>
<td>Women &amp; Children's</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>278</td>
<td>20/02/2015</td>
<td>Non-compliance with Diabetes Peer Review Standards causing delayed and sub-optimal care of diabetic paediatric patients.</td>
<td>Women &amp; Children's</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>721</td>
<td>08/03/2019</td>
<td>Lack of resources to implement HB NICE policy.</td>
<td>Medical Directorate (MD)</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>849</td>
<td>07/05/2020</td>
<td>Security operations at COVID-19 sites</td>
<td>Estates &amp; Facilities</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

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** - All very high and high risk areas are now being audited and have been completed, wherever possible, in June 2020. The only exception to this would be on health and safety grounds such as positive/suspected COVID-19 patients receiving aerosol generating procedures within a room. Supervisors would not be expected to enter the room to undertake audits. This would pose very little risk to the cleanliness of the room as cleaning regimes have been increased and deep cleaning of rooms is carried out regularly due to COVID-19. *Risk assessment will be undertaken week commencing 29th June 2020.*

- **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. *Risk is currently being drafted and reviewed by the service.*

- **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 – *risk has been added to Datix (868).*
  - Availability of workforce to meet future peaks/troughs in demand – *risk has been added to Datix (870).*
  - Occupational Health (OH) checks for the new starters - *risk has been added to Datix (869).*
  - Training capacity – *risk assessment has been undertaken, with risk to be added to Datix.*
  - Employee relations delays - *risk assessment has been undertaken, with risk to be added to Datix.*
  - Black, Asian and Minority Ethnicity (BAME) – *risk assessment has been undertaken with further work required before risk being added to Datix.*

**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: (rhai d cwblhau)
#### Objectives: (must be completed)

<p>| Committee ToR Reference: |<br />
| 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. |
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfrewdol: |
| Datix Risk Register Reference and Score: |
| Contained within the report |
| 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 |</p>
<table>
<thead>
<tr>
<th>Effaith: (rhaid cwblhau)</th>
<th>Impact: (must be completed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ariannol / Gwerth am Arian: Financial / Service:</td>
<td>No direct impacts from report however impacts of each risk are outlined in risk description.</td>
</tr>
<tr>
<td>Ansawdd / Gofal Claf: Quality / Patient Care:</td>
<td>No direct impacts from report however impacts of each risk are outlined in risk description.</td>
</tr>
<tr>
<td>Gweithlu: Workforce:</td>
<td>No direct impacts from report however impacts of each risk are outlined in risk description.</td>
</tr>
<tr>
<td>Risg: Risk:</td>
<td>No direct impacts from report however impacts of each risk are outlined in risk description.</td>
</tr>
<tr>
<td>Cyfreithiol: Legal:</td>
<td>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.</td>
</tr>
<tr>
<td>Enw Da: Reputational:</td>
<td>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.</td>
</tr>
<tr>
<td>Gyfrinachedd: Privacy:</td>
<td>No direct impacts</td>
</tr>
</tbody>
</table>
| Cydraddoldeb: Equality: | Has EqIA screening been undertaken? /No
<p>| | Has a full EqIA been undertaken? No |</p>
<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Health and Care Standards</th>
<th>Directorate</th>
<th>Lead Committee</th>
<th>Date Risk Identified</th>
<th>Date reviewed</th>
<th>Current Likelihood</th>
<th>Current Impact</th>
<th>Current Risk Score</th>
<th>Additional Risk Action Required</th>
<th>By Whom</th>
<th>By When</th>
<th>Progress Update on Risk Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>114</td>
<td>USC: Radiology</td>
<td>Perry, Sarah</td>
<td>Evans, Amanda</td>
<td>01/01/2016</td>
<td>15/05/2020</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>Evans, Amanda</td>
<td>Completed</td>
<td>Eight trained reporting radiographers in post. No increase this year.</td>
</tr>
<tr>
<td>114</td>
<td>USC: Radiology</td>
<td>Perry, Sarah</td>
<td>Evans, Amanda</td>
<td>01/01/2016</td>
<td>15/05/2020</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>Evans, Amanda</td>
<td>Completed</td>
<td>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.</td>
</tr>
<tr>
<td>114</td>
<td>USC: Radiology</td>
<td>Perry, Sarah</td>
<td>Evans, Amanda</td>
<td>01/01/2016</td>
<td>15/05/2020</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>Evans, Amanda</td>
<td>Completed</td>
<td>Process is in place and constantly monitored.</td>
</tr>
<tr>
<td>114</td>
<td>USC: Radiology</td>
<td>Perry, Sarah</td>
<td>Evans, Amanda</td>
<td>01/01/2016</td>
<td>15/05/2020</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>Evans, Amanda</td>
<td>Completed</td>
<td>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, WiO/D and Medical Recruitment.</td>
</tr>
</tbody>
</table>

There is a risk of delay in diagnosis, not achieving 8 week diagnostic waiting times, 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.

Use of overtime and external reporting as required to meet demand.

SBAR completed for 7 day working.

On going SBAR - awaiting response.

Working with the Programme Management office on a demand optimisation project to reduce the amount of inappropriate requests.

Workforce and on call review to ensure right people, right place, right time.
<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Domain</th>
<th>Risk Statement</th>
<th>Existing Control Measures Currently in Place</th>
<th>Additional Risk Action Required</th>
<th>Progress Update on Risk Actions</th>
<th>By Whom</th>
<th>DateReviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>71</td>
<td>E&amp;F: Property Performance</td>
<td>There is a risk of potential pollution, a risk to human health through incorrect handling of sharp and infectious waste, fines, inefficient disposal and negative public perception, e.g. poor reuse and recycling.</td>
<td>The Waste Management Policy (V2 2017) is in place. Departmental waste procedures are in place in, for example, labs, Hotel Services and Pharmacy. Legal compliance monitoring as part of ISO 14001 standard. Auditing as part of ISO 14001 including operational audits of storage and transport and internal audits of training, segregation, etc.</td>
<td>Improve links with in hours practices, particularly around the provision of ‘Special Notes’ via WebAccess system.</td>
<td>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.</td>
<td>Environmental Team to collate and review departmental procedures for hotel services, Pathology, Pharmacy, Theatres, Maintenance, hotel services, Pathology, Pharmacy, Theatres, Maintenance and provide feedback as required.</td>
<td>Completed</td>
</tr>
<tr>
<td>55</td>
<td>Statutory duty inspections</td>
<td>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).</td>
<td>Individual Health Records (IHR) improve access to clinical information. Roll out of new system access to 30%.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>This is caused by insufficient clinical information specifically SPNs and inaccurate or incomplete information available to clinicians in the out of hours period.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>This will lead to an impact/affect 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.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Risk location, Health Board wide.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quality/Compliance/Audit</td>
<td>8</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Completed</td>
</tr>
<tr>
<td>Risk No</td>
<td>Risk Management</td>
<td>Risk Description</td>
<td>Date Identified</td>
<td>Date Risk Identified</td>
<td>Risk Statement</td>
<td>Existing Control Measures Currently in Place</td>
<td>Additional Risk Action Required</td>
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<tr>
<td>394</td>
<td>Standard 2.3 Medical Devices. Equipment and Diagnostic Systems</td>
<td>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.</td>
<td>23/09/2017</td>
<td>25/09/2017</td>
<td>There is a risk of avoidable non-compliance with statutory and implied statutory standards where medical devices are concerned.</td>
<td>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 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 serving capital decision making. Improved ultrasound governance in place. Training Needs Analysis has been undertaken in conjunction with L&amp;D Team. Servicing and inspection capacity restored to 2015 levels in clinical engineering. Broader control over all aspects of medical device management to include radiology and estates now in place. Medical Device Policy now operational.</td>
<td>Deliver waste segregation project at Prince Philip and Wbllysh hospitals in line with Welsh Government requirements. Develop training schedule to complete waste paper work training and waste portering training. Waste training for staff will be undertaken in line with the roll out of waste segregation projects.</td>
</tr>
<tr>
<td>8</td>
<td>Statutory Audit/Inspection</td>
<td>There is a risk of avoidable non-compliance with statutory and implied statutory standards where medical devices are concerned.</td>
<td>05/06/2020</td>
<td>05/06/2020</td>
<td>There is a risk of avoidable non-compliance with statutory and implied statutory standards where medical devices are concerned.</td>
<td>Implement Medical Devices Action Plan (inc development of inventory, categorisation of incidents) - delivery is monitored by Medical Devices Control Group. Operations Prioritisation System and Programme in place which feeds into annual capital planning process. Review Medical Devices Assurance Group which reports to Operational QSE Sub-Committee to improve reporting of assurance. Review Medical Devices Assurance Group which reports to Operational QSE Sub-Committee to improve reporting of assurance. Establish Information Governance requirements for medical devices.</td>
<td>Agreement on funding arrangements for remaining action outstanding. Discussions taking place with Director of Nursing, Quality and Patient Experience. This has been resolved and the Medical Devices Group now formally reports to Operational QSE Sub-Committee with escalation to QSEAC. This has been resolved and the Medical Devices Group now formally reports to Operational QSE Sub-Committee with escalation to QSEAC. List of all equipment that holds PII or connects to the internet has now been forwarded to the IG team.</td>
</tr>
<tr>
<td>Risk Ref</td>
<td>Health and Care Standards</td>
<td>Risk Statement</td>
<td>Existing Control Measures Currently in Place</td>
<td>Additional Risk Action Required</td>
<td>Progress Update on Risk Actions</td>
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<tr>
<td>USC: Radiology</td>
<td>Safety - Patient, Staff or Public</td>
<td>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</td>
<td>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 accommodate. Reporting radiographers trained for appropriate studies. Use of some locums and low cost agency to fill some gaps.</td>
<td>Advertise for substantive and locum radiologists and recruit trainee reporting radiographers.</td>
<td>8 reporting radiographers now trained and in post.</td>
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<tr>
<td>111</td>
<td>Standard 3.1 Safe and Clinically Effective Care</td>
<td>Monitor delay in unreported studies. Unreported studies sent to third party tele-radiology company.</td>
<td>Increase number of reporting Radiographers.</td>
<td>Review to commence, with HR support, on efficiency of current staff and to evaluate the gaps.</td>
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<td></td>
<td></td>
<td>Reporting radiographers working to capacity, worklists redone to accommodate. Reporting radiographers trained for appropriate studies.</td>
<td></td>
<td>Review completed, identification of succession planning. Current staff able to fill the capacity. Robust governance identified and implemented.</td>
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<tr>
<td></td>
<td></td>
<td>Use of some locums and low cost agency to fill some gaps.</td>
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<td>Software installed to permit bulk upload of images to 3rd party reporting company. Routinely used across all sites.</td>
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<td></td>
<td></td>
<td>Work with the National Imaging Academy to recruit trainee radiologists</td>
<td></td>
<td>Radiology Services Manager and Clinical Director in contact with deanery to improve training facilities Radiologist who is trainer working in conjunction with NAID.</td>
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<td></td>
<td></td>
<td>Job description approval</td>
<td></td>
<td>Trainees to start 1st August</td>
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<td></td>
<td></td>
<td>Re-launch the campaign for substantive radiologists with the support of workforce</td>
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<td>Communication team about to launch new recruitment video in Arabic</td>
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<td></td>
<td></td>
<td>Continual monitoring of radiology reporting lists to ensure no delays in turn around</td>
<td></td>
<td>Working across all sites to maximise current levels of capacity</td>
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<tr>
<td>Risk Ref</td>
<td>Directorate</td>
<td>Risk Statement</td>
<td>Existing Control Measures Currently in Place</td>
<td>Risk Tolerance Score</td>
<td>Current Impact</td>
<td>Current Risk Score</td>
<td>Additional Risk Action Required</td>
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<tr>
<td>657</td>
<td>Women &amp; Children’s, Midwifery/Maternity</td>
<td>There is a risk 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.</td>
<td>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. PROMPT reviewing current policies to incorporate COVID 19 guidelines.</td>
<td>8</td>
<td>1</td>
<td>5</td>
<td>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.</td>
</tr>
<tr>
<td>658</td>
<td>USC: Radiology</td>
<td>There is a risk of avoidable delay in diagnosis and treatment of patients, leading to a poorer quality of care.</td>
<td>There is a risk of avoidable delay in diagnosis and treatment of patients, leading to a poorer quality of care.</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>Review radiology referral pathways and levels of inappropriate tests</td>
</tr>
<tr>
<td>802</td>
<td>Standard C.1 Marketing Risk and Promoting Health and Safety</td>
<td>There is a risk 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/afect on all staff not being compliant with mandatory training requirements. In addition staff's skill set and competency may be affected resulting in non adherence to guidelines and policies and potentially poor patient outcome.</td>
<td>There is a risk 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/afect on all staff not being compliant with mandatory training requirements. In addition staff's skill set and competency may be affected resulting in non adherence to guidelines and policies and potentially poor patient outcome.</td>
<td>8</td>
<td>1</td>
<td>5</td>
<td>All Wales HOM to review in partnership with Welsh Government and with Welsh Risk Pool the future plans for Mandatory Training requirements across Wales.</td>
</tr>
<tr>
<td>803</td>
<td>Standard C.1 Marketing Risk and Promoting Health and Safety</td>
<td>There is a risk 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/afect on all staff not being compliant with mandatory training requirements. In addition staff's skill set and competency may be affected resulting in non adherence to guidelines and policies and potentially poor patient outcome.</td>
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<td>1</td>
<td>5</td>
<td>All Wales HOM to review in partnership with Welsh Government and with Welsh Risk Pool the future plans for Mandatory Training requirements across Wales.</td>
</tr>
</tbody>
</table>

**Operational Quality, Safety & Experience Sub Committee**
<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Domain</th>
<th>Risk location, Health Board wide.</th>
<th>Risk Statement</th>
<th>Existing Control Measures Currently in Place</th>
<th>Additional Risk Action Required</th>
<th>Progress Update on Risk Actions</th>
<th>Lead Owner</th>
<th>Target Date</th>
<th>Target Impact</th>
<th>Target Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>572</td>
<td>Safety - Patient, Staff or Public</td>
<td>There is a risk of delayed patient transfers resulting in further deconditioning of patients and hence avoidable harm. Increase of hospital acquired infection and being able to maintain patients within their own home. Risk location, Ceredigion.</td>
<td>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.</td>
<td>Review of all training records including food hygiene training by all catering managers by 11.7.20</td>
<td>Review of all training records including food hygiene training by all catering managers by 11.7.20</td>
<td>07/09/2020</td>
<td>New action</td>
<td></td>
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<tr>
<td>846</td>
<td>Safety - Patient, Staff or Public</td>
<td>There is a risk of that a patient, member of staff or a member of the public may receive a meal that contains an allergen that they are allergic to. This is caused by a meal containing one of the recognised allergens being consumed by someone allergic to a particular allergen. This will lead to an impact/affect on the health of a person with very serious consequences. Risk location, Health Board wide.</td>
<td>Catering staff are trained in allergens as part of their food hygiene training. Allergen Information is displayed in dining rooms.</td>
<td>Ensure supervision is available to cover new due to Covid and existing staff and catering managers to check supervision is always available</td>
<td>Ensure supervision is available to cover new due to Covid and existing staff and catering managers to check supervision is always available</td>
<td>07/09/2020</td>
<td>Rota check of supervision will be on going process</td>
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<tr>
<td>846</td>
<td>Safety - Patient, Staff or Public</td>
<td>There is a risk of delayed patient transfers resulting in further deconditioning of patients and hence avoidable harm. Increase of hospital acquired infection and being able to maintain patients within their own home. Risk location, Ceredigion.</td>
<td>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.</td>
<td>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.</td>
<td>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.</td>
<td>07/09/2020</td>
<td>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.</td>
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<tr>
<td>846</td>
<td>Safety - Patient, Staff or Public</td>
<td>There is a risk of that a patient, member of staff or a member of the public may receive a meal that contains an allergen that they are allergic to. This is caused by a meal containing one of the recognised allergens being consumed by someone allergic to a particular allergen. This will lead to an impact/affect on the health of a person with very serious consequences. Risk location, Health Board wide.</td>
<td>Catering staff are trained in allergens as part of their food hygiene training. Allergen Information is displayed in dining rooms.</td>
<td>Develop a SBAR demonstrating the risk associated with funding of the interim care beds in relation to the TCS strategy. Data has been collated.</td>
<td>Develop a SBAR demonstrating the risk associated with funding of the interim care beds in relation to the TCS strategy. Data has been collated.</td>
<td>07/09/2020</td>
<td>Data has been collated.</td>
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<tr>
<td>846</td>
<td>Safety - Patient, Staff or Public</td>
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<td>Catering staff are trained in allergens as part of their food hygiene training. Allergen Information is displayed in dining rooms.</td>
<td>Engage with the Transformation programme in order to develop a 24/7 service which can respond for a short term.</td>
<td>Engage with the Transformation programme in order to develop a 24/7 service which can respond for a short term.</td>
<td>07/09/2020</td>
<td>Work has commenced with Ceredigion County Council to develop a service spec and business case.</td>
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<tr>
<td>846</td>
<td>Safety - Patient, Staff or Public</td>
<td>There is a risk of that a patient, member of staff or a member of the public may receive a meal that contains an allergen that they are allergic to. This is caused by a meal containing one of the recognised allergens being consumed by someone allergic to a particular allergen. This will lead to an impact/affect on the health of a person with very serious consequences. Risk location, Health Board wide.</td>
<td>Catering staff are trained in allergens as part of their food hygiene training. Allergen Information is displayed in dining rooms.</td>
<td>Utilise data to understand the scope and demand for a 24 / 7 response service.</td>
<td>Utilise data to understand the scope and demand for a 24 / 7 response service.</td>
<td>07/09/2020</td>
<td>Work has commenced with Cardigan Hospital to scope the service.</td>
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<tr>
<td>846</td>
<td>Safety - Patient, Staff or Public</td>
<td>There is a risk of that a patient, member of staff or a member of the public may receive a meal that contains an allergen that they are allergic to. This is caused by a meal containing one of the recognised allergens being consumed by someone allergic to a particular allergen. This will lead to an impact/affect on the health of a person with very serious consequences. Risk location, Health Board wide.</td>
<td>Catering staff are trained in allergens as part of their food hygiene training. Allergen Information is displayed in dining rooms.</td>
<td>Working with the LA, a service specification is being developed aligned with Programme 1 and Programme 3 of the Transitional Framework.</td>
<td>Working with the LA, a service specification is being developed aligned with Programme 1 and Programme 3 of the Transitional Framework.</td>
<td>07/09/2020</td>
<td>Programme 3 draft submitted to Regional Operational Quality, Safety &amp; Experience Sub Committee</td>
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<tr>
<td>Risk Ref</td>
<td>Health &amp; Care Standards</td>
<td>Domain</td>
<td>Date Risk Identified</td>
<td>Risk Statement</td>
<td>Existing Control Measures Currently in Place</td>
<td>Additional Risk Action Required</td>
<td>Progress Update on Risk Actions</td>
<td>Date Reviewed</td>
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<tr>
<td>7/20</td>
<td>Safety - Patient, Staff or Public</td>
<td>Safety - Patient, Staff or Public</td>
<td>01/04/2016</td>
<td>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.</td>
<td>Trying to assure that appropriate patients are placed within Tregaron Hospital, whose needs can be met.</td>
<td>Work with the Regional partnership to agree a scheme to fit within the Programme 1 and 3 Transitional Framework. Prioritize the outcomes required for sustainable projects. Monitor and review capacity and waiting times on a regular basis. Options paper to be taken forward in order to reduce the risk of patient harm in Tregaron hospital. The CMT needs to review the contingency planning associated with staff shortages on both a short and medium term. Risk needs to be escalated. Report to be written clearly demonstrating that all effort has been undertaken to ensure safety regarding staff and patient care. The staffing levels reflect the number and acuity of patients admitted in to Tregaron hospital. Ongoing review of staffing levels and patient acuity. The site to enable flow from the acute sites during the COVID-19 pandemic and therefore utilise additional capacity associated with the pandemic.</td>
<td>Local plans are being developed alongside Regional priorities. 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. Daily (Mon - Fri) COVID-19 Touch Point meetings have been established which have Social Care representation. Reglar reviews and updates of situation. Options paper has been written. Contingency plan and options paper developed and submitted to Mandy Rayani. Beds have been reduced to 7. Processes in place to ensure that the hospital is staffed appropriately. Processes in place to ensure that the hospital is staffed appropriately to meet patient need. Develop an SBAR to enable Tregaron to be used as a green step down / step up and re-hab facility to enable patient flow.</td>
<td>18/05/2020</td>
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<tr>
<td>Risk Name</td>
<td>Domain</td>
<td>Risk Statement</td>
<td>Existing Control Measures Currently in Place</td>
<td>Additional Risk Action Required</td>
<td>Progress Update on Risk Actions</td>
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<td>Appendix 2</td>
<td>Safety - Patient, Staff or Public</td>
<td>There is a risk of to Carmarthen\ncommunity nursing staff and their ability to correctly adhere to the social distancing regulations. This is caused by current office design and layout that they currently occupy and the requirement for social distancing within the community teams during the current COVID-19 pandemic. This will lead to an impact/affect on potential for staff to contract COVID-19, Increase in sickness level, on-going medical concerns for staff. This may affect the functions of Community Nursing within Carmarthenshire. Risk location, Carmarthenshire.</td>
<td>Where applicable desks have been moved to accommodate the 2m social distancing requirements. Hot desks is now prohibited. Staff who come into the office observe social distancing. Clinell wipes and hand sanitizers are available in each office and staff are asked to clean desks at the start/end of occupation. Offices are locked when not in use. Staff have been allocated new Health Board laptops and associated soft tokens, also the use of Skype and Microsoft Teams is promoted. Only 1 person allowed in the kitchen areas at any one time. Staff also announce when they need to go down the corridor or access the kitchen/toilet facilities.</td>
<td>Secure additional accommodation centrally in Carmarthenshire which would reduce high numbers of staff in Llanelli and Carmarthen. Monitor Covid-19 related sickness trends as a measure of compliance to mitigating actions.</td>
<td>New action, to be updated at next review.</td>
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<td>Standard 2.1 Managing Risk and Promoting Health and Safety</td>
<td>Safety - Patient, Staff or Public</td>
<td>There is a risk of avoidable harm by nursing services being unable to provide the level &amp; 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 may and 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.</td>
<td>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.</td>
<td>Update response for the 6-monthly monitoring of the response for the Chief Nursing Officer staffing principles for DN teams to be completed. Create a second staffing principles for DN teams six monthly monitoring report for the Chief Nursing Officer</td>
<td>New action, to be updated at next review.</td>
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<td>3 Counties: Ceredigion</td>
<td>Operational Quality, Safety &amp; Experience Sub Committee</td>
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### Covid-19 Theme: Service Level Risk Register June 2020

**Appendix 2**

**Existing Control Measures Currently in Place**

<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Domain</th>
<th>Risk Statement</th>
<th>Existing Control Measures Currently in Place</th>
<th>Risk Tolerance Score</th>
<th>Current Likelihood</th>
<th>Current Risk Score</th>
<th>Additional Risk Action Required</th>
<th>By When</th>
<th>By Whom</th>
<th>Progress Update on Risk Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Clrs</td>
<td>Safety - Patient, Staff or Public</td>
<td>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/affection 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 &amp; increased exposure to hospital-acquired infection (HAI). Risk location, Health Board wide.</td>
<td>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.</td>
<td>8</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>Implement escalation policy. Regularly review the service.</td>
<td>30/06/2020</td>
<td>Skitt, Peter</td>
</tr>
<tr>
<td>4 Clrs</td>
<td>Safety - Patient, Staff or Public</td>
<td>Monitor and evaluate the Lindsey Leg Club activity and patient outcomes.</td>
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<td>4 Clrs</td>
<td>Safety - Patient, Staff or Public</td>
<td>Monitor and evaluation, especially in relation to the sustainability of volunteers as they are fundamental to the approach.</td>
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<td>4 Clrs</td>
<td>Safety - Patient, Staff or Public</td>
<td>There is a risk of avoidable harm by nursing needs and ensure a safe quality service. Negative impact on the ability to meet patients and new referrals being directed onto district nurses’ caseloads.</td>
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<td>Risk Ref</td>
<td>Domain</td>
<td>Risk Statement</td>
<td>Existing Control Measures Currently in Place</td>
<td>Overview</td>
<td>Risk Tolerance Score</td>
<td>Current Likelihood</td>
<td>Current Impact</td>
<td>Current Risk Score</td>
<td>Additional Risk Action Required</td>
<td>Progress Update on Risk Actions</td>
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<td>949</td>
<td>Safety - Patient, Staff or Public</td>
<td>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.</td>
<td>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.</td>
<td>6 3 4 12</td>
<td>Increase stock holding by approximately 25% to be undertaken by Site Leads.</td>
<td>Daily - Mon - Fri: COVID-19 Touch Point meetings have been established where leg Club activity is being reported.</td>
<td>01/06/2020</td>
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<tr>
<td>701</td>
<td>Safety - Patient, Staff or Public</td>
<td>There is a risk of failure of the Storz camera systems in theatre 2 and Preseli theatre. This is caused by the age of the camera systems currently in use within theatre 2 and Preseli theatre which are now out of support by the manufacturer. This will lead to an impact/affect on service delivery, complaint &amp; organisational reputation. Risk location, Glangwili General Hospital.</td>
<td>Regular servicing of camera systems and repair where parts are available.</td>
<td>6 4 3 12</td>
<td>To identify if a managed service is a viable option.</td>
<td>Discussions underway on an All Wales basis.</td>
<td>30/06/2020</td>
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**Status:**
- **Completed:** The issue has been resolved.
- **Discussions:** Meetings or discussions are currently ongoing.
- **On Hold:** The issue is currently on hold.

**Progress:**
- **Daily:** Daily progress updates are provided.
- **Weekly:** Weekly progress updates are provided.
- **Monthly:** Monthly progress updates are provided.
- **Annually:** Annually progress updates are provided.

**By When:**
- **Emerg:** Immediate action required.
- **Daily:** Daily action required.
- **Weekly:** Weekly action required.
- **Monthly:** Monthly action required.
- **Annually:** Annually action required.

**Target Risk Score:**
- **1:** Low risk.
- **2:** Medium risk.
- **3:** High risk.
- **4:** Very high risk.
### Appendix 2

#### Existing Control Measures Currently in Place

<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Domain</th>
<th>Risk Statement</th>
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<th>Domain</th>
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<th>Domain</th>
<th>Risk Statement</th>
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</thead>
<tbody>
<tr>
<td>492</td>
<td>E&amp;F: Ceredigion</td>
<td>There is a risk of the potential failure of the Storz camera system in DSU 1, DSU 2 &amp; DSU 3. This is caused by the age of the camera system currently in use within DSU 1, DSU 2 and DSU 3 which is now out of support with the manufacturer. This will lead to an impact/afflict on service delivery, complaint &amp; organisational reputation. Risk location, Bronglais General Hospital.</td>
<td>492</td>
<td>E&amp;F: Ceredigion</td>
<td>There is a risk of the potential failure of the Storz camera system in DSU 1, DSU 2 &amp; DSU 3. This is caused by the age of the camera system currently in use within DSU 1, DSU 2 and DSU 3 which is now out of support with the manufacturer. This will lead to an impact/afflict on service delivery, complaint &amp; organisational reputation. Risk location, Bronglais General Hospital.</td>
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<tr>
<td>750</td>
<td>Scheduled Care: Theatres</td>
<td>There is a risk of the potential failure of the Storz camera system in PPH. This is caused by the age of the camera system currently in use in main theatres which is now out of support with the manufacturer. This will lead to an impact/afflict on service delivery, complaints and organisational reputation. Risk location, Prince Philip Hospital.</td>
<td>750</td>
<td>Scheduled Care: Theatres</td>
<td>There is a risk of the potential failure of the Storz camera system in PPH. This is caused by the age of the camera system currently in use in main theatres which is now out of support with the manufacturer. This will lead to an impact/afflict on service delivery, complaints and organisational reputation. Risk location, Prince Philip Hospital.</td>
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<td>754</td>
<td>Scheduled Care: Theatres</td>
<td>There is a risk of the potential for the failure of the Storz camera system in theatre 1. This is caused by the age of the camera system in use in theatre 1 which is now out of support with the manufacturer. This will lead to an impact/afflict on service delivery, complaint &amp; organisational reputation. Risk location, Withybush General Hospital.</td>
<td>754</td>
<td>Scheduled Care: Theatres</td>
<td>There is a risk of the potential for the failure of the Storz camera system in theatre 1. This is caused by the age of the camera system in use in theatre 1 which is now out of support with the manufacturer. This will lead to an impact/afflict on service delivery, complaint &amp; organisational reputation. Risk location, Withybush General Hospital.</td>
<td>754</td>
<td>Scheduled Care: Theatres</td>
<td>There is a risk of the potential for the failure of the Storz camera system in theatre 1. This is caused by the age of the camera system in use in theatre 1 which is now out of support with the manufacturer. This will lead to an impact/afflict on service delivery, complaint &amp; organisational reputation. Risk location, Withybush General Hospital.</td>
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**Risks Continue on the Next Page**
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<th>Risk Location</th>
<th>Risk Identified</th>
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<th>Current Impact</th>
<th>Current Risk Score</th>
<th>Risk Tolerance Score</th>
<th>By When</th>
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<th>Additional Risk Action Required</th>
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<td>274</td>
<td>Safety - Patient, Staff or Public</td>
<td>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.</td>
<td>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.</td>
<td>01/03/2019</td>
<td>6</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>Action owner to discuss at site senior managers meeting when decant of ward can potentially take place. This currently continues to be delayed due to COVID-19.</td>
<td>Need to arrange when ward decant can take place to allow flooring work to be undertaken.</td>
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## Risk Statement

### Standard 6.1 Planning Care to Promote Independence

**Risk Ref:**

**Domain:** Safety - Patient, Staff or Public

**Risk Location:** Health Board wide.

**Date Identified:** 18/05/2020

**Date Reviewed:** 19/06/2020

**Operational Quality, Safety & Experience Sub Committee**

**Target Likelihood:** 1

**Target Impact:** 4

**Target Risk Score:** 4

**Progress Update on Risk Actions**

- BCAP's submitted via email to Community Bronze Group on 08/04/20 and are attached to this risk.

- Daily touch point meetings in place

- Regular communications with Local Authority.

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<th>Risk Statement</th>
<th>Existing Control Measures Currently in Place</th>
<th>Owner</th>
<th>Risk Tolerance Score</th>
<th>Current Likelihood</th>
<th>Current Impact</th>
<th>Current Risk Score</th>
<th>Additional Risk Action Required</th>
<th>By Whom</th>
<th>By When</th>
<th>Progress Update on Risk Actions</th>
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<td>There is a risk of harm to patients due to a lack of resilience within domiciliary care / care homes during the Coronavirus pandemic</td>
<td>3 Counties: Ceredigion</td>
<td>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) &amp; 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.</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Regular communications with Local Authority.</td>
<td>Devonald-Morris, Margaret</td>
<td>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. Progress delayed due to COVID.</td>
<td>26/04/20</td>
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<td>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.</td>
<td>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.</td>
<td>Devonald-Morris, Margaret</td>
<td>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.</td>
<td>3 Counties: Carmarthenshire and Ceredigion</td>
<td>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.</td>
<td>30/06/2020</td>
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<td>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.</td>
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<td>602.3.2</td>
<td>Medical Device, Equipment and Diagnostic Systems</td>
<td>Service Location Risk Register</td>
<td>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/affection 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.</td>
<td>6</td>
<td>3</td>
<td>9</td>
<td>Secure funding to implement the new regulations.</td>
<td>Completed</td>
<td>15/05/2020</td>
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<tr>
<td>602.3.2</td>
<td>Medical Device, Equipment and Diagnostic Systems</td>
<td>Service Business Interruption Risk Register</td>
<td>There is a risk 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 which 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/affection 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.</td>
<td>6</td>
<td>9</td>
<td>54</td>
<td>Establish a local Task and Finish Group under the guidance of the Medical Device Governance and Assurance Group.</td>
<td>Completed</td>
<td>15/05/2020</td>
<td></td>
</tr>
<tr>
<td>602.3.2</td>
<td>Medical Device, Equipment and Diagnostic Systems</td>
<td>Service/Business interruption/disruption</td>
<td>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 which 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/affection 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.</td>
<td>6</td>
<td>9</td>
<td>54</td>
<td>Establish a local Task and Finish Group under the guidance of the Medical Device Governance and Assurance Group.</td>
<td>Completed</td>
<td>15/05/2020</td>
<td></td>
</tr>
<tr>
<td>602.3.2</td>
<td>Medical Device, Equipment and Diagnostic Systems</td>
<td>Service/Business interruption/disruption</td>
<td>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/affection 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.</td>
<td>6</td>
<td>3</td>
<td>9</td>
<td>Secure funding to implement the new regulations.</td>
<td>Completed</td>
<td>15/05/2020</td>
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<tr>
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<td>Medical Device, Equipment and Diagnostic Systems</td>
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<td>6</td>
<td>3</td>
<td>9</td>
<td>Secure funding to implement the new regulations.</td>
<td>Completed</td>
<td>15/05/2020</td>
<td></td>
</tr>
</tbody>
</table>

**Appendix 2**

**Risk Statement**

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 which 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/affection 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.

**Risk Description**

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.

**Risk Location**

Health Board wide.

**Risk Description**

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.

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<tr>
<th>Risk Ref</th>
<th>Health &amp; Care Standard</th>
<th>Domain</th>
<th>Risk Statement</th>
<th>Existing Control Measures Currently in Place</th>
<th>Owner</th>
<th>Risk Tolerance Score</th>
<th>Current Likelihood</th>
<th>Current Impact</th>
<th>Current Risk Score</th>
<th>Additional Risk Action Required</th>
<th>Progress Update on Risk Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>85.5</td>
<td>Standard 1.1 Managing Risk &amp; Safety</td>
<td>Safety - Patient, Staff or Public</td>
<td>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.</td>
<td>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.</td>
<td></td>
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<td></td>
<td>Capacity in Cardigan Integrated Care centre to be maintained to enable emergency clinics when required.</td>
<td></td>
</tr>
<tr>
<td>85.5</td>
<td>Standard 1.1 Managing Risk &amp; Safety</td>
<td>Safety - Patient, Staff or Public</td>
<td>Incident reporting procedure in place Corporate induction includes incident reporting Satix 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)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Monitor the quantity of outpatient clinics operational in Ceredigion, currently operating 15% of pre-covid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>85.5</td>
<td>Standard 1.1 Managing Risk &amp; Safety</td>
<td>Safety - Patient, Staff or Public</td>
<td>There is a risk of that NICE and other National Guidance is not effectively disseminated and implemented across the Health Board</td>
<td>AMU for Quality and Safety is in place; Clinical Director for Clinical Audit has been appointed.</td>
<td></td>
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<td>Appoint to clinical roles - Quality Improvement site leads (x4).</td>
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</tr>
<tr>
<td>85.5</td>
<td>Standard 1.1 Managing Risk &amp; Safety</td>
<td>Safety - Patient, Staff or Public</td>
<td>There is a risk of that NICE and other National Guidance is not effectively disseminated and implemented across the Health Board</td>
<td>This is caused by a lack of clinical engagement in the Effective Clinical Practice agenda, and a failure to identify the appropriate clinical leads</td>
<td></td>
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<td></td>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>85.5</td>
<td>Standard 1.1 Managing Risk &amp; Safety</td>
<td>Safety - Patient, Staff or Public</td>
<td>This is caused by changes in wards and staffing during the Covid-19 pandemic.</td>
<td>This is caused by changes in wards and staffing during the Covid-19 pandemic.</td>
<td></td>
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<td></td>
<td>Progress the clinical engagement and communications workstreams identified within the project plan for clinical effectiveness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>85.5</td>
<td>Standard 1.1 Managing Risk &amp; Safety</td>
<td>Safety - Patient, Staff or Public</td>
<td>This will lead to an impact/affect on service developments to improve outcomes for patients, and delivery of safe and effective care.</td>
<td>This will lead to an impact/affect on service developments to improve outcomes for patients, and delivery of safe and effective care.</td>
<td></td>
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<td></td>
<td>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.</td>
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</tbody>
</table>

**Covid-19 Theme: Service Level Risk Register June 2020 Appendix 2**
<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Domain</th>
<th>Risk Ref</th>
<th>Risk Statement</th>
<th>Existing Control Measures Currently in Place</th>
<th>Additional Risk Action Required</th>
<th>Progress Update on Risk Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>50414</td>
<td>MD: Effective Clinical Practice</td>
<td>Women &amp; Children's Community Children's Services</td>
<td>There is a risk of clinicians delivering care/treatment on behalf of the Health Board who are unable to specify the standards that guided their care and management of the patient, or explain any deliberate and informed departure</td>
<td>NICED Guidance is disseminated to owning groups and leads to onward cascade, according to NICED and Other National Guidance Implementation Policy. A system exists to capture dissemination of NICED Guidance and record the status, using a Status Feedback Form and Baseline Assessment if required.</td>
<td>Review and further develop processes to disseminate, assess and record compliance with NICED/other Guidance.</td>
<td>Review has commenced. Exploring systems/software to support dissemination, assessment and recording compliance with NICED/other Guidance. Systems are currently being identified and assessed, including AMaT and Datix Cloud IQ.</td>
</tr>
<tr>
<td>88</td>
<td>Safety - Patient State of Public</td>
<td>Operational Quality, Safety &amp; Experience Sub Committee</td>
<td>There is a risk of clinicians delivering care/treatment on behalf of the Health Board who are unable to specify the standards that guided their care and management of the patient, or explain any deliberate and informed departure</td>
<td>NICED Guidance is disseminated to owning groups and leads to onward cascade, according to NICED and Other National Guidance Implementation Policy. A system exists to capture dissemination of NICED Guidance and record the status, using a Status Feedback Form and Baseline Assessment if required.</td>
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<td>Review has commenced. Exploring systems/software to support dissemination, assessment and recording compliance with NICED/other Guidance. Systems are currently being identified and assessed, including AMaT and Datix Cloud IQ.</td>
</tr>
<tr>
<td>67-04</td>
<td></td>
<td></td>
<td>There is a risk of unsustainable care delivery for children and young people who have continuing care packages delivered by only two third sector providers.</td>
<td>Implemented impact assessments and contingency plans for all care packages HB wide. Children's Community Nursing Service working with Health &amp; 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.</td>
<td>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.</td>
<td>Discussions have commenced to review scope to amend current processes.</td>
</tr>
</tbody>
</table>

GB 1, 2018

There is a risk of clinicians delivering care/treatment on behalf of the Health Board who 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 the failure of Directorates (as owning groups) to respond to existing feedback from Discharge After Treatment (DAT), including AMaT and Datix Cloud IQ. There is a risk of uncharted care delivery for children and young people who have continuing care packages delivered by only two third sector providers.

This will lead to an impact/affect on the provider covering Pembrokeshire on one package which 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 admissions to secondary care and or use of Health Board Bank Staff.

Risk location, Health Board wide, Pembrokeshire.

Task Leader to plan monthly meetings with 3rd sector provider to develop action plans around recruitment and retention.

Seek authorization from Bronze Command to maintain contract payment for Continuing Care package delivery in Carmarthen, Ceredigion and Pembrokeshire.

SDM/SN Community liaising with finance team to explore increase in nursing resource to develop 'In-house home care team' funded via the Continuing Care Budget.

Nurse Assessor to ensure the lease is in place and the lease will continue with the family’s dynamics and expectations.

SDM/SN Community liasing with finance lead sharing SBAR development. Establishment for Continuing care packages identified on IMTP. Delayed due to COVID pandemic.

Team Leader to plan monthly meetings with 3rd sector provider to develop action plans around recruitment and retention.

Meeting booked with 3rd sector provider, Health Board Procurement and Team Leader to review position.

SDM/SN Community liaising with finance team to explore increase in nursing resource to develop 'In-house home care team' funded via the Continuing Care Budget.

Nurse Assessor to ensure the lease is in place and the lease will continue with the family’s dynamics and expectations.

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Nurse Assessor to ensure the lease is in place and the lease will continue with the family’s dynamics and expectations.
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<tr>
<th>Risk Ref</th>
<th>Health &amp; Care Setting</th>
<th>Directorate</th>
<th>Date Identified</th>
<th>Risk Location</th>
<th>Risk Statement</th>
<th>Existing Control Measures Currently in Place</th>
<th>Additional Risk Action Required</th>
<th>Progress Update on Risk Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>830</td>
<td>Central Operations OOH Service</td>
<td>Pembrokeshire</td>
<td>03/01/2020</td>
<td>Pembrokeshire, Carmarthenshire, Ceredigion</td>
<td>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.</td>
<td>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.</td>
<td>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 demand cross-border agreements where GPs operate from their particular base but cover calls across the HB footprint. 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. 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 secure. This will avoid affecting capacity of existing ART caseload. Increase the deployment of WAST Advanced Paramedic Practitioners into the OOH rotation. Currently utilises skills of 2 WTE, looking to increase to 3 WTE. Recruitment of additional clinicians (to include GP and Advanced Nurse Practitioners) upon the receipt of potential applications.</td>
<td>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. Service leads and medical directors to meet and address issue and agree lines of communication. Meeting has been arranged for 28/01/2020 and invite circulated- responses awaited. Expressions of interest received and workforce approval gained- currently meeting with staff to ensure roles are appropriate and ascertain availability- rota to be prepared meeting with staff to ensure roles are appropriate and ascertain availability- rota to be prepared meeting with staff to ensure roles are appropriate and ascertain availability- rota to be prepared meeting with staff to ensure roles are appropriate and ascertain availability- rota to be prepared</td>
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<tr>
<td></td>
<td>People, Planning &amp; Performance Assurance Committee</td>
<td>21/05/2020</td>
<td>30/06/2020</td>
<td>31/12/2021</td>
<td>Completed</td>
<td>Completed</td>
<td>Completed</td>
<td>Completed</td>
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<tr>
<td>Risk Ref</td>
<td>Health and Care Standards</td>
<td>Directorate</td>
<td>Directorate lead</td>
<td>Management or service lead</td>
<td>Date risk Identified</td>
<td>Risk Statement</td>
<td>Existing Control Measures Currently in Place</td>
<td>Current Likelihood</td>
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<tr>
<td>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 reconfiguration of services, 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 the Antenatal Screening Wales Guidelines. Resulting in virtual consultations and streamlined antenatal and postnatal care due to the COVID 19 pandemic. 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.</td>
<td>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.</td>
<td>Update Standing Operating Pathway and clinical documentation in line with RCOG guidelines</td>
<td>Update Standing Operating Pathway and clinical documentation in line with RCOG guidelines</td>
</tr>
<tr>
<td>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.</td>
<td>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.</td>
<td>Follow de-escalation pathway for maternity services as pandemic allows in conjunction with Bronze control group</td>
<td>Follow de-escalation pathway for maternity services as pandemic allows in conjunction with Bronze control group</td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td>Monitor existing caseload, referrals to be reviewed against the traffic light framework to ensure a safe, sustainable service delivery.</td>
<td>Ongoing appraisal of case load and referrals monitored.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ensure investment for service delivery is included in the Delivery Action Plans.</td>
<td>No investment to date. Investment for 2020-2022 included in IMTP.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop a paediatric action &amp; delivery plan in line with NICE guidance self assessment.</td>
<td>Action &amp; Delivery Plan completed, to present at the next Q6S meeting.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop an additional SBAR which includes nursing and medical staffing as an action from the Paediatric Task and finish Group.</td>
<td>SBAR completed and presented to Paediatric Task and finish group.</td>
</tr>
</tbody>
</table>
## Existing Control Measures Currently in Place

<table>
<thead>
<tr>
<th>Risk Statement</th>
<th>Date Identified</th>
<th>Risk Tolerance Score</th>
<th>Current Likelihood</th>
<th>Current Impact</th>
<th>Current Risk Score</th>
<th>Additional Risk Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a risk of service provision impacted if Junior Doctor posts are removed. This is caused by the failure to deliver the GMC Standards for training and failing to deliver the specialty curriculum. This will lead to an impact/affet on the Health Boards ability to recruit or retain medical staff due to poor training resources and facilities. Risk location, Health Board wide.</td>
<td>23/05/2016</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>Team review of case management, working practices, and the acuity across each patch to ensure quality and safety, and equitable distribution of staff.</td>
</tr>
<tr>
<td>Review of physical space to deliver clinical skills/simulation and review of Educators across the Health Board. Review to be complete by end of February 2018. Clinical Skills Hub set up, first meeting held on 11th Jan. Clinical Skills/Simulation Faculty to be organised first meeting to be held by March 2018. Monitor Educational Contract adherence. Work with College Tutors. Monitor education contract components through the ECAS system for all Specialties from August 2017. Raise issues early if any deterioration.</td>
<td>20/05/2016</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>8</td>
<td>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.</td>
</tr>
<tr>
<td>Lack of physical space to deliver clinical skills/simulation in BGH. Review Clinical Skills Educators in PPH. TaFG to be organised to review resources for Clinical Skills across the Health Board. Highlight lack of space in the LAKS Services (Library and Knowledge Services) for GGH. Monitor educational contract, adopting ‘live’ system from the Wales Deanery.</td>
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<td></td>
<td>Collaborative review teaching rooms in BGH awaited, progress reliant on other Services. Clinical Skills/Faculty sub group. Clinical Skills Hub working to collate all equipment and personnel.</td>
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<tr>
<td>Monitor educational contract, adopting ‘live’ system from the Wales Deanery.</td>
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<td>Deanery to continue monitoring educational contracts and provide Health Board with exception reports from August 2017 through to July 2018.</td>
</tr>
<tr>
<td>Work with College Tutors if deterioration occurs.</td>
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<td>Implement reporting system for College Tutors through the Medical Education Board.</td>
</tr>
<tr>
<td>Risk Ref</td>
<td>Health and Care Standards</td>
<td>Director of Service</td>
<td>Domain</td>
<td>Risk Tolerance Score</td>
<td>Current Likelihood</td>
<td>Current Impact</td>
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Noble, Jayne
31/07/2019

Evans, John
23/05/2016

There is a risk of service provision impacted if Junior Doctor posts are removed. This is caused by the failure to deliver the GMC Standards for training and failing to deliver the specialty curriculum. This will lead to an impact/affect on the Health Board's ability to recruit or retain medical staff due to poor training resources and facilities.
<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Category</th>
<th>Subcategory</th>
<th>Risk Location</th>
<th>Risk Statement</th>
<th>Existing Control Measures Currently in Place</th>
<th>Current Likelihood</th>
<th>Current Impact</th>
<th>Current Risk Score</th>
<th>Additional Risk Action Required</th>
<th>By Whom</th>
<th>By When</th>
<th>Progress Update on Risk Actions</th>
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<td>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 psychology 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.</td>
<td>Paediatric Diabetes nurse capacity combined across the Health Board to maximise availability of current resource to each county. Paediatric team prioritise patient access and reviews according to known clinical priority.</td>
<td>Safety - Patient, Staff or Public</td>
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17 of 19
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<th>Health and Care Standards Directorate</th>
<th>Directorate Lead</th>
<th>Risk Statement</th>
<th>Existing Control Measures Currently in Place</th>
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<td>278</td>
<td>678</td>
<td>Devonald-Morris, Margaret</td>
<td>Due to COVID-19 a phased reduction in service as detailed on the attached Business Continuity Action Plans (BCAP), version 1 and version 2.</td>
<td>BCAP reviewed and revised in response to the Welsh Government directive on social isolation and the revision to acute paediatric service delivery. Submission of BCAP via email to the Community Bronze Group on 08/04/20. SBAR submitted to COVID-19 ACUTE SERVICES BRONZE MANAGEMENT MEETING on 3rd June 2020 to commence Drive-thru clinics allowing blood sampling for HbA1C to allow monitoring and adjustments to treatment.</td>
<td>6 2 3 6</td>
<td>Combined medical and nursing SBAR to be developed as an action of the paediatric task and finish group.</td>
<td>SBAR completed at Pediatric Task and Finish.</td>
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<td>392</td>
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<td>Humphrey, Lisa</td>
<td>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 the timeliness of care and follow up review for patients.</td>
<td>Recruitment continues and employment of NHS focus staff. Community paediatric referrals are triaged and prioritised. Existing job plans regularly reviewed.</td>
<td>6 2 3 6</td>
<td>Development of an ‘action plan’ to address the issues identified following the Demand and Capacity Review.</td>
<td>Action Plan completed, further work is ongoing to address the issues.</td>
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<td>01/12/2017</td>
<td>678</td>
<td>Devonald-Morris, Margaret</td>
<td>Review of service delivery in response to Welsh Government directive on COVID 19 and the revision to 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.</td>
<td>On-going validation as part of normal process.</td>
<td>6 2 3 6</td>
<td>Active validation of waiting list for new and follow up appointments.</td>
<td>1405/20: attached BCAP to this risk for ADHD, Epilepsy, Antipsychotic Medication, adoption, Genetics, Paediatric Outreach Oncology service.</td>
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<td>Standard</td>
<td>Health and Safety (NQPE)</td>
<td>Date Risk Identified</td>
<td>Risk Statement</td>
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<td>849</td>
<td>Standard 2: Managing Risk and Promoting Health and Safety</td>
<td>Harrison, Tim</td>
<td>07/06/2020</td>
<td>There is a risk of 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 staffing 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.</td>
<td>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.</td>
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<td>72</td>
<td>Standard 1: Safe and Clinically Effective Care</td>
<td>Davies, Lisa</td>
<td>06/03/2020</td>
<td>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. 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.</td>
<td>Review of NICE policy initiated. Clinical Effectiveness Co-ordinator recruited, increased to 1 W.T.E. NICE Support Officer 1 W.T.E. Review of system for dissemination and collection of baseline information.</td>
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