Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR DIWYLLIANT, POBL A DATBLYGU SEFYDLIADOL
PEOPLE, ORGANISATIONAL DEVELOPMENT & CULTURE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	20 June 2022
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Operational Risks Assigned to People, Organisational Development & Culture Committee (PODCC)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Lisa Gostling, Director of Workforce and Organisational Development (OD)
SWYDDOG ADRODD: **REPORTING OFFICER:**	Joanne Wilson, Board Secretary Charlotte Beare, Assistant Director of Assurance and Risk

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

Er Sicrwydd/For Assurance

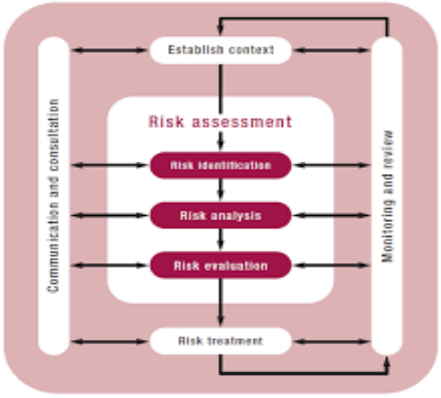
ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The People, Organisational Development & Culture Committee (PODCC) is responsible for providing assurance to the Board that operational risks aligned to PODCC in the Datix Risk Module are being identified, assessed and managed effectively.

Cefndir / Background

Effective risk management requires a 'monitoring and review' structure to be in place to ensure that risks are effectively identified and assessed and that appropriate controls and responses are in place.



(Risk Management Process, ISO 31000)

Operational risks should be managed within directorates under the ownership and leadership of the individual responsible Executive Director, who should establish local arrangements for the review of their risk registers, which includes the validation of the information and risk scores, and the prioritisation and identification of solutions to their risks. In addition to these local arrangements, there are formal monitoring and scrutiny processes in place within Hywel Dda University Health Board (HDdUHB) with the aim of providing assurance to the Board that it is managing its risks effectively.

All risks identified within the Datix Risk Module must be aligned to a formal Board Committee, Sub-Committee or Group who will be responsible for monitoring and scrutinising risks which relate to their remit.

The Committee, Sub Committee and Group structure is responsible for the monitoring and scrutiny of operational risks within their remit. They are responsible for:

- Scrutinising operational risks within their remit, either through receiving the risk registers or through service reports.
- Gaining assurance that risks are being appropriately managed, effective controls are in place and planned additional controls are being implemented.
- Challenging pace of delivery of risk actions.
- Identifying through discussions, new and emerging risks and ensuring these are assessed by those with the relevant responsibility.
- Providing assurance to its parent committee that risks are being managed effectively and to report risks which have exceeded tolerance through its sub-committee/group update report: and
- Using risk registers to inform meeting agendas.

It is therefore essential that the membership of these Committees and Sub Committees includes the appropriate representation from Directorates and that they are in attendance to provide assurance and respond to queries.

The discussion should be reflected in the Committee Update Report to Board to provide assurance on the management of significant risks. This would include risks that are not being managed within tolerance levels (see attached risk appetite statement) and any other risks, as appropriate.

Asesiad / Assessment

The PODCC Terms of Reference reflect the Committee's role in providing assurance to the Board that principal risks are being managed effectively by the risk owners (Executive Leads).

The Terms of Reference state that:

2.6 To 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.

2.7 To recommend acceptance of risks that cannot be brought within the UHBs risk appetite/tolerance to the Board through the Committee Update Report.

There are currently no risks to report to PODCC based on the following criteria:

- PODCC has been selected by the risk lead as the 'Assuring Committee' on Datix.
- The current risk score exceeds the tolerance level, (discussed and agreed by the Board on 27 September 2018).
- Risks have been approved at Directorate level on Datix risk module.
- Risks have not been escalated to the Corporate Risk Register.

Generally risks on Datix are aligned to the relevant Committee based on the main impact of the risk. For example risk 232 *Compromised patient care due to insufficient nurses on shift affecting WGH*, high nursing vacancies, recruitment and retention is causing the risk but the impact is on the potential harm and poor care to patients, is reported to Operational Quality, Safety and Experience Sub-Committee. Whilst there are no risks aligned to PODCC for reporting, Appendix 1 details the 101 risks (both Directorate and Service level) that have been identified on Datix by risk owners as having a Workforce theme. Workforce themed risks are shared with the Workforce and Organisational Development Directorate on a bi-monthly basis to allow them to maintain oversight and provide necessary guidance to those responsible for the risk and develop/improve organisational controls, i.e. policies, procedures, systems, processes, to reduce the risk to HDdUHB.

Argymhelliad / Recommendation

PODCC is asked to seek assurance that Workforce theme risks are shared with the Workforce and Organisational Development Directorate to allow them to maintain oversight and provide necessary guidance to those responsible for the risk and develop/improve organisational controls

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	Contained within the body of the report
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Contained within the body of the report
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability
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 2019-20	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Underpinning risk registers on the Datix Risk Module from across the HDdUHB's services reviewed by risk leads/owners
Rhestr Termau: Glossary of Terms:	Risk Appetite - *the amount of risk that an organisation is willing to pursue or retain*' (ISO Guide 73, 2009)

	Risk Tolerance - *the organisation's readiness to bear a risk after risk treatment in order to achieve its objectives* (ISO Guide 73, 2009) Hyperlinked
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Cynllunio Pobl a Sicrwydd Perfformiad: Parties / Committees consulted prior to People Planning and Performance Assurance Committee:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts from report however impacts of each risk are outlined in risk description.
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts from report however impacts of each risk are outlined in risk description.
Gweithlu: Workforce:	No direct impacts from report however impacts of each risk are outlined in risk description.
Risg: Risk:	No direct impacts from report however organisations are expected to have effective risk management systems in place.
Cyfreithiol: Legal:	No direct impacts from report however proactive risk management including learning from incidents and events contributes towards reducing/eliminating recurrence of risk materialising and mitigates against any possible legal claim with a financial impact.
Enw Da: Reputational:	Poor management of risks can lead to loss of stakeholder confidence. Organisations are expected to have effective risk management systems in place and take steps to reduce/mitigate risks.
Gyfrinachedd: Privacy:	No direct impacts
Cydraddoldeb: Equality:	Has EqIA screening been undertaken? No Has a full EqIA been undertaken? No

Risk Ref	Status of Risk	Health and Care Standards	Directorate	Directorate lead	Management or service lead	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Risk Tolerance Score	Current Likelihood	Current Impact	Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score	Detailed Risk Decision	Review date
86	Directorate Level Risk	Standard 7.1 Workforce	USC: GGH	Perry, Sarah	Morgan, Olwen	13-Sep-17	There is a risk avoidable harm to patients and detriment to the quality of patient care as insufficient nurses are on shift to provide safe nursing care. This is caused by high vacancy rates within nurse staffing, recruitment & retention, sickness & absence, limited availability of nurse bank and reduced fill rate of agency nurses. This will lead to an impact/affect on the quality of care provided to patients leading to clinical deterioration and poor patient experience. A failure to comply with the statutory requirements of the Nurse Staffing Levels Act Wales. Poor working experience for nurses leading to increased stress, anxiety and sickness. Risk location, Glangwili General Hospital.	Effective roster management. Block booking of agency staff. Daily review of nurse staffing levels / skill mix and reallocation of staff. Risk assessment and management across site at the time of shortfall. Provision of nurse bank on weekend period to support bookings and escalation to bank and Agency. All Wales streamlining recruitment process for newly qualified nurses. All ward establishments are designed to meet the requirements of the Nurse Staffing Act (Wales). All clinical incident investigations include assessment the nurse staffing levels at the time of the incident. Deployment of staff from other areas to cover key wards when required. Allocate has now been implemented and in place	Safety - Patient, Staff or Public	6	4	5	20	Recruitment into Registered Nurse vacancies	Morgan, Olwen	Completed	Action closed- this is an ongoing process.	Operational Quality, Safety and Experience Sub Committee	2	5	10	Treat	05-May-22
														Health Board wide approach in place to identify and train nursing workforce, to further mitigate the inability to recruit into the registered nurse vacancies (Grow Your Own, apprenticeships and overseas recruitment.).	Morgan, Olwen	~~31/03/2022~~ 30/09/2022	There is a national programme to develop the Band 4 roles. Scoping and planning work progressing within the UHB to train and recruit band 4 roles. We are now actively planning to recruit Band 4 roles on targeted wards in the first instance. May 22 - 20 overseas RN to commence in May, and a further 20 to commence in June.					
														Implementation of Allocate in order to provide enhanced oversight of rostering	Morgan, Olwen	Completed	Allocate has now been implemented in place of RosterPro. As at May 22, the new system is in place, and in its implementation phase.					
														Recruitment of A&E and CDU rota co-ordinator	Morgan, Olwen	~~31/03/2022~~ 30/09/2022	Vacancy has been filled, however funding only available until March 22. Role is being reviewed, with discussions to be held with Finance to secure funding. As at May 22, substantive funding being sourced from existing nurse staffing budget, and the role to be advertised on a permanent basis.					
														Recruit to ward administrator role	Morgan, Olwen	~~31/03/2022~~ 30/09/2022	4 out of 7 posts have been filled, but funding only secured until 31st March 2022. Funding for posts to be reviewed with Finance. As at May 22, substantive funding being sourced from existing nurse staffing budget with the requirement to advertise on a permanent basis.					

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1210	Directorate Level Risk		USC: GGH	Perry, Sarah	Morgan, Olwen	01-Jul-21	There is a risk unavoidable delays in the treatment of patients in A&E at GGH. This is caused by medical staffing deficits, high reliance on agency locum cover, and exacerbated by an increase 'exit block' from the hospital which affects the movement of patients from A&E into appropriate in-patient beds. This will lead to an impact/affect on on patient safety and care by delaying diagnosis and treatments and through prolonged stays in ED and delays in transferring patients to appropriate specialty. This in turn can result in poorer outcomes and increased ambulance off load delays outside A&E. This also leads to poor patient experience of the service as well as increased A&E clinical breaches, claims and complaints. There is an associated increased pressure on GGH financial position through use of high cost agency. Risk location, Glangwili General Hospital.	Utilising Medical agency. Urgent Response Group has been established, led by the Acute Service Triumvirate and supported by Hospital Triumvirate, Workforce & OD leads. The aim of the group is to pro-actively support the Directorate in securing additional temporary and longer term staffing solutions. Detailed action plan with leads and timescales, together with a supporting financial plan. Extension of British Red Cross to provide cover on a 7 day basis (until 6pm) to assist with departmental workload and the transport home and settling in of patients who can be discharged. Weekly A&E meeting where medical roster is discussed Weekly medical recruitment meeting with focus on GGH site	Safety - Patient, Staff or Public	6	4	5	20	Consider potential for junior doctors with an interest or capacity to attend the department at weekends as part of the GP registrars.	Perry, Sarah	31/10/2021	To be discussed at the January 2022 Governance meeting	Operational Quality, Safety and Experience Sub Committee	2	5	10	Treat	05-May-22
														Recruit 2 Physician Associates and a second Advance Nurse Practitioner to help provide a more robust medical staffing model.	Perry, Sarah	~~31/10/2021~~ ~~31/03/2022~~ 30/09/2022	As at May 2022 1 PA appointed, and ANPs in post.						
														Recruit Middle Grades via NHS Locum/Agency.	Perry, Sarah	~~30/09/2021~~ 30/08/2022	Over-recruitment in to clinical fellow roles to support team - individuals have been appointed but yet to commence in post.						
														IMTP submission includes request for funding Red Cross provision from 6pm - 2am	Evans, Iona	30/06/2022	Awaiting outcome of the IMTP submission						
1223	Directorate Level Risk		USC: Radiology	Perry, Sarah	Roberts-Davies, Gail	01-Jul-21	There is a risk of patients not receiving Radiology procedures out of hours across the Health Board, affecting CT and General Radiography This is caused by on call being a voluntary rota and additional to basic working hours, exacerbated by staff shortages due to vacancies and illness and long-term sickness - particularly at WGH and GGH. Increased activity during on call shifts. This will lead to an impact/affect on timely and safe patient care and diagnosis, and commencement of required treatment. Also has an impact on staff morale. Reputational damage to the Health Board, and a potential negative impact on RTT times. Risk location, Health Board wide.	Services can be provided at alternative sites where possible, therefore patients can be diverted when critical On call rotas done in advance to determine where shortfalls may arise, at which point alternative arrangements are considered to plug the gap Continued recruitment cycle and sourcing agency staff - reviewed on a monthly basis Additional Elective Recovery Planning (ERP) lists in place over the weekends to try and manage backlog of work Cross-site working of staff where possible when there are workforce gaps identified Continual review of staffing capacity, streamlining opportunities and locum staff availability, cross-site cover Engagement with the Society of Radiographers to explore potential staffing models	Safety - Patient, Staff or Public	6	4	5	20	Review of Radiology establishment and on call in progress	Roberts-Davies, Gail	~~31/10/2021~~ ~~31/03/2022~~ 30/11/2022	Feb 22 - on-call fact finding process commenced in advance of the establishment and on call review.	Operational Quality, Safety and Experience Sub Committee	3	3	9	Treat	17-Mar-22
														Recommendations raised within IA on Radiology Directorate are being progressed, with a follow up due in March 2022.	Roberts-Davies, Gail	~~31/12/2021~~ 30/11/2022	Current service demands in and out of hours has to be reviewed. The implementation of a shift system was reliant on an effective Streamlining process. Unfortunately only 4 of the 14 positions available were filled in 2021. Any implementation of a new system relies upon increased numbers of staff, therefore realistically following what is hoped to be a successful Streamlining process in 2022 (particularly at WGH) along with induction of staff the revised date for this process should be 30/11/2022. Should recruitment improve and a very efficient OOH system be realised, then this date may be pulled forwards.						

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														Contractual arrangements discussion with Workforce	Perry, Sarah	~~31/12/2021~~ 31/03/2022	21/12/2021 - to be confirmed if meetings have been undertaken.						
1363	Service or Department Level Risk		Scheduled Care: Critical Care	Hire, Stephanie	Knight, Diane	31-Jan-22	There is a risk inability to support a safe roster to maintain safe Consultant Anaesthetic cover of Critical care provision across PPH and GGH. This is caused by vacancies and long-term sickness across Consultant cadre in Carmarthenshire Anaesthetics. The current roster is not sustainable as is impacting on wellbeing of remaining Consultant body. This will lead to an impact/affect on timely and appropriate supervision and decision making of critically ill patients. Potential clinical delay resulting in deterioration of patient care. Impact on wellbeing of remaining consultants who are already working to full capacity. There is no capacity to support further emergent consultant sickness which could result from work related pressures. Risk location, Glangwili General Hospital, Prince Philip Hospital.	Adverts out for Consultant vacancies Current staff backfill Requests with Agency for Consultant cover	Safety - Patient, Staff or Public	6	5	4	20	Decision on implementation of level 3 critical care patients being removed from PPH and based at GGH. Resulting in change to care provision pathway at PPH to speciality consultant led service with anaesthetic support caring for level 2 and level 1 patients only.	Harries, Mr Ken	~~30/06/2022~~ 31/12/2022	SBAR completed and to be discussed with relevant colleagues. 17/05/2022 Risk remains	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	17-May-22
820	Directorate Level Risk		USC: PPH	Morgan, Olwen	Williams, Meinir	19-Dec-19	There is a risk avoidable harm to patients and detriment to the quality of patient care as insufficient nurses are on shift to provide safe nursing care. This is caused by high vacancy rates within nurse staffing, recruitment, sickness & absence, limited availability of nurse bank and reduced fill rate of agency nurses. This will lead to an impact/affect on the quality of care provided to patients leading to clinical deterioration and poor patient experience. A failure to comply with the statutory requirements of the Nurse Staffing Levels Act Wales. Poor working experience for nurses leading to increased stress, anxiety and sickness. Increased likelihood of patient harm due to falls	Roster management and sign off by Senior Nurse Manager Redeployment policy and flexible use of staff. Daily review of nurse staffing levels, skill mix and reallocation of staff. Block booking of agency staff for high risk areas. Risk assessment and management across site at the time of shortfall. Datix incident report all shortfalls and quantify harm to patients and impact on staff well-being. Review of incidents in Nurse Scrutiny & Assurance. Escalation of issues to the Assistant Director of Operational Nursing and Quality Acute Services Provision of nurse bank on weekend period to support temporary staff bookings.	Workforce/OD	8	5	4	20	Plan a recruitment event for PPH.	Webber, Gill	Completed	Unable to run recruitment event for PPH due to Covid.	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	26-May-22
														HB wide recruitment is ongoing and being advertised regularly.	Williams, Meinir	Completed	Ongoing recruitment campaign now in place, and has been added to the controls of the risk. Action therefore to be closed after discussion with the HoN and DHoN in May 2022.						
														Draw up a service profile for required Registered Nurses to support schedule care activity in Prince Philip Hospital.	Williams, Meinir	Completed	Service profile exercise completed as confirmed by the HoN and DHoN in May 2022. Action to be closed.						

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							Increased likelihood of patient harm due to falls, pressure damage and medication errors. Risk location, Prince Philip Hospital.	Escalation process for the use of off contract. Contain surge beds where possible. Daily review of activity levels Ongoing recruitment via centralised system, piloted at PPH with a view to establishing a HB wide recruitment system						Identify number of nursing vacancies and support in place.	Long, Melanie	Completed	Review of vacancies an ongoing process therefore the action has been moved to the control section of the risk. Monitoring of the vacancies is a driver behind the changes to the current risk score, and noted accordingly in the current rationale.						
														To recruit additional staff to the site via the HB wide overseas recruitment campaign	Williams, Meinir	31/03/2023	To be provided at next risk review						
1399	Service or Department Level Risk		USC: Radiology	Perry, Sarah	Roberts-Davies, Gail	19-Oct-21	There is a risk IRMER non-compliance This is caused by a lack of dedicated Quality Lead, a lack of dedicated document control systems within the service, and staffing pressures. Current document control systems in place are not capable of the level of document control that is required to ensure compliance with IRMER standards. This will lead to an impact/affect on Radiology services in the Health Board, as risk of non-compliance could lead to services being stopped, therefore directly impacting on wider services in the Health Board, including (but not limited to) General Surgery, Cancer, Trauma and Stroke. Current staff are unable to take on additional work required in order to meet standards due to operational and workforce pressures. The Health Board will also be unable to achieve accreditation by Quality Standards in Imaging without a dedicated individual or document control system in place within the Directorate to drive quality standards and ensure adherence to requirements. Risk location, Health Board wide.	1. Monthly site lead meetings and regular communication on quality issues 2. All Wales Radiology Quality Forum (informal group) which is attended by site leads 3. Radiology QSE meetings, standing agenda item on Quality which encompasses IRMER requirements 4. Use of shared drives and document sharing facilities on Teams	Safety - Patient, Staff or Public	6	4	5	20	Appoint to Quality Lead role	Roberts-Davies, Gail	31/08/2022	Update to be provided at the next risk review.	Operational Quality, Safety and Experience Sub Committee	1	5	5	Treat	16-May-22
														Purchase document management system	Roberts-Davies, Gail	31/12/2022	Update to be provided at the next risk review.						

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1388	Service or Department Level Risk		USC: GGH	Perry, Sarah	Morgan, Olwen	25-Mar-22	There is a risk that patient care and safety will compromised, and patients will not receive appropriate and timely treatment, resulting in poor patient experience and potential serious harm or death. Patient documentation such as fundamentals of care, risk assessments and intentional rounding may not be completed within required timeframes. There is also a risk that current staffing pressures will compromise staff wellbeing due to excessive workloads and lack of breaks. This is caused by Registered Nurses (RN) deficit on Teifi ward, and appropriate patient care cannot be given without the required staff number per shift. This will lead to an impact/affect on the potential that patients will come to severe harm or death. Delays in completing fundamentals of care, risk assessments and intentional rounding, resulting in an increase in cases of developed hospital acquired pressure damage, patient falls, medication errors, moisture damage and malnutrition. Increase in staff sickness, exacerbating the current vacancy rates Increased use of agency staff compromising the skill mix on the ward. Staff fatigue and anxiety, which will negatively affect staff recruitment and retention. Increase in patient complaints and concerns, and potential reputational damage to the ward, hospital and the Health Board. Staff well-being and morale due to the inability to take breaks while on shift and excessive workloads, which may lead to further RNs leaving and exacerbating the current vacancy rates Risk location, Glangwili General Hospital.	Utilise Sister/Charge Nurse Clinical lead shifts to back fill deficits when no other option available. Utilise Sister/Charge Nurse Clinical lead shifts to back fill deficits when no other option available. Daily Senior Nurse Manager (SNM) risk review of staffing across GGH site - dependent on acuity & dependency Escalation process in place for patient flow - safety meetings x2 daily. Increase in HCSW per shift to assist with fundamentals of care. Review of Nurse Staffing Levels twice a year to review agreed establishment. All RN vacant shifts are sanctioned to on contract agencies 6 weeks in advance - escalated to TNS if not covered. Allocate roster compliance monitored by Sister/Charge Nurse & SNM to ensure compliance and efficiency including sickness management/ annual leave and study time allowance. Block booking of agency/bank staff where possible. Supporting staff development to promote knowledge, skill and resilience within the environment. Support Preceptorship for NQ RN's. Monthly monitoring of mandatory training including e-learning %.	Safety - Patient, Staff or Public	6	4	4	16	Increase RN numbers per shift by introducing alternative shift patterns. Ongoing recruitment campaign to include a recruitment video completed with recruitment team. Utilise and develop band 4 to fill band 5 deficit. Maintain the well-being of the staff to promote retention and resilience within team by working closely with the Workforce team.	Evans, Iona Evans, Iona Evans, Iona Evans, Iona	30/09/2022 31/05/2022 30/09/2022 30/09/2022	To be provided at next risk review. To be provided at next risk review To be provided at next risk review To be provided at next risk review	Operational Quality, Safety and Experience Sub Committee	2	4	8		05-May-22

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1389	Service or Department Level Risk		USC: GGH	Perry, Sarah	Morgan, Olwen	25-Mar-22	There is a risk that patient care and safety will compromised, and patients will not receive appropriate and timely treatment, resulting in poor patient experience and potential serious harm or death. Patient documentation such as fundamentals of care, risk assessments and intentional rounding may not be completed within required timeframes. There is also a risk that current staffing pressures will compromise staff wellbeing due to excessive workloads and lack of breaks. This is caused by the current Registered Nurses (RN) deficit on CDU, and appropriate patient care cannot be given without the required staff number per shift. This will lead to an impact/affect on The potential that patients will come to severe harm or death. Delays in completing fundamentals of care, risk assessments and intentional rounding, resulting in an increase in cases of developed hospital acquired pressure damage, patient falls, medication errors, moisture damage and malnutrition. Increase in staff sickness, exacerbating the current vacancy rates Staff fatigue and anxiety, which will negatively affect staff recruitment and retention. Increase in patient complaints and concerns, and potential reputational damage to the ward, hospital and the Health Board. Staff well-being and morale due to the inability to take breaks while on shift and excessive workloads, which may lead to further RNs leaving and exacerbating the current vacancy rates. Increased use of agency staff compromising the skill mix on the ward. Risk location, Glangwili General Hospital.	Utilise Sister/Charge Nurse Clinical lead shifts to back fill deficits when no other option available. Daily SNM risk review of staffing across GGH site - dependent on acuity & dependency. Escalation process in place for patient flow - safety meetings x2 daily. Increase in HCSW per shift to assist with fundamentals of care. All RN vacant shifts are sanctioned to on contract agencies 6 weeks in advance - escalated to TNS if not covered. Allocate roster compliance monitored by Sister/Charge Nurse & SNM to ensure compliance and efficiency including sickness management/ annual leave and study time allowance. Block booking of agency/bank staff where possible. Supporting staff development to promote knowledge, skill and resilience within the environment. Support Preceptorship for NQ RN's. Monthly monitoring of mandatory training including e-learning %.	Safety - Patient, Staff or Public	6	4	4	16	Increase RN numbers per shift by introducing alternative shift patterns.	Evans, Iona	30/09/2022	To be provided at next risk review	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	05-May-22
														Ongoing recruitment campaign to include a recruitment video completed with recruitment team.	Evans, Iona	31/05/2022	To be provided at next risk review						
														Utilise and develop band 4 to fill band 5 deficit.	Evans, Iona	30/09/2022	To be provided at next risk review						
														Maintain the wellbeing of the staff to promote retention and resilience within team. Working closely with the Workforce team.	Evans, Iona	30/09/2022	To be provided at next risk review						

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1276	Service or Department Level Risk	Standard 3.1 Safe and Clinically Effective Care	Carmarthenshire:Palliative Care	Dawson, Rhian	Cameron, Sarah	03-Nov-21	There is a risk of lack of medical cover for the first on call tier of the South West Wales Specialist Palliative Care Out of Hours rota. This is caused by a combination of vacant posts, maternity leave, sick leave and the impact of Covid with doctors needing to self isolate/work from home at times. This will lead to an impact/affect on the amount of work being covered by the Consultant on call. If there is no doctor first on call then the Consultant is covering 2 in-patient units as well as taking advice calls for Swansea Bay and Hywel Dda acute hospitals (5 in total) and the Community across both Health Boards. This could result in delays in patients being assessed across all settings as well as delays in being able to respond to advice calls from other healthcare professionals. Ultimate risk is to patient safety as a result of this. Risk location, Health Board wide, Ty Bryngwyn, Ty Cymorth.	Where there are gaps in the Specialist Palliative Care Out of Hours rota, the doctors on this tier of the rota are being asked to do extra as locums. Both Health Boards are exploring the use of technology to support virtual consultations. Specialty Doctor appointed.	Safety - Patient, Staff or Public	6	4	4	16	The Clinical Lead for Swansea Bay Health Board plans to re-advertise for the vacant Specialty Doctor post. Updates via Palliative Care SMT	Dawson, Rhian	Completed	17/04 - Swansea Bay have responsibility for the on-call arrangements and Hywel Dda HB have done as much as they can and are unable to do anything further agreed to closed action.	Operational Quality, Safety and Experience Sub Committee	2	4	8	Tolerate	04-May-22
														Carmarthenshire SPC team have recently recruited a Specialty Doctor who may be in a position to support the first on call tier once he has more Specialist Palliative Care experience. Updates via Palliative SMT.	Dawson, Rhian	Completed	07/04 - Agreed to close at monthly risk meeting.						
														Carmarthenshire Specialist Palliative Care team have successfully secured a new trainee due to start in August 2022. This post will be shared with Swansea Bay and will be able to support the first on call rota during the periods of time that they are working in Specialist Palliative Care. Updates via Palliative Care SMT	Dawson, Rhian	Completed	07/04 - Agreed to close action as progress will be tracked locally via the Palliative Care SMT.						

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232	Directorate Level Risk		USC: WGH	Cole-Williams, Janice	Johns, Helen	31-Oct-14	There is a risk compromised patient safety and care and avoidable harm. This is caused by insufficient nurses on shift due to high vacancy rates, recruitment & retention difficulties, high sickness & absence, increase in patient acuity & dependency and limited availability of nurse bank and on/off contract agency. This is additional impacted by a high number of junior staff within the workforce. This will lead to an impact/affect on potential for patient harm which is avoidable. Poor patient care and patient experiences. Reduced quality and timeliness of patient care. Inadequately skilled nursing staff to take overall responsibility for clinical areas, lack of mentorship for newly registered/student nurses, healthcare support workers' supervision and guidance. High usage of temporary staff impacts on delays in treatment and timely discharge planning. Surge demands and sickness increasing likely-hood of shifts whereby there are no substantive staff in areas. Risk location, Withybush General Hospital.	Daily review of nurse staffing levels/skill mix and reallocation of staff. Dependency & acuity review by Senior Nurse Manager. Review of non-essential study leave. Senior Nurse (8a) 7 day working model. Redeployment policy & flexible use of staff. Workforce group established to monitor and expedite recruitment position. Escalation process to expedite any delays in lead in times with shared services. Nurse bank open 7 days a week to support late deficits/ temporary staff bookings. Daily staffing matrix in place to identify gaps and cover. Block booking temporary staff. Bank nurse recruitment Scrutiny of patient safety events Roster management with SNM review before sign off. Adherence and monitoring of staff to COVID guidance. Monitor staffing templates in line with Welsh Government All Wales Nurse Staffing Act. Active continuous process in place for recruiting into nursing vacancies. Review of Nurse establishment completed. Process in place to deploy staff to support staffing deficits. Early escalation of staffing shortfalls to off contract agency. Block booking of off contract agency Temporary removal of electronic staff escalation risk assessments to reduce any delays in escalation. Three times daily review of operational bed capacity.	Safety - Patient, Staff or Public	6	4	4	16	Review the workforce module to include employment of Assistant Practitioners and ward admin staff. To ensure that Nursing staff are supported to be able to do their duties.	Thomas, Carol	~~31/03/2022~~ ~~22/12/2021~~ 11/04/2022	New action will be updated at next review. Ward admin staff are now in place. Ward admin staff are still in place.	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	11-Apr-22
														Developing Roster support officers to support ward managers.	Thomas, Carol	**Completed**	New action to be updated at next review. 2 Roster support officers are now in place.						

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1360	Service or Department Level Risk	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk	NQPE: Safeguarding	Passey, Sian	Nichols-Davies, Mandy	21-Mar-22	There is a risk of non- compliance with the statutory duty to safeguard adults at risk of abuse or neglect. This is caused by by an increase in activity as a result of the pandemic and gaps in sustainable capacity in the corporate adult safeguarding team. This will lead to an impact/affect on on adults at risk of abuse or neglect and potential services / individual perpetrators involved resulting caused by delays in to inform multi-agency risk management and decisions to safeguard people at risk of abuse and neglect. This could result in adverse publicity / reduction in statutory partner confidence in the UHB. Risk location, Health Board wide.	1. Corporate safeguarding team Business Continuity Plan. 2. Cancelled attendance at UHB regular service meetings where corporate adult safeguarding representation is required. 3. Continue to limit travel across sites and LAs 3. Redirect single point of contact telephone via Safeguarding Admin to field calls and prioritise responses. 4. Lead Safeguarding Adult Practitioner covers the single point of contact when there is unplanned absence in the team. 5. Cancel adult safeguarding training if necessary to meet other priorities. 6. Head of Safeguarding manages a caseload of professional concerns. 7. Head of Safeguarding provides operational advice and support to services and statutory partners.	Statutory duty/inspections	8	4	4	16	Review capacity and structure in the adult safeguarding resource to provide sustainable capacity to meet workload.	Nichols-Davies, Mandy	31/05/2022	Review of available resource to meet demand is in progress.	Quality, Safety and Experience Assurance Committee	2	4	8	Treat	28-Mar-22
														Service leads to provide own reports for reporting assurance and exceptions to Safeguarding Service Delivery Groups and Strategic Safeguarding Working Group.	Nichols-Davies, Mandy	31/03/2023	Service leads to be formally advised via Service Safeguarding Delivery Groups.						
1295	Directorate Level Risk	Standard 5.1 Timely Access	Pembrokeshire	Lorton, Elaine	Hay, Sonia	25-Nov-21	There is a risk that current domiciliary care and care home providers are unable to deliver sustainable service models to meet the system wide demands of patients in Pembrokeshire. This is caused by by a fragile domiciliary workforce limiting provision of timely care packages for patients across Pembrokeshire due to challenges with retention and recruitment, an increasingly aging population is resulting in increasing demand for domiciliary packages of care and care home placements; limited availability of General and EMI nursing home placements within Pembrokeshire and challenges. This will lead to an impact/affect on domiciliary and care home providers being unable to accommodate timely referrals resulting in increasing delays in patients accessing care in the community, and for acute and community inpatient services being able to discharge patients in a timely manner, increased length of hospital stays resulting in deterioration of patients physical and mental health, reduced functional ability and deconditioning leading to increased care needs and increased demands on already limited service providers. Risk location, Pembrokeshire.	Processes have been established for daily community sitrep positions to be reported which include the position of care home and domiciliary care availability and highlights any staffing issues or concerns for early intervention. All patients waiting for care home placement or domiciliary care packages in either acute or community hospital beds are monitored regularly by the Discharge Liaison Nurse (DLN) Team working collaboratively with the MDT and utilising the SharePoint System which is supporting with the earlier identification of patients requiring care. The Long-Term Care Team are closely monitoring care homes and nursing homes, providing support and guidance as required. They are also working collaboratively with wards and local authority to support the continuing health care process to meet discharge requirements. Regular scrutiny meetings have been established with the Long-Term Care Team to support with the relocation of patients to new nursing and EMI homes and to monitor potential impact of further destabilisation of the care home sector New processes have been implemented to mitigate delays in transfers to care home through discharge to assess pathways and Welsh Government guidance and a Home of Choice policy has been implemented throughout the health board to support patient, family and ward staff in ensuring a smooth transition of care. Social Care services have developed a number of initiatives including: opening Martello House as an additional step-down facility to create capacity within acute services, recruitment for a 'releasing time to care' post to reduce demand by encouraging single hand care referrals, working with providers to develop new runs and to increase capacity of domiciliary care provision and undertaking recruitment events to increase domicillary care capacity. HDHB and PCC, and third sector have established processes to work together to identify opportunities to resolve the shortage of domiciliary care provisions by promoting alternatives, e.g.	Safety - Patient, Staff or Public	6	4	4	16	Service Delivery Manager asked to review this risk and identify current actions to be delivered.	Hay, Sonia	Completed	SDM requires access to system	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	25-Apr-22
														Recruitment of HCSWs to pilot a health board home based care staff to provide short term 'dom' care until March 2022	Hay, Sonia	Completed	Completed recruitment and currently 11 patients on the 'dom' care caseload. Action completed						
														Recruitment of 12.75 WTE HCSWs to provide enhanced bridging service aligned to the D2RA pathway 2 model.	Hay, Sonia	Completed	Recruited to post and currently providing enhanced bridging care which supports patients being discharged to recover then assessed by care assessor so patients do not have to wait in hospital for the social care assessment.						
														Working closely with Local Authority, continuously monitor the situation	Lorton, Elaine	Completed	Weekly Whole system challenges meeting established with senior management from health and local authority, Monthly Oversight meeting established with key stakeholders across the system to review the situation and identify opportunities, recruitment campaign being driven by LA and support by Health to attract individuals to the social care sector						

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								~~domiciliary care providers by promoting alternatives, e.g.~~ microenterprise and direct payments co-operative. An enhanced bridging care service from ART and Care at Home has been funded through Winter Pressures Monies and is working in conjunction with the Home First Team to facilitate early discharge and improve patient flow.						3 County Basis - develop a legal framework which will enable HDUHB to support LA and private providers deliver care in extraordinary circumstances	Lorton, Elaine	Completed	3 county service level agreement has been taken through COVID 3 counties group						
														Regional whole system escalation process to be developed	Lorton, Elaine	Completed	Escalation policies have been submitted to 3 County Bronze						
														Regional whole system escalation process to be communicated	Lorton, Elaine	Completed	Regional group to collate escalation policies processes to determine interdependencies						
														Development of an integrated apprenticeship programme to provide a regional, integrated, work-based learning route for young people to enter the health and social care professions	Lorton, Elaine	29/03/2024	Submitted a proposal for Regional Integrated Fund to support this project as a pilot in Pembrokeshire over three years						
														Further development of the D2RA Pathway 2 to get people home to recover then assess to ensure level of care is right sized	Svetz, Jess	Completed	Submitted a proposal for enhance workforce through the regional integrated fund to support the pathway. This is linked to the enhanced bridging/home based care actions.						
737	Service or Department Level Risk	Standard 3.4 Information Governance and Communications Technology	Finance: Digital: Information and Communication Technology	Tracey, Anthony	Holman, Roy	01-May-18	There is a risk that the staff working on the switchboards within the Health Board are not able to comply with the European Working Time Directive (EWTD). This is caused by the inability for cover single handed shifts at night, weekend and bank holidays. Currently shifts are 8 hours long. The current rotas do not allow for workers to have breaks whilst covering the night, evening, weekend, bank holiday shifts. This will lead to an impact/affect on the European Working Time Directive (EWTD) is an EU initiative designed to prevent employers requiring their workforce to work excessively long hours, with implications for health and safety. Specifically the right to a rest break if the working day is longer than six hours. Risk location, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital.	Each switchboard has a lockable door, and a panic button function is installed in each switchboard, which is linked to the security teams within the hospital site. Health Board successful for an Invest to Save bid from Welsh Government to undertake a replacement and modernisation programme for the switchboard. The project has been running for 8 months, and a tender was recently awarded based on the technical design of a modern switchboard environment. The work on the technical design is being taken forward by a third party vender (4C Strategies), who have extensive knowledge within the area. Project Team established with representation from Sites triumvirates, Estates, Workforce and OD and Informatics. Project team overseeing 2 sub-workstreams to the project-technical aspects and workforce implications.	Workforce/OD	8	4	4	16	Implement new switchboard technology to allow the seamless redirecting of calls between sites to ensure that we have business continuity.	Holman, Roy	31/03/2022	New switchboards are on all sites undergoing field trials, within the next few months on completion of successful trials we will be implementing these across the health board enable all switchboard sites to cover each other enabling us to meet the EWTD regarding staff breaks.	People, Organisational Development and Culture Committee	3	2	6		20-Oct-21
														Oganisation change programme (OCP) to be undertaken due to the need to alter a number of the staff contracts to allow either movement to a different rota pattern, or a reduction in hours.	Holman, Roy	Completed	Update OCP in line with current situation						

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1224	Directorate Level Risk		Women and Children: Community Children Services	Humphrey, Lisa	Bucknell, Tracey	24-Sep-21	There is a risk children and young people with complex needs will not receive the care and treatment for their continuing care packages. This is caused by lack of 3rd Sector providers and an inability to recruit and retain cares. This will lead to an impact/affect on a reduction in care for children and young people, and subsequently patient safety. Existing service support shortfalls in cover leading to stress on staff. This causes additional pressure to the service and a negative impact on sickness and retention. Possible damage to the reputation of the HB. Risk location, Health Board wide.	Implemented impact assessments and contingency plans for all care packages HB wide. Children's Community Nursing Service working with Health & Safety and Social Care to address the family's dynamics and expectations. Use of HB core community staff and bank staff to cover packages of care to avoid admission to secondary care. Meet with 3 sector providers and HB procurement Team and SDM and SNM to review the position.	Safety - Patient, Staff or Public	6	4	4	16	Meet with 3 sector providers and HB procurement Team and SDM and SNM to review the position.	Bucknell, Tracey	Completed	SDM met with relevant staff.	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	06-Apr-22
														Develop an SBAR, to gain approval for developing in house community care provision.	Bucknell, Tracey	Completed	SBAR developed and submitted to the W&C QSE meeting in Jan 2022.						
														Enabling Quality Improvement in Practice the community children's nurses applied to participate in this program.	Bucknell, Tracey	30/12/2022	The program runs for 1 year and the children's community nurses were successful.						
1245	Directorate Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	Women and Children: Community Children Services	Humphrey, Lisa	Bucknell, Tracey	08-Oct-21	There is a risk of delayed assessment and review of community paediatric patients. This is caused by long standing vacancies within the Community Paediatric Team. It is compounded by a change in use of the SAS doctors. It is also caused as an unintended consequence following a change in Children's Services post-reconfiguration. This will lead to an impact/affect on on care for children and young people seeking access to community paediatrics, as they are not receiving the care which they need. Also impacts on service delivery and medical staff welfare. Resulting in complaints and concerns. Negative impact on the reputation of the Health Board. Breaching 26 week wait for initial assessment of ADHD as set by WG. Risk location, Health Board wide.	Recruitment program in place. Implementation of waiting list validation - HB wide and Parent Initiated Follow Up(PIFU). Existing job plans regularly reviewed. QB-test installed to aid the diagnosis of ADHD.	Safety - Patient, Staff or Public	6	4	4	16	SDM to work with Workforce and OD and with internal staff to review roles and responsibilities.	Bucknell, Tracey	~~31/03/2022~~ ~~30/05/2022~~ 30/09/2022	Initial conversations have taken place and are ongoing. This forms part of the CYP Working Group.	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	09-May-22
														SDM working on a service review requesting support from colleagues.	Bucknell, Tracey	Completed	Service review has been requested to the Executive Team and approved, currently awaiting formalised plans for the review.						
														Internal review of community paediatrics being undertaken by Consultant Community Paediatrician.	Bucknell, Tracey	30/09/2022	The review has been agreed by the Medical Director and is due to commence in June 2022. Once the review has been completed, action plans will be formulated to help manage and mitigate this risk going forward.						
														SDM working through "Covering All Bases" RCPCH 2017. This will inform the Health Board of the Paediatric workforce required for the service.	Bucknell, Tracey	30/06/2022	To be provided at the next risk review						

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525	Directorate Level Risk	Standard 7.1 Workforce	Scheduled Care: Theatres	Hire, Stephanie	Knight, Diane	18-Jun-18	There is a risk financial pressure for the department through both payments and the requirement for an increased nursing and Operating Department Practitioners (ODP) workforce to provide safe staffing levels. This is caused by the site specific policy for compensatory rest following on-call weekend shifts. This will lead to an impact/affect on the financial sustainability of the service. Safe staffing levels through pressure to recruit a larger workforce. Risk location, Bronglais General Hospital.	Maintenance of current model of compensatory rest, which contradicts Agenda for Change agreements as identified by the Internal Audit review of theatres.	Finance inc. claims	6	4	4	16	SBAR for removal of compensatory rest has been submitted for review by the Nursing Directorate.	Knight, Diane	**Completed**	Subsequent request for Executive Team paper.	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	25-Jan-22
														Implementation plan following the Executive decision to be drafted and agreed with the BGH Theatre team and TU reps.	Knight, Diane	**Completed**	Action completed.						
														Rota to have final sign off by Director of Operations and Director of Nursing, Quality and Patient Experience.	Hire, Stephanie	~~30/11/2021~~ ~~31/01/2022~~ 31/03/2022	SBAR to be submitted. Awaiting feedback and draft rota to be signed off by Director of Operations.						
632	Directorate Level Risk	Standard 3.1 Safe and Clinically Effective Care	Scheduled Care: Ophthalmology	Hire, Stephanie	Buckingham, Carly	27-Sep-18	There is a risk the UHB not being able to fully comply the WG Eye Care Measures (ECMs). This is caused by nursing and medical staffing constraints, service capacity due to lack of physical space and identification of long term funding. This will lead to an impact/affect on delivery of the Ophthalmology RTT plan, lead to delays in the treatment and care of patients, adverse publicity/reduction in stakeholder confidence and increased scrutiny/escalation from WG. Risk location, Health Board wide.	Eye Care Collaborative Group meets quarterly to oversee performance against eye care standards. ECM Coordinators in place. 4 prescribing hubs set up across the Health Board were successful in reducing the number of patients requiring Hospital Eye Services. Adhering to appropriate WG guidance. Transformational funding from Welsh Government in place until March 2022. Recovery funding in place until March 2023. Optometrists working collaboratively with the Hospital Eye Service. Continuous work around outsourcing for cataract surgery. ARCH workstreams in place- looking at Glaucoma, Diabetic retinopathy, cataracts and workforce. Review of financials plans has been undertaken. Full Business Case for OpenEyes software (National Electronic Patient Record for Ophthalmology) approved and dedicated Project Manager has been appointed to oversee implementation. 4 optometric practices/day across HDUHB offering acute eye care support, ensuing that only those eye conditions which require surgery or laser treatment are referred on to the hospital eye service. Ongoing arrangement of Optometrists enrolling in prescribing training. SBAR for money for additional staff has been approved and incorporated into IMTP, to assist with Age related Macular Degeneration (AMD) service within Pembrokeshire.	Safety - Patient, Staff or Public	6	4	4	16	Root and branch review of operational, workforce and sustainability models.	Buckingham, Carly	~~31/10/2019~~ ~~31/01/2020~~ ~~30/06/2020~~ ~~31/08/2020~~ ~~30/06/2021~~ ~~31/03/2022~~ 30/09/2022	Root and branch review being undertaken through ARCH group which meets regularly on both a regional and sub-specialty basis.	Operational Quality, Safety and Experience Sub Committee	2	2	4	Treat	29-Nov-21
														Roll out and implementation of National Electronic Patient Record for Ophthalmology.	Barreiro, Marta	~~13/07/2020~~ ~~30/11/2020~~ ~~31/07/2021~~ ~~31/10/2021~~ ~~31/01/2022~~ ~~31/03/2022~~ ~~31/05/2022~~	Roll out start planned for the 21st of March for the RACE sub-specialty. Following the successful implementation, the other sub-specialties will follow. Update: further delays from the national team; new target date for July 2022 launch.						
														To comply with Eye Care Measures and the backlog created from the impact of covid, the IVT service now needs to be relocated in order to free up theatres for cataract delivery. This will imply applying for capital bid to transform the AVH OPD area into an appropriate clinical area to deliver the IVT service and free up theatre.	Buckingham, Carly	~~31/08/2022~~ 30/04/2022	Capital bid has been approved, with work to improve physical space at Amman Valley Hospital (AVH) to be completed by March 2022. Update: works are on track to be completed by end of March 2022. Delays are expected in transferring the clinical activity due to recruitment times and equipment delivery times. Update 31st May: works completed, minor snags and deliveries pending. Most staff have successfully been recruited to support this and are undergoing training. Plans to start a phased approach from 5th July 2022.						

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														Continue with outsourcing for cataract surgery.	Buckingham, Carly	31/03/2023	New action.						
														Plan for Cataracts and Glaucoma pathways to be implemented through ARCH.	Barreiro, Marta	30/06/2022	Business case has been approved and implementation to now take place for both pathways. Pathway has been designed and now requires consultant to drive this forward.						
														Recruitment of approx. 7 nursing staff and 2 technicians.	Barreiro, Marta	30/06/2022	Currently going through Trac process for recruitment.						
														Recruitment of theatre staff and admin support to enable the optimisation of AVH theatres for cataracts.	Barreiro, Marta	~~31/03/2022~~ 30/08/2022	Positions are currently out to advert. Update: admin positions appointed into but staff not yet started. DSU staff are able to cover 2 days of cataract surgery from June/July.						
														Devise and approve plan for Diabetic retinopathy service through ARCH.	Barreiro, Marta	30/06/2022	Currently in development, possibility to adopt model from Swansea Bay UHB. Transformation funding available until March 2022 which will assist with this. Next ARCH meeting taking place mid December 2021.						
														Recruitment drive for Glaucoma Consultant.	Barreiro, Marta	30/09/2022	Advertising for 2 Glaucoma Consultant to work across Hywel Dda and Swansea Bay UHB.						
														Remodelling the capacity and demand associated with Wet AMD and Amman Valley.	Barreiro, Marta	31/03/2023	Reviewing where the delays are. Currently reviewing patients for suitability, as well as to undertake audit on patient pathways.						
														Implement virtual review clinics for patients undergoing HCQ treatment.	Barreiro, Marta	30/09/2022	New action.						

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														Approve contract with existing Glaucoma Consultant.	Barreiro, Marta	Completed	Contract discussions taking place.						
1354	Directorate Level Risk	Standard 3.2 Communicating Effectively	Ceredigion	Skitt, Peter	Evans, Tracey -	21-Feb-22	There is a risk Datix incidents not following appropriate allocation for resolution This is caused by pressure sore incidents identified in acute sites are subsequently inappropriately allocated to community teams This will lead to an impact/affect on patient safety as the incident is not being reported to the appropriate service area who has contact with the patient. Risk location, Ceredigion.	Issue raised with the DATIX team.	Safety - Patient, Staff or Public	6	4	4	16	Escalate issue to the RL DATIX team	Evans, Tracey -	Completed	Issue has been raised with the RL DATIX team	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	19-Apr-22
														Escalated the risk to a Directorate level	Skitt, Peter	31/05/2022	Communications have commenced						
830	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	Central Operations: Out of Hours	Rees, Gareth	Richards, David	03-Jan-20	There is a risk 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 the a deterioration in the demand to capacity ratio, 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.	Interviewed and recruited 8 salary doctors (6WTE) - 2/3 in final stages of recruitment, and 1 which has deferred. 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. This has been extended to 31/01/2022. SOP in place for Comfort Calling, and another for ED Redirection	Safety - Patient, Staff or Public	6	4	4	16	Recruit and deploy clinical shift lead GPs (where engagement can be secured) at times of highest demand to direct demand to available clinicians and to allocate available resources. This will require cross-border agreements where GPs operate from their particular base but cover calls across the HB footprint	Davies, Nick	Completed	Expressions of interest have been received. Clinical Lead, Deputy MD and 111 Clinical Advisor will all support with immediate pressures. Interviews to be arranged for remaining applicants	Strategic Development and Operational Delivery Committee	1	4	4	Treat	12-Apr-22
														Direction and challenge of current GP activity and cultural behaviour is required by Medical Directorate to ensure all GPs contribute fairly to HB wide demand (to include telephone advice and face to face consultation- including home visiting- regardless of geographical location.	Davies, Nick	Completed	Service leads and medical directors to meet and address issue and agree lines of communication						
														To hold a senior management/ service lead and 111 lead meeting to discuss current concern, understand risks and discuss potential solutions- to be chaired by Director of Operations	Davies, Nick	Completed	Meeting has been arranged for 28/01/2020 and invite circulated- responses awaited						

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														Maximise clinician availability to support wider workforce pressure- while developing multi-disciplinary approach to service delivery. 2 month pilot utilising Acute Response Team (ART)staff on a bank basis to support OOH demand on a 3-county basis, ensuring access to patients (especially palliative care) is secures- without affecting capacity of existing ART caseload	Davies, Nick	Completed	Expressions of interest receieved and workforce approval gained- currently meeting with staff to ensure roles are appropriate and ascertain availability- rota to be prepared by 24/01/2020 with a view to initial deployment on 01/02/2020						
														Increase the deployment of WAST Advanced Paramedic Practitioners into the OOH rotation. Currently utilises skills of 2 WTE, looking to increase to 3 WTE.	Davies, Nick	Completed	New WAST APP rota has been negotiated and optimised to provide enhanced OOH cover						
														Recruitment of additional clinicians (to include GP and Advanced Nurse Practitioners)upon the receipt of potential applications.	Davies, Nick	Completed	Now have sufficient sessional GPs in place.						
														Complete service redesign is needed and this work is being undertaken in collaboration with the Transformation Directorate.	Richards, David	31/12/2025	Work was stalled as a result of Covid (transformation team reassigned to other work and out of hours team focused on service delivery during Covid). Workstreams to be re-established. Working with Workforce colleagues to map out the workforce requirements. No timescales defined as yet. Currently scoping with Senior Workforce Development Manager to agree how this will be progressed. This was been stalled due to school holidays/summer annual leave 2021. We are making increasing contact with colleague involved with TCS to get re-engaged with the process. Jan 22 - no further update available at this point.						

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														SDM to assess the potential benefit of a Triage Nurse service- and possible implementation- to support with current service demand and delivery	Davies, Nick	Completed	07/10/20- given change in clincial working practice to maximise telephone advice, the performance profile has improved significantly and capacity has increased as a result. Given the need for wider workforce planning, along with the improved performance this action will be closed in relation to this risk						
														Review the impact of the new '111 First' on OOH service.	Richards, David	~~30/07/2021~~ ~~31/03/2022~~ 31/08/2022	Review still in progress- To go live has been postponed from July 2021 to March-April 2022- concerns are being expressed by the SBUHB OOH SDM, as this seems to be undermining the OOH rota. This concern has also expressed by other OOH colleagues outside of the UHB. Jan 22 - review has not yet commenced, however there is a risk that the current resource pool may be reduced as GPs have the option to work elsewhere. Phase 1 of review due to commence Q1 22/23.						
														Recruit 6 salary doctors.	Richards, David	Completed	Interviewed and recruited 5 salary doctors. 3 are now working under salary terms, the other 2 will finish their scheme in December 2021/January 2022 (both in Pembs). An additional 2 salary doctors are being interviewed 02/11/2021 - one doctor to be ready immediately, and the other to be ready for Christmas 2021.						
720	Service or Department Level Risk	dard 3.1 Safe and Clinically Effective Care	Ceredigion	Skitt, Peter	Hawkes, Jina	15-Apr-19	There is a risk avoidable harm to patients and staff due to lack of registered and HCSW 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 quality of patient care and staff wellbeing due to insufficient staffing levels to meet patient need. Risk location, Tregaron Hospital.	There is a pro-active operating process associated with ensuring appropriate patients are admitted into the hospital. The process is led by the community staff. Business continuity plans have been reviewed and updated in 2022.	Safety - Patient, Staff or Public	6	4	4	16	Whole system review of staffing to be undertaken on a daily basis in line with escalation process	Evans, Tracey -	Completed	Daily touch point meetings are used to prioritise staffing requirements	itional Quality, Safety and Experience Sub Committee	1	4	4	Treat	16-May-22
														Decision required in relation to on-going funding of additional staff brought in to cover the COVID pandemic to increase the bed base.	Hawkes, Jina	Completed	Communications with decision makers commenced						

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		Stand												Develop a plan to safely staff the hospital post October 22	Hawkes, Jina	30/09/2022	Planning and development of an OCP taking place	Opera					
1341	Service or Department Level Risk		USC: Radiology	Perry, Sarah	Roberts-Davies, Gail	28-Jan-22	There is a risk of the loss of radiology services at community hospitals in Pembrokeshire This is caused by the need to centralise Radiology services at WGH by withdrawing X Ray services at both Tenby Cottage Community Hospital and South Pembrokeshire Community Hospital in order to provide a safer service as a result of critical staff shortages. Reason for staff shortages at WGH include: •Long term sickness absence •Long standing recruitment issues and retirement. •Underestimation of projected increase in workload and workforce review. •The OOH system •Historical part time and term friendly contracts. •No planned backfill for radiographers leaving the general area prior to them going to other modalities. This will lead to an impact/affect on •The inability to deliver of X-ray services in the community hospitals •Cause additional fragility to the out of hours on call system •Potential for loss of services at WGH if staff absence increases, or we are not successful via recruiting. Risk location, Pembrokeshire, Withybush General Hospital.	*Centralising services in Withybush to improve working conditions for radiographers and increase safety of service, therefore keeping essential services running. *Seek assistance via Medacs for additional staff - currently permanent advert out for general radiography staff. *Review of service provision to identify potential gaps or service failures in good time to reduce further risk	Safety - Patient, Staff or Public	6	4	4	16	Develop a business case in order to obtain additional funding for band 6 radiographers	Lingwood, Gill	~~01/03/2022~~ 31/12/2022	Wider establishment review is ongoing, and this action is being considered as part of this demand and capacity work.	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	16-May-22
														Improving cultures and working environments within general X ray	Lingwood, Gill	**Completed**	Working with other site leads to share good practice and embed an improved culture and instil confidence, with PPH site lead visiting WGH on a weekly basis. Staff are also encouraged to raise concerns with the WGH site lead via an open-door policy, encouraging a more open and improved culture on site.						

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1083	Directorate Level Risk		Scheduled Care	Hire, Stephanie	Hire, Stephanie	01-Apr-21	There is a risk harm to patients due to increased waiting times. This is caused by the Health Board response to the Covid-19 pandemic resulting in the reduction in elective theatre capacity and outpatient consultations across all specialities. This will lead to an impact/affect on delays in care and poorer outcomes for patients, significant clinical deterioration, increased claims, increased burden on non-scheduled care services (e.g. A&E, MH&LD), further increase in waiting times for new patients. Risk location, Health Board wide.	All waiting lists have been, and will continue to be, clinically risk stratified. Communication with patients on waiting lists, especially the longest waiting patients, and enable them to access supportive services, while we both restart services and plan to increase capacity. The Scheduled Care Directorate working closely with both the Assistant Director of Nursing, Quality and Patient Experience and Welsh Government colleagues on a process to communicate with stage 4 patients and have also commenced work with the longest waiting stage 1 patients. This process is referred to as FPOC (first point of contact). These principles will underpin the process to maintain personalised contact with all patients currently waiting for elective care which is a Strategic Priority for the organisation and satisfies to Planning Objectives: (SPOC). Evidence of significant increase in accessing Health Board Life Style advice page following first contact letter. MDT working group established to continuously review the process in place. Process includes a team of nurses monitoring and replying to queries, and FAQs and comms process. Following contact has been undertaken with patients: - Recontacted stage 4 (over 52 weeks) patients who did not respond to first contact letter. - Contact stage 1 non responders from initial telephone validation workstream. - Contact remaining stage 4 patients over 36 weeks. - Contact > 52 week Ophthalmology patients, Stage 1 and 4. - Posted letters to Stage 1 patients in batches of 1500, identified by speciality and wait. -Contacted > 36 week Ophthalmology patients , Stage 1 and 4. Single Point of Contact (SPOC) now in place. Clinical risk stratification completed in stage 4 as P 1,2,3&4 and urgent and routine in stage 1. Recommendations from the 2021/22 Internal Audit Waiting list report have been implemented. Waiting list support service team has been established but they are currently only working in two specialties. There is a programme to increase specialties supported (see risk action section below).	Safety - Patient, Staff or Public	6	3	5	15	Implement Waiting list Support Service.	Hire, Stephanie	31/03/2022	Team has been established but they are currently only working in two specialties. There is a programme to increase specialties supported, however this has been delayed due to staff being redeployed to the Covid command centre.	Operational Quality, Safety and Experience Sub Committee	2	5	10	Treat	17-Dec-21
														Explore green protected capacity to treat urgent/cancer patients.	Hire, Stephanie	31/01/2022	Secured on the BGH, PPH and GGH sites and plan to open in WGH in January 2022, however this will be dependent on Covid surge.						
														Outsource external provision to deliver urgent outpatient activity.	Hire, Stephanie	31/03/2022	This continues to be scoped.						

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818	Service or Department Level Risk	Standard 5.1 Timely Access	Scheduled Care: Neurology	Hire, Stephanie	Buckingham, Carly	11-Dec-19	There is a risk avoidable harm and deterioration in clinically diagnosing Neurology (including epilepsy) patients, both in the outpatient setting and inpatient service across the 4 sites. This is caused by current reduced consultant staffing provision available due to: * lead MND consultant on long term sick. * Current consultant formally requested to reduce hours via Swansea Bay team. * Current consultant has stepped down as clinical lead for Hywel Dda. * Lead epilepsy consultant retired, resulting in a cohort of Learning Disabilities (LD) patients not under Neurology review. This will lead to an impact/affect on inpatient and outpatient neurology and neurophysiology patients (including a cohort of LD patients) having poorer outcomes from delays in the commencement of treatment, increased complaints and claims and increased scrutiny from Welsh Government. Risk location, Health Board wide.	Medinet Clinical Services are providing locum consultant to address demand - funding through Referral to Treatment (RTT) process. Inpatient referrals in GGH/WGH and BGH are being referred to the neurologist on call (rotational between Swansea Bay and Hywel Dda UHB), however there is significant delays. Swansea Bay continue to advertise for a locum to support the service. Telemedicine facilities in use by visiting Consultants to reach outpatients in BGH. Hywel Dda UHB in collaboration with ARCH for ongoing delivery plan.	Safety - Patient, Staff or Public	6	3	5	15	Regional Neurological Conditions Regional Plan ongoing between Swansea Bay/ Hywel Dda in collaboration with ARCH to establish Swansea Bay as the hub for the Neurology service.	Thomas, Anna	~~20/01/2021~~ ~~30/04/2021~~ 31/12/2022	Monthly ARCH meetings in place. The Regional Plan and establish actions were reviewed. Hywel Dda working with Swansea Bay to provide demand and capacity data - ongoing.	Operational Quality, Safety and Experience Sub Committee	1	5	5	Treat	25-Jan-22
														Job planning sessions for all neurology consultants	Cullum, Louise	**Completed**	Job plans for all consultants now complete						
														Review SLA internally prior to discussions with Swansea Bay.	Thomas, Anna	~~31/05/2021~~ ~~31/07/2021~~ ~~30/09/2021~~ 31/03/2022	Senior Service Manager has met with Finance to review the current costs of the SLA, and further meeting required with the Commissioning and Contracts Manager to establish the original SLA agreement. A new SLA to be written, as the previous agreement is not relevant to current service demands. The SLA will be agreed through Hywel Dda and Swansea Bay executive teams, including Finance input. Discussions are ongoing.						
														Agree cover for interim Clinical lead for Hywel Dda.	Thomas, Anna	~~31/08/2021~~ ~~31/10/2021~~ 31/03/2022	Current clinical lead has stepped down. Discussions to take place at ARCH to establish an interim clinical lead. Hywel Dda has no official clinical lead but continues to have support from substantive Neurologist if need be. These are ongoing discussions through ARCH. Support is being provided by Clinical Director at Hywel Dda.						

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1114	Service or Department Level Risk	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk	NQPE: Safeguarding	Passey, Sian	Nichols-Davies, Mandy	11-May-21	There is a risk that with out maximising the opportunities for early identification and strengthening the use of preventative remedies available to primary care services through IRISi we will not be able to intervene early in response to domestic violence and abuse. This is caused by lack of knowledge by GPs how to specialist support services for patients who are victims of domestic violence and abuse and a lack of a recognised evidence based system such as IRISi to support GPs to recognise and respond to domestic violence and abuse supported by specialist services. This will lead to an impact/affect on patients attending GP practice may not be identified as suffering from domestic violence and abuse, with the potential impact potentially leading to long term mental and physical health problems or death. Risk location, .	GPs have access to awareness raising resources GPs have access to Group 2 Ask and Act training and safeguarding child and adult training provided by the Corporate Safeguarding Team.	Safety - Patient, Staff or Public	6	3	5	15	Complete tender and implement a 3 year pilot of IRISi in Carmarthen Primary Care clusters	Bond, Rhian	Completed	Funding has been agreed for Year 1. The tender process is ongoing. 08/02/22 The contract for the specialist provider has been awarded led by the corporate safeguarding team and Procurement.	Quality, Safety and Experience Assurance Committee	1	5	5	Treat	08-Feb-22
														Lead VAWDASV and Safeguarding Practitioner to work with West Wales Domestic Abuse Services (WWDAS) to meet with individua GP practices to raise their awareness of domestic abuse and make links with local specialist services	Munkley, Rachel	Completed	Meetings already completed with WWDAS. They are willing to offer support. As still awaiting response from surgery staff. Escalated to medical Lead- he will ensure engagement with practice. Also Lead VAWDASV to attend cluster meeting with WWDAS to share learning across other practices in Ceredigion. 08/11/2021 There have been challenges engaging the GP Practice involved in a specific DHR and the cluster generally. This has been escalated to the Deputy Medical Director for Community and Primary Care.						
														Make all GP Practices aware of the Regional Mid and West Wales GP Pathfinder guidance (based on Safelives guidance) with details of specialist services and guidance o how to ask about domestic abuse.	Luke, Sonia	Completed	The Head of Safeguarding requested that the guidance was sent out on 12th April 20221, but there is no evidence that this was actioned. 15.07.21 SL has confirmed that the guidance has been re-sent out to all GP practices and a read/receipt requested.						
														Lead VAWDASV and Safeguarding Practitioner will meet with Pembrokeshire GP clusters to provide them with VAWDASV resources, raise awareness and establish links to provide support as required.	Munkley, Rachel	Completed	Meetings are in progress. 9/6/21 Lead VAWDASV Nurse met with Newport Practice surgery to advise of training available to improve recognition and response to domestic abuse. Discussed specific issues with disclosing in primary care. Offered further support through third sector agencies attending future practice meetings to advise on specific local support. which the surgery staff agreed to. Also provided resources including posters, cards for patients with contact for national support helpline. Live fear free contact advice posters also sent to all other GP practices in Pembrokeshire						

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														Implement the pilot of IRISi in Carmarthenshire clusters with a robust process for evaluation to inform a Business case for rollout in Pembs and Ceredigion GP practices.	Nichols-Davies, Mandy	31/03/2023	The specialist provider contract has been awarded and the Clinical Lead is to be recruited to support the pilot. 19/04/22 Clinical lead has been appointed and the Advocate Educator. Waiting confirmation of IRISi training dates before implementation commences.						
628	Directorate Level Risk Standard 3.1 Safe and Clinically Effective Care		Therapies and Health Science	Reed, Lance	Reed, Lance	27-Sep-18	There is a risk that patients in need of therapy and rehabilitation services do not receive them in a timely manner or do not receive the required level or intensity. This is caused by gaps or fragile staffing levels in the rehabilitation and therapy service provision across acute, community and primary care settings from historical under-resourcing, exacerbated by recurrent savings targets, vacancies and recruitment/retention issues due to national shortages. There is the additional challenge that COVID-19 has placed upon workforce models due to increased complexity and acuity of patients presenting post lockdown having had treatments suspended and of not able to access timely care. This will lead to an impact/affect on patient outcomes, longer recovery times, increased length of stay, a reduction in performance against performance targets including 14 week waiting time, non-compliance with clinical guidance, and potential adverse impact on patient safety/harm. Risk location, Health Board wide.	Individual service risks identified and discussed at a range of fora; i.e. QSEAC, OQSESC, Performance Reviews and Therapy Forum. Priority areas agreed in the 2021/22 Annual Plan, to increase capacity in key areas identified in plan. Additional Capacity created in MSK service, Long Covid, ESD. Locum staff utilised where appropriate, funded from within core budget (2 vacancies required to fund 1 Locum) Short-term contracts/additional hours within budget used to cover maternity leave. Training of support staff to safely deliver delegated tasks. Over-recruitment of Newly Qualified Staff / B5 & B6 staff where appropriate and approved by the Clinical Director to mange foreseeable and predictable staffing level capacity gaps. Local solutions include review of each vacant post to make them attractive, including skill mix review, early advertisements for new graduates. Student streamlining of B5 graduates from June 2021. Prioritisation of patients is undertaken through triage and risk assessment by therapy services. Use of Digital Platforms to support agile working and remote access. Continued training of the Malcomess Care Aims Framework for MDT/Therapy Service. Workforce plan being reviewed in light of emerging pressures.	Safety - Patient, Staff or Public	8	3	4	12	Developing robust plans to evidence improved patient outcomes and experience through reprovision of resource from elsewhere in the health and care system aligned with strategic direction of the HB. This is a significant, long term piece of work, which will need to run alongside strategic development through the Health and Care Strategy. This will include skill mix review such as new HCSW and Advan	Reed, Lance	Completed	Plans under development. Funding already secured for developments in pulmonary rehab, dementia, lymphoedema and to support some increase in front door/acute therapy input including plans to address malnutrition. Continued operational and strategic engagement with DoTHS, DOO, HoS, CDs and GMs to address COVID-19 response and to service developments that would release resource and savings from the wider health and care system through increased therapy provision, including areas of pathway re-design. WG funding for Therapy Assistant Practitioner HCSW role to support workforce model changes.	Operational Quality, Safety and Experience Sub Committee	3	4	12	Treat	12-Apr-22
														Ensure process for robust workforce planning is in place to inform HEIW in respect to future graduate numbers required by the UHB/Region, which are aligned to the Health and Care Strategy workforce plan.	Shakeshaft, Alison	Completed	Long-term piece of work informed by action above on an annual basis. Lead in time of 3 years to benefit from graduate programme. HEIW AHP Streamlining to commence 2021						
														Pursue opportunities to attract local people into therapy careers in the HB, eg 'grow your own' schemes, apprenticeship programmes, development of career pathways from HCSW to graduate, development of local graduate training programme.	Reed, Lance	Completed	Commitment given to extend apprenticeship scheme to AHPs, agreed from 2020. Variety of HCSW training modules for level 3 and 4 developed and being implemented. HEIW review to commission local training provision for Physio & Occupational Therapy Undergraduate Training locally.						

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														Develop robust workforce plans that align to stroke, major trauma and neurology and COVID-19 rehabilitation service needs to maximise workforce opportunities.	Shakeshaft, Alison	~~31/03/2020~~ 31/03/2022	Plan being developed as part of Therapy 3 Year Plan 2021/23 to include extended and 7 day working.						
565	Directorate Level Risk	Standard 3.1 Safe and Clinically Effective Care	USC: GGH	Perry, Sarah	Morgan, Olwen	16-Apr-18	There is a risk avoidable harm to patients and detriment to the quality and timeliness of patient care. This is caused by a reduction of bed capacity on the GGH site to balance the risk of the lack of nurse staffing within Trauma wards. This will lead to an impact/affect on patient care and treatment leading to poor A&E performance, poor Welsh Ambulance Services Trust (WAST) performance and response times in the community to emergencies, reduction of elective activity, increased number of patients stranded in A&E, and the ability to manage emergency trauma demand within Carmarthenshire. Risk location, Glangwili General Hospital.	Designated Trauma outlier areas to maintain patient demand and support medical reviews. The Trauma Clinical Nurse Specialist monitors trauma patients ensuring that timely care, treatment plans and discharge are being achieved. Quality Improvement workstreams are in place to support a reduction in demand on front door through WAST transportation rates, admission avoidance, length of stay reduction, prevention of patient deconditioning and provision of ambulatory care. Closely monitoring trauma demand for inpatient care both at A&E and community trauma cases requiring surgery. Escalation to the Triumvirate team is in place. Working with Therapy leads to ensure maximum use of community beds to continue patient care. Close monitoring of elective activity and cancellations due to bed availability through daily bed flow meetings and weekly Operational meeting. Maximising the use of Day Surgery Capacity and day of surgery admission. Weekly reviews of all patients on the working list and deemed medically fit for discharge and escalation of patient delays. Daily monitoring of medical and trauma outliers. Close monitoring of ambulance offload delays and site escalation status. For trauma cases the medical day unit is utilised to support appropriate day of surgery admissions, coordinated by CNS team. Daily trauma senior huddle for escalation of trauma patients	Safety - Patient, Staff or Public	6	4	3	12	Review of current trauma demand on site and management of any increase in activity or challenge on available beds, ensuring timely escalation to the Director of Operations for consideration of maximising use of Health Board trauma beds to maintain services across all sites.	Lewis, Bethan	Completed	Trauma capacity at GGH maintained through provision of beds within surgical wards. Pathways for patients requiring rehabilitation within community beds and frailty at PPH in place.	Operational Quality, Safety and Experience Sub Committee	3	3	9	Tolerate	05-May-22
														Urgent timely review of a long term permanent solution to the reconfiguration of surgical and trauma beds on the GGH site to continue management of the risk identified and support the required provision of trauma beds on site.	Lewis, Bethan	Completed	Review underway and recognition of permanent stage 2 reconfiguration agreed.						
														Identification and implementation of an Elective Surgical Admissions Lounge to support day of surgery admission.	Morgan, Olwen	Completed	Action closed- this action is currently superseded by COVID and bed reduction due to COVID social distancing requirements therefore this is not an option.						
														Contingency plan for surge capacity to be identified on site to support peak demand when the impact is evident on A&E and WAST.	Lewis, Bethan	Completed	Additional trauma beds provided through surgical bed base. Patients requiring rehabilitation are referred to Ceri ward to maintain flow within trauma. Additional surge capacity identified through vacant ward (Dewi ward) and utilised as staffing allows and when peak demand evident to maintain flow.						
														Implementatiion of Stage 2 permanent reconfiguration of surgical wards at GGH.	Morgan, Olwen	Completed	Action closed as not currently relevant due to COVID pandemic.						
														"Team around the patient" pilot scheme to be held on the Teifi ward to support consistent timely rehabilitation for patients.	Evans, Iona	30/09/2022	To be updated at next risk review						

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1309	Directorate Level Risk		USC: Pathology	Perry, Sarah	Jones*, Dylan	01-Mar-11	There is a risk that there is insufficient capacity to meet the demand for cellular pathology clinical diagnostic reporting of tissue biopsies. This is caused by long term unfilled consultant Cellular Pathologist vacancies (4 WTE), as well as aging consultant workforce. This is a national issue. This will lead to an impact/affect on on delays in the turnaround of diagnostic clinical reports for cancer patients and routine tissue biopsies. Potentially delaying treatment eg: surgical procedures and chemo/radio therapy. No MDT's are able to be supported by Consultant Cellular Pathologists, with potential missed opportunities for direct discussion of cases with the Pathologist. Risk location, Health Board wide.	Additional sessions have been job planned into the 2.0 WTE substantive Consultant posts. In Lieu of Locum sessions have been implemented to help reduce waiting times for reporting. The service is committed to the ARCH Regional Pathology project, as the long term solution for Cellular Pathology which will provide a new regional laboratory to house a regional cellular pathology service as part of the outcome. The Strategic Outline Case for the Project has been completed and signed off by Welsh Government to proceed to Outline Business Case stage. Continue to advertise vacant posts and try and secure additional locum cover.	Safety - Patient, Staff or Public	6	4	3	12	Work with SBUHB to establish a joint recruitment strategy for clinical staff	Stiens, Andrea	~~31/03/2022~~ 30/09/2022	Task and Finish group set up to progress this action. April 22, hoping to agree the regional structure which will then allow to recruit.	Operational Quality, Safety and Experience Sub Committee	3	3	9	Treat	01-Jun-22
														Complete Regional Pathology Strategic Outline Case (SOC)	Stiens, Andrea	**Completed**	SOC completed in formally completed in March 2022, thus allowing the OBC to be progressed.						
														Complete Regional Pathology Outline Business Case (OBC)	Stiens, Andrea	19/07/2024	With the SOC now complete, work now commencing on progressing the OBC.						
														Complete Regional Pathology new build	Stiens, Andrea	23/06/2026	This action dependent on other actions being completed as part of overall process.						

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90	Directorate Level Risk	Standard 2.3 Falls Prevention	USC: GGH	Perry, Sarah	Morgan, Olwen	13-Sep-17	There is a risk avoidable harm to patients arising from falls whilst at hospital. This is caused by increasingly frail and complex older people who are at a higher risk of falling being admitted to hospital. The risk of injurious falls is exacerbated by staffing skill mix and ward environment. An inability to discharge patients in a timely manner to an appropriate environment results in deconditioning which in turn increases the risk of falls and injury. The requirement to surge additional beds during times of high demand increases the risk of patient harm including falls. This will lead to an impact/affect on on deterioration and harm to patient health, wellbeing and increased LOS. High levels of falls and injuries results in reputable harm to the site and the Health Board and associated increased redress and claims. Risk location, Glangwili General Hospital.	All areas have undertaken safe staffing reviews in line with safe Staffing Act requirements. Additional staffing for enhanced patient support achieved through risk assessments and escalation to Senior Nurse Managers. Use of E-Roster in conjunction with use of bank and agency escalation for ward staffing levels. Training in Dementia Awareness through e-learning and Dementia Friendly training in place. Introduction of RITA systems across 4 wards at GGH to support patients with cognitive impairment. Nurse Staffing Act Wales and Welsh Levels of Care standards in place, reviewed on a six monthly basis by the Executive Director of NQPE. . Inpatient falls policy (currently under review). Butterfly scheme passport in place. Incidents being recorded on Datix with data now being captured of harm as a consequence of falls. Enhanced/ specialist equipment based on risk assessment e.g. high-low beds. Quality Improvement Team are supporting falls improvement work which includes implementing a safety briefing, use of falling stars on Patient Status at a Glance (PSAG) boards and patient beds and scatter grams. Identification of learning and future improvement work from Level 4 & 5 falls through ASI team investigations. Assurance scrutiny of incidents led by Head of Nursing. Action plans are to be monitored through the GGH Governance meeting. Sharing of lessons learned through the GGH Governance meeting and Sisters' meetings. In the monthly assurance meeting the ward Sisters share the improvements they have instigated following a patient event/incident. Regular Butterfly scheme and Falling Star audits take place as well as a live action plan updated following scrutiny panels. Senior Nurse Managers do complete review and check action plan every 6 months.	Safety - Patient, Staff or Public	6	3	4	12	To review current use of Butterfly scheme and re energise its use across all areas. Embed use of the Falling Star across all areas to clearly identify patients at high risk of falls.	Morgan, Olwen	Completed	Completed- regular audits take place as well as a live action plan updated following scrutiny panels. Ongoing process with monitoring in place.	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	05-May-22
														Development of a Band 4 nursing workforce to compliment and support the registered nurse workforce.	Morgan, Olwen	Completed	There is a national programme to develop the Band 4 roles. Scoping and planning work progressing within the UHB to train and recruit band 4 roles. We are now actively planning to recruit Band 4 roles on targeted wards in the first instance. 08/12/2021 - action closed, please see new action re: Grow Your Own						
														Implement a Carmarthenshire system wide approach including Home First services, discharge to recover and assess, etc. This will reduce the lengths of stay, and therefore reduce the chances of patients deconditioning.	Perry, Sarah	31/03/2023	2 year plan has commenced.						
														Health Board wide approach in place to identify and train nursing workforce, to further mitigate the inability to recruit into the registered nurse vacancies (Grow Your Own).	Morgan, Olwen	30/09/2022	There is a national programme to develop the Band 4 roles. Scoping and planning work progressing within the UHB to train and recruit band 4 roles. We are now actively planning to recruit Band 4 roles on targeted wards in the first instance.						
														"Tram around the patient" scheme to be introduced hospital wide, post pilot at Teifi Ward in order to further manage the falls risk	Evans, Iona	30/09/2022	To be provided at the next risk review						

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1238	Directorate Level Risk	Standard 3.1 Safe and Clinically Effective Care	USC: Respiratory	Willis, Matthew	Davies, Claire	06-Oct-21	There is a risk avoidable detriment to the quality and timely provision of respiratory patient care at BGH. This is caused by the inability to substantively recruit a respiratory consultant. Single practice locum consultant currently in place. Links directly to clinical strategy for Bronglais Hospital to establish clinical services and make recruitment attractive. This will lead to an impact/affect on increased reliance on locums, financial risk, poor sustainability, reduced options to improve models of care and support good decision making, longer waiting times for patients to access care. Risk location, Bronglais General Hospital.	Experienced middle grade doctor acting up as consultant Recruitment to posts is ongoing Human Resources leave and retirement processes followed Consultant Health Board colleagues able to support the service Consultant available on ad-hoc basis to provide annual leave cover for main consultant.	Safety - Patient, Staff or Public	6	3	4	12	Recruit substantively for replacement and additional consultant.	Willis, Matthew	~~04/03/2022~~ 31/03/2023	Recruitment ongoing, both on locum and substantive basis with no suitable candidates. Out to agency with little success. Continuation of several adverts, including in the BMJ. Working with external recruitment agency to establish permanent consultant post.	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	29-Mar-22
														Remove the risk of single practice consultants	Willis, Matthew	03-Sep-22	IMTP includes a plan to invest in consultant posts at Bronglais Hospital to help ongoing recruitment. Existing consultants have been re-job planned, reducing their general medicine commitment (on call) to focus on specialist respiratory service HB wide.						
														Work with recruitment team in W&OD Directorate to make recruitment adverts more attractive.	Davies, Claire	31/08/2022	Discussions ongoing.						
1374	Service or Department Level Risk		Scheduled Care: Critical Care	Hire, Stephanie	Knight, Diane	21-Mar-22	There is a risk of inability to support a sustained roster to maintain safe Consultant Anaesthetic cover of Anaesthetics and Critical Care provision in BGH This is caused by by vacancies across the Consultant cadre in BGH Anaesthetics. There is funding for 11 Consutlant Anaesthetists, (146.5 sessions) with current substantive of group of 8 (90.75 sesisons) + 2 Locum Consultant (23 sessions). There is a short fall of 30.75 sessions, which have been recurrently out to advert. This will lead to an impact/affect on the absence of adequate anaesthetic cover, there are limited options to backfill for emergent leave, which after assuring safe cover for critical care and emergency theatre would lead to cancellation of elective surgery. Risk location, Bronglais General Hospital.	Current staff backfill - Locum x 2, existing staff supporting as additional sessions, and Medical Bank. Staff from other sites picking up occasional shifts. Requests with MEDACs agency to support vacancies. Continue to work with MEDACs in support of temporary backfill whilst working towards sustained recruitment.	Safety - Patient, Staff or Public	6	3	4	12	Vacancies out to advert. Working with Medical Recruitment on options to raise profile of the roles.	Harries, Mr Ken	29/07/2022	SBAR completed and to be discussed with relevant colleagues.	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	21-Apr-22

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1393	Service or Department Level Risk		Therapies and Health Science: Occupational Therapy	Reed, Lance	Sims, Claire	04-Apr-22	There is a risk of not being able to recruit to current vacancies, as well as support the development of our future workforce. This is caused by * insufficient registered workforce applying for vacant posts in Hywel Dda * reliance on current clinical workforce to meet the range of demands for workforce development support worker qualifications, undergraduate practice placements, as well as supporting schemes external to the profession i.e.healthcare apprenticeships and work experience placements. * difficulty supporting sufficient staff to undertake undergraduate and post graduate courses and maintain clinical services due to lack of backfill for study leave * Some vacancies being fixed term (due to funding) which impacts on attractiveness of the post. This will lead to an impact/affect on current service delivery for patients and the development of the future workforce model to deliver the strategic transformational plans of the Health Board. Detrimental impact on service waiting lists due to workforce capacity. Risk location, Health Board wide.	1. Links with Universities and Placement Coordinators to support undergraduate practice placements 2. Service prioritisation of undergraduate training, support worker development and post graduate studies. 3. Working across the service and with Workforce to offer and deliver support worker qualifications to meet requirements of All Wales Support Worker Development Framework 4. Use of social media/professional networks to share vacancies on top of other recruitment methods in Health Board 5. Use of additional hours, overtime, agency and bank staff to sustain workforce capacity to deliver services. 6. Use of workforce policies to encourage recruitment and retention i.e. Annexe 21 development posts, flexible working policy	Workforce/OD	8	3	4	12	Scope issues and agree plan to address insufficient practice placement offers for undergraduate OT students.	Davies, Sharon	30/09/2022	Update to be provided at next risk review	Operational Quality, Safety and Experience Sub Committee	4	2	8	Treat	16-May-22
														Agree plan with L&D to facilitate support staff to access new part time Occupational Therapy Course at Swansea University whilst remaining employed within the Health Board.	Sims, Claire	30/09/2022	Update to be provided at next risk review						
														Work with Workforce colleagues to support further AHP recruitment activity and campaigns.	Sims, Claire	31/03/2023	Update to be provided at next risk review						
														Escalate risk to Directorate level to benefit from cross therapies actions to mitigate risk.	Sims, Claire	31/07/2022	Update to be provided at next risk review						
														Work with workforce to access and learn from exit interviews	Sims, Claire	30/09/2022	Update to be provided at next risk review						
														Review of fixed term posts proactively to ensure retention of staff	Adams, Jon	31/12/2022	Update to be provided at next risk review						
205	Directorate Level Risk		USC: BGH	Willis, Matthew	Davies, Claire	25-Nov-16	There is a risk avoidable harm to patients due to our current nursing vacancies. This is caused by This is caused by insufficient substantive nurses to fill ward templates, potentially leading to inappropriate skill mix. This will lead to an impact/affect on impact/affect patient safety, inability to meet clinical guidelines, Fundamentals of Care and National Critical Care Guidance. Impacts directly on staff morale and sickness due to constant need to monitor and augment staffing levels. Impacts on site flow as nurses are unable to prioritise discharge. Risk location, Bronglais General Hospital.	Increasing potential for Registered bank nurses. Streamlined process to recruit students and newly qualified nurses Local ability to book bank. Partnership nurses in post with contracts for regular agency staff Active recruitment to vacancies	Workforce/OD	8	3	4	12	Develop a workforce strategy.	Davies, Claire	**Completed**	Workforce strategy is in place	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	10-Mar-22
														Improve rostering to reduce unavailability and increase substantive staff on shifts.	Davies, Claire	**Completed**	Bank and pool nurse rotas are all managed on site.						
														Review nursing skill mix/ration to determine ratio in a given area.	Davies, Claire	**Completed**	Skill mix ratio review has been completed which showed that 25% of shifts are covered by a substantive post, the rest by agency or bank.						
														Annexe 2 submission for 13.7 wte RN posts to bring HASU & CMU beds up to the required 1,2 ratio.	Davies, Claire	**Completed**	Funding has been approved within run rate						

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														Wards rostering 3 months in advance to improve workforce planning	Jones, Dawn	Completed	Complete						
														Nursing vacancies to be subject to targeted recruitment	Davies, Hazel	Completed	Bronglais Hospital specific recruitment campaign launched Spring 2018. Nursing open days across the HB are underway to encourage newly qualified nurses to apply for our vacancies. Completed date revised as recruitment and resourcing are currently targeting nursing vacancies which should have a positive impact and is due to be completed by Summer 2019. Further to this, the nurse specific campaign video has now gone live (May 2019)						
														Raise profile of Bronglais General Hospital to attract potential candidates by attending careers fairs, Recruitment events nationally.	Davies, Hazel	Completed	Senior nurses from Bronglais attended a Newly Qualified Nurses event on 14th July 2018. A portfolio of presentations, photos and information about the hospital and surrounding area has been collated to be used at future events. 2 newly qualified nurses were interviewed and appointed on the day for Bronglais General Hospital with a total of 12 new staff nurses due to commence in September 2018.						
														Advertise vacancies in line with the recruitment campaign.	Jones, Dawn	Completed	Vacancies at staff nurse level and senior nurse level are currently live. We have appointed a cardiology ANP who is now in post and similar posts are in progress for oncology and respiratory. Completed date revised as recruitment and resourcing are particularly focusing on nurse recruitment in the coming months which should have a positive impact and due to be completed by Winter 2018.						
														Nurse specific recruitment campaign to be launched.	Jones, Dawn	Completed	Filming to be completed on 18th December 2018. Awaiting launch of recruitment video from AMP						

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														All options explored to reduce the unit cost of agency backfill. BGH team have met with three key nurse agencies and are seeking a strategic partnership to drive down cost, improve cover and therefore improve quality and safety. If successful, this would be a key action to reduce this risk to its target level.	Davies, Hazel	Completed	11/12/2018 met with agencies. Feedback with proposals from agencies due 7/1/2019. Further meeting with agency leaders arranged 16th May 2019						
														"Partnership" formed under the governance of the existing All Wales Framework. Provision of 38 nurses assigned to rosters to stabilise the workforce and with OT/ Bank this delivers close to 100% cover.	Davies, Hazel	Completed	Completed						
														Quarterly meetings or reviews. Agreements in place under MOU. This underpins the nurse staffing need and reduces cost whilst the longer term plan and nurse strategy for education is enacted.	Willis, Matthew	18/08/2022	Regular scrutiny and discussions with the agencies are taking place on an ongoing basis						
														Five year plan to implement Aberystwyth University faculty and Health Sciences School of Nursing by 2022	Willis, Matthew	~~06/10/2022~~ 01/09/2022	Plan agreed and students selected for first cohort in September 2022. Completion date revised accordingly						
														Recruit to vacancies	Jones, Dawn	18/08/2022	Overseas nurses recruited at health board level - 8 for Bronglais Hospital. Due to commence in post April 2022. 1 band 4 for dyfi ward/ Heart failure support appointed and due to start 14th March 2022.						
180	Directorate Level Risk	Standard 3.1 Safe and Clinically Effective Care	Scheduled Care: Ophthalmology	Hire, Stephanie	Buckingham, Carly	05-Nov-15	There is a risk avoidable harm to patients' sight due to Glaucoma and Age related Macular Degeneration (AMD) as a result of patients not receiving timely care. This is caused by capacity not meeting demand currently. The 14-day pathway for AMD appointments currently experiences delays which impacts on patients being seen and treated appropriately. This will lead to an impact/affect on the potential sight of patients and longer term impacts on future lifestyle. Inability to meet Referral to Treatment (RTT) targets. Risk location, Amman Valley Hospital, Cardigan Integrated Care Centre, Glangwili General Hospital, North Road Clinic, Prince Philip Hospital, Withybush General Hospital.	Weekly monitoring of each sites AMD demand and capacity to allow review of resources when demand outweighs capacity. Identification of patients suitable to undergo Community Glaucoma data capture and virtual review by Consultant Ophthalmologists. Clinical validation with established Consultant through waiting list sessions to validate clinical notes and take a decision on the need for treatment. Full Business Case for OpenEyes software (National Electronic Patient Record for Ophthalmology) approved and dedicated Project Manager has been appointed to oversee implementation. ARCH Glucoma workstreams in place. Admin validation taking place.	Safety - Patient, Staff or Public	6	3	4	12	Roll out and implementation of National Electronic Patient Record for Ophthalmology.	Barreiro, Marta	~~30/07/2021~~ ~~07/06/2021~~ ~~31/10/2021~~ ~~31/03/2022~~ ~~31/06/2022~~ 30/09/2022	Update: planned launch for RACE on the 21st of March. Agreed with consultant that AMD will be given priority and be the second or third sub-specialty to go live. Update May: further delays from national team; launch now planned for July 2022.	erational Quality, Safety and Experience Sub Committee	2	4	8	Treat	29-Nov-21
														Root and branch review of operational, workforce and sustainability models.	Buckingham, Carly	~~30/06/2021~~ ~~31/03/2022~~ 31/10/2022	Root and branch review being undertaken through ARCH group which meets regularly on both a regional and sub-specialty basis.						

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														Refurbish and establish a nursing team in the Outpatient Department in Amman Valley Hospital to provide intravitreal treatment for the patients currently attending the day theatre area for their treatment. This will ensure continuity of care for those patients when cataract surgery activity is returned to day theatre.	Sheldon, Amanda	~~31/01/2022~~ ~~31/03/2022~~ 30/04/2022 30/09/2022	Capital bid has been approved, with work to improve physical space at Amman Valley Hospital (AVH) to be completed by March 2022. Update: works are planned to finish by end of March, all on track. Delays are expected in recruitment and equipment. Update May: works finished, some snags to sort out and some equipment delivery pending. Staff recruited and currently undertaking training. IVT in OPD aimed to start on the 5th of July in a phased manner.	Op					
														Undertake clinical trail top explore option of taking patients to primary care setting.	Barreiro, Marta	**Completed**	This is now taking place.						
														Plan for Glaucoma pathways to be implemented through ARCH.	Barreiro, Marta	30/06/2022	Business case has been approved and implementation to now take place. Pathway has been designed and now requires consultant to drive this forward.						
														Recruitment of approx. 7 nursing staff and 2 technicians.	Barreiro, Marta	30/06/2022	Currently going through Trac process for recruitment.						
														Recruitment drive for Glaucoma Consultant.	Barreiro, Marta	30/09/2022	Advertising for 2 Glaucoma Consultant to work across Hywel Dda and Swansea Bay UHB.						
														Remodelling the capacity and demand associated with Wet AMD and Amman Valley.	Barreiro, Marta	31/03/2023	Reviewing pathway, discussing with Finance on costs and reviewing to optimise the service. Currently reviewing patients for suitability, as well as planning to undertake audit on patient pathways.						
														Approve contract with existing Glaucoma Consultant	Barreiro, Marta	**Completed**	Achieved						

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689	Service or Department Level Risk	Standard 3.5 Record Keeping	MD: Effective Clinical Practice	Evans, John	Davies, Lisa	28-Jan-19	There is a risk compromised patient safety. This is caused by improper completion or organisation of medical records and non-conformity to agreed best practices and standards. This will lead to an impact/affect on unnecessary delay, frustration, clinical misadventure and litigation. Risk location, Health Board wide.	Regular audits are being undertaken to monitor standards of record keeping. Concerns highlighted relating to individual and or Team record keeping performance are addressed through signposting to relevant courses based on required record keeping standards. Concerns highlighted relating to individual and or Team record keeping performance are reflected upon at appraisal and evidence of remediation included as part of the appraisal information. Doctors are being reminded of the importance of good record keeping on a regular basis by the Medical Director through email and letter communication. Series of actions being progressed as part of measures reported to ARAC.	Quality/Complaints/Audit	8	3	4	12	Medical Director to increase communications regarding the importance of good record keeping and send regular bimonthly updates with details of relevant courses.	Evans, John	Completed	Letter was sent out on 10th July 2018. Further correspondence to follow and important of good record keeping to be added to MD newsletter.	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	06-Jun-22
														Medical Appraisers to reinforce the importance of good record keeping during appraisal and signpost to relevant courses where applicable.	Williams, Helen	Completed	To be included on agenda for next Appraiser meeting. Confirmed that it is not appropriate to include Record Keeping as part of appraisal.						
														Health Board e-learning module relating to good record keeping is in the process of being developed and will be complete by the end of April 2019.	Davies, Lisa	Completed	Action to be closed as Learning and Development Team have advised on a suite of resources rather than an e-learning module. Work is in progress. The content of the e-learning module will be dependent upon the principles agreed for the Clinical Record Keeping Policy which is in draft. The e-learning module has been revisited on the basis of the draft Policy, and several sections have been updated. Final version is dependent on the approved version of the new policy. Delayed due to redeployment of staff during COVID wave.						
														There is a long-term plan in development, which will commence with an approach to audit 10 sets of notes initially, per specialty and site, and inclusion of the audit on the Clinical Audit Forward Plan, making it mandatory for each specialty to undertake yearly.	Davies, Lisa	Completed	Each site will develop local QI plan for record keeping, based on audits completed. QI Leads will lead, along with Hospital Director and QIST members. QI project will focus on cultural/behavioural change.						
														Quality Improvement (QI) Leads are to be recruited and will be responsible at hospital sites to work with Hospital Directors and clinical leads in order to progress the audit. Associate Specialist doctors in each specialty to take a lead role in achieving the work. The Clinical Director for Clinical Audit will discuss with the QI leads and disseminate from there down to each specialty lead.	Davies, Lisa	Completed	QI Lead in WGH taking forward work on that site and lessons learned to be rolled out across all sites, using the QI Leads network.						

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														Review of Clinical Record Keeping Policy to clearly identify record keeping standards and explore potential development of single Health Board wide Record Keeping Policy.	Davies, Lisa	~~31/12/2020~~ 30/06/2022	Steering Group has been convened with representation from medical/surgical, nursing, therapies, health sciences, pharmacy, legal, complains, informatics, medical records, coding. Meetings held on 24/11/20, 24/02/21, 26/05/21 and 22/09/2021. Terms of reference agreed and mapping existing record keeping standards completed. Sub-Group established to review common set of standards, and content of the record. Document circulated for comment. Policy in draft and T&F Group meeting in April 22 to develop into version for consultation. Progress has been impacted by lack of capacity within the department and deployment of staff to frontline.						
														Re-audit of WGH and quality improvement plan to address findings. To be rolled out across all sites using QI Leads Network.	Davies, Lisa	**Completed**	WGH re-audit has taken place, results being analysed and findings will inform QI plan. Meeting on 9.12.2020 to discuss roll-out of the approach to BGH, GGH and PPH.						
														Each site to develop local QI plan for record keeping, based on audits completed. QI Leads will lead, along with Hospital Director and QIST members. QI project will focus on cultural/behavioural change. Progress to be provided to ARAC in 9-12 months.	Davies, Lisa	~~19/10/2021~~ 30/06/2022	Re-audits in completed on BGH, GGH and PPH, following the approach developed in WGH, and under leadership of the QI Leads. Outcomes to inform local QI projects. Timescales are impacted by COVID and different approaches may need to be progressed as prospective ward based audits are challenging. Clinical Audit Team are supporting. Meeting with QI Leads taking place on 8/11/21 To be supported by securing dedicated capacity to take this work forward however this has been delayed due to re-deployment of this capacity during recent further wave of COVID.						
														Develop a suite of resources for education and awareness raising on the Health Board's standards for Clinical Record Keeping.	Davies, Lisa	30/12/2022	New action - progress to be reported at next update.						

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1368	Service or Department Level Risk		MHLD: Learning Disability Services	Carroll, Mrs Liz	Evans, Melanie	16-Jun-21	There is a risk of avoidable harm to patients who have a learning disability with Epilepsy, who are at increased clinical risk due to the complex co-morbidities. This is caused by the resignation of a Consultant Psychiatrist with a specialist interest in Epilepsy who manages this caseload, and the inability to recruit to this or other vacant neurology posts in Hywel Dda University Health Board. This will lead to an impact/affect on the physical health of this patient group who are at risk of clinical deterioration due to: odelayed diagnosis omonitoring of medication regimes ospecialist advice and assessment olack of continuity of care oPoorer clinical outcomes •reduced quality of care, •patient dissatisfaction •increased hospital admissions for emergency management and control of seizures. Risk location, Health Board wide.	All patients on this caseload are monitored (minimum yearly update of risk assessment and profile) by nurses working in the Learning Disability Service with access to a Consultant Psychiatrist for basic advice on management of Epilepsy and preventative medication. Patients and carers have been made aware of the resignation of the Specialist Consultant and know that they can contact the LD teams with any concerns. There is an active VNS (Vagus Nerve Stimulation) clinic for those patients with a VNS device in situ. LD service and Neurology department to continue to communicate to review risks and prioritise patients on the caseload Link with Communications Team to ensure consistency of information in responding to complaints The Learning Disability Health Action Team (HAT) monitor all hospital admissions of people with a learning disability and presenting with Epilepsy to identify any trends LD Senior Nurse monitors all deaths of People with a Learning Disability and open to CTLD, to identify if SUDEP was a cause of death or if Epilepsy was a contributory factor	Safety - Patient, Staff or Public	6	3	4	12	The LD service and Chronic Condition Management Team have created a Specialist Epilepsy Nurse role with a specialist interest in LD. This post was successfully recruited to and the nurse commenced in post in January 2022 .	Evans, Melanie	Completed	Additional joint reviews of cases are being undertaken by this nurse and a Consultant LD Psychiatrist through late March and April 2022.	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	07-Jun-22
														Review the current Epilepsy Pathway outlined in Policy 850 Adults with a Learning Disability and Epilepsy Guideline, to strengthen the nurse led element of the pathway.	O'Connor, Eleanor	31/08/2022	An Epilepsy Pathway has been agreed and signed off by Written Control Group in 2020. A review of pathways across wales has been completed and closer working with Swansea Bay has lead to us reviewing our current pathway against theirs, so we can align joint working going forwards. Draft review document presented to Epilepsy Working Group and once approved will be tabled for discussion at MH&LD Written Control Group.						
														An independent review of the Epilepsy service for people with a Learning Disability has been commissioned which will be led by Dr Shankhar, Clinical Director for LD external to the HB.	Carruthers, Andrew	30/09/2022	Meetings with Dr Shankhar have been held to confirm the scope of the review. Joint paper presented to Quality & Safety Experience Committee on 12th April 2022 in collaboration with Scheduled Care colleagues.						
														Following departure of substantive consultant, the role of the specialist epilepsy nurse is being reviewed to ensure appropriate supervision and line management arrangements.	Evans, Melanie	07-May-22	New action.						

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233	Directorate Level Risk		USC: Stroke	Jones, Keith	Andrews, Bethan	28-Oct-14	There is a risk poorer outcomes and increased mortality for stroke patients. This is caused by insufficient nursing staff to patient ratio. Insufficient stroke therapy staff and lack of 7 day consultant cover. This will lead to an impact/affect on delayed assessments and treatments of patients. Increased length of stay due to insufficient therapy treatment. Failure to meet National Stroke Standards. Non compliance of Tier 1 targets, Stroke performance. Evidence, Delays in admission to Stroke unit. Untimely care. Mortality reviews. Risk location, Health Board wide.	Compliance with agreed levels of treatment/therapy monitored annually via Royal College of Physician audit and monthly via Quality Improvement Meetings (QIMs) with appropriate action taken as follows. Active recruitment for all vacancies. Allied Health Professional leads allocate staff to ensure staffing is as equitable and safe as possible. Weekly stroke review meetings to monitor progress against national stroke targets. Monthly Health Board stroke committee meetings. Nurse staffing levels were presented to QSEC 07/12/2021, whereby QSEC took an assurance that the nurse staffing levels that are in place for the current HB model have undertaken a robust challenge and scrutiny process. These have been agreed by the 'Designated Person' as professionally appropriate, whilst recognising that the nurse staffing levels within the HB are not in line with the national standards when bed numbers alone provide the criteria upon which nurse staffing levels are set.	Quality/Complaints/Audit	8	3	4	12	Nurse Staffing Programme Lead is currently reviewing Nurse staffing levels and deficits and also the Clinical Director of Therapies is reviewing the Therapist staffing levels as identified against national stroke standards.	Andrews, Bethan	~~30/04/2018~~ ~~01/10/2021~~ ~~31/03/2022~~ 31/06/2022	Nurse staffing levels and deficits review has been completed. Therapist staffing levels still being reviewed as at April 2022.	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	25-Apr-22
														Stroke delivery reviewed by QSEAC and the Health Board Stroke Steering Group and investment priorities identified.	Mansfield, Simon	**Completed**	Tier 1 target for classification of stroke consultant changed, therefore compliance is likely to improve from August 2017.						
														Develop a Hyperacute stroke unit in conjunction with SBUHB as part of the ARCH programme.	Andrews, Bethan	~~01/04/2018~~ ~~01/11/2021~~ ~~31/03/2022~~ 30/06/2022	Swansea Bay UHB have informed UHB that they are unable to support Hywel Dda patients in their initial HASU plans due to their own pressures. Exec leads continue to communicate with Swansea Bay for potential joint working.						
														Service Delivery Manager will work with Clinical Stroke Leads and Executive Director Of Therapies & Health Science to complete the redesign work for the HB.	Andrews, Bethan	~~31/12/2021~~ 31/03/2024	The redesign work was put on pause during COVID, and the stroke team are anxious to re start the work. In view of this, workforce sustainability concerns and the inability to make major changes to WGH flows until the new hospital is built, and BGH due to geography, a decision has been made to focus on Carmarthenshire stroke services at the first stage. Discussions to start taking place in May 2022. The UHB Chair is supportive of this work.						

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835	Service or Department Level Risk	Standard 3.3 Quality Improvement, Research and Innovation	USC: Pathology	Perry, Sarah	Jones*, Dylan	01-Jan-20	There is a risk of loss of reputation, increased scrutiny by Welsh Government, increased likelihood of an Medicines and Healthcare products Regulatory Agency (MHRA) inspection of Blood Transfusion services due to the voluntary withdrawal of two sites from the independent United Kingdom Accreditation Service (UKAS) assessment process against International Organization for Standardization (ISO) 15189 quality standards. This is caused by the lack of resilience within Blood Science services in GGH and BGH and to some extent lower levels of staff engagement with the Pathology Quality management system and UKAS accreditation process to meet ISO 15189 standards. This will lead to an impact/affect on the perception of a poorer quality service to our users and the potential for loss of income. Risk location, Bronglais General Hospital, Glangwili General Hospital.	Action plans have been developed following the last UKAS inspection of all four Blood Science sites. Executive Led Pathology Control Group has been established to monitor progress. Temporary locum BMS staff member is in post to release a staff member in GGH to focus on quality management actions especially within Blood transfusion.	Statutory duty/inspections	8	4	3	12	Actions identified following the UKAS assessment in relation to the BGH site to be evidenced and closed as completed.	Markham, John	Completed	Action plan is being monitored by Pathology Quality manager and via the Executive led pathology Control Group.	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	01-Jun-22
														Actions identified following the UKAS assessment process at GGH to be evidenced and completed.	Richards, Catrina	Completed	Progress against action plan is being monitored by Pathology Quality manager and Executive led Pathology Control group						
														Pathology Quality Manager to undertake a review of outstanding non conformances for BGH Pathology.	Albery, Hannah	Completed	Review of outstanding non conformances undertaken, action plan to be completed. New action raised re: Action plan.						
														Pathology Quality Manager to undertake a review of outstanding work in Blood Sciences GGH.	Albery, Hannah	Completed	Review has been undertaken, action plan to be undertaken. New action raised.						
														Action plan from the review undertaken in January 2022 to be completed at BGH	Albery, Hannah	30/06/2022	As at May 2022, work is ongoing and action plan not yet complete. Action plans are being monitored at monthly quality management meetings, and reviewed by the quality manager fortnightly.						
														Action plan from the review undertaken in January 2022 to be completed at GGH	Albery, Hannah	30/06/2022	As at May 2022, work is ongoing and action plan not yet complete. Action plans are being monitored at monthly quality management meetings, and reviewed by the quality manager fortnightly.						
														Consideration to be given to apply for re-accreditation with UKAS in Autumn 2022.	Albery, Hannah	31/10/2022	Ongoing						

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1003	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	Ceredigion	Skitt, Peter	Skitt, Peter	19-Oct-20	There is a risk community nursing services in Ceredigion being increasingly required to absorb additional work that may have been carried out in Primary or Acute services, or had not previously been identified, impacting on the provision of safe and effective care to patients on district nursing caseloads. This is caused by existing and continued pressures within the system have forced some Primary care contractors to review the work they undertake and to give back services that do not fall under their required GMS contract. This, together with acute services reducing their services due to COVID has put increasing pressure on the community nursing teams to pick up this work, e.g. non house bound patients. These services are required to be provided without any additional funding or resources. This will lead to an impact/affect on the quality and safety of patient care being delivered; reduced capacity of teams to respond to patient care in timely manner; increased numbers of missed or cancelled visits; increased number of avoidable admissions due to lack of capacity; increased number of emergency/OOH contacts and patient complaints. Reduced staff well being; increased sickness levels and increased pressure on services, reduced retention and recruitment of staff. Risk location, Ceredigion.	3 County Community DN Service Specification developed to outline service provision and patient criteria to ensure standardised and consistent service provision across the health board. A 3 County HDdUHB Community Nursing Escalation Policy has been developed for community nursing teams. Regular reviews of caseloads are undertaken by team leaders. Clinical pathways implemented to support staff managing complex patients. Regular meetings are held operationally and professionally to support staff and identify areas of concern for escalation to County Management Team (CMT). County Heads of Nursing are participating in DN Staffing Principles and Safe Staffing work streams. Escalation of concerns raised through Operational QSEAC	Safety - Patient, Staff or Public	6	4	3	12	Identify relevant stakeholders to work with County teams to scope the demand, cost and resource pressures related to additional service provision being requested.	Evans, Tracey -	Completed	3 County Heads of Nursing meeting planned to identify support mechanisms required to address actions.	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	16-May-22
														Formally add to 3 County Operational Group (COG) agenda as standing item to ensure regular scrutiny of requests of community nursing services to absorb additional working pressures.	Evans, Tracey -	Completed	3 County COG meetings in place						
														Formally add to 3 County Operational Group (COG) Escalation of concerns relating to further services being transferred to community nursing services in Ceredigion to be submitted to Operational QSEAC	Evans, Tracey -	Completed	Risks to be reviewed and additional actions added following a 3 county discussion. The Director for Primary Care has requested a SBAR to be taken through the Execs.						
														SBAR has been presented to Operational QSEAC	Evans, Tracey -	Completed	Awaiting feedback relating to SBAR						
														Guidance to be issued from Operational QSEAC	Evans, Tracey -	Completed	SBAR has been presented to Operational QSEAC						
														Seek guidance from Operational QSEAC	Skitt, Peter	Completed	Ceredigion County Director to communicate with the Director of Primary, Community and Long term Care						
														SBAR to be presented at 3 County Bronze Meeting	Evans, Tracey -	Completed	Revised SBAR approved by Heads of Nursing at County level						
														County Director to ensure that the SBAR is appropriately escalated	Skitt, Peter	Completed	Communications to ensure that Operational Touchpoint has the SBAR on agenda have commenced						

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														County Director to write to Director of Primary Care, Community and Long Term Care and to Director of Carmarthenshire County to obtain status of SBAR	Skitt, Peter	31/01/2022	Ceredigion County Director has communicated on the issue twice, but is yet to receive the status. County Director to escalate to Director of Nursing, Quality and Patient Experience							
														Clinical Nurse Leads to work alongside workforce to develop a plan for targeted recruitment, skill mix review etc.	Evans, Tracey -	31/07/2022	Communications have commenced						
1315	Service or Department Level Risk	Standard 3.1 Safe and Clinically Effective Care	Cancer Services	Humphrey, Lisa	Bennett, Debra	10-Dec-21	There is a risk that Hywel Dda UHB will not be able to deliver systemic anti-cancer treatment (SACT) to cancer patients in a timely or safe manner. This is caused by difficulties in recruitment and retainment of registered nurses who have the relevant (SACT)competencies to administer treatment. Difficulties in recruitment and retainment of non-medical prescribers (Clinical Nurse Specialists and Pharmacists) who have the relevant experience, education and competencies to assess, review and prescribe. No headroom built into the Non-medical oncology team across the UHB, or the SACT nursing team at WGH and GGH. COVID pressures: staff having to isolate/not work in SACT role if a contact of COVID positive individual. Annual expected increase of 10-15% (nationally) of SACT activity adding further risk in the future. No dedicated clinical educator in UHB support to maintain specialist skills that maintain SACT competencies for staff. This will lead to an impact/affect on systemic anti-cancer treatment may have to be delayed, interrupted or suspended due to lack of SACT competent registered nurses. Safety of the management of patients on SACT, and or timely review of patients on SACT due to fragility of the non-medical oncology team. Risk location, Health Board wide.	Headroom is in place in SACT Teams at BGH and PPH. SACT units cross cover where possible where workforce gaps exist on given days. Extra hours are paid (cost pressure) to staff to cover workforce gaps that would compromise patient safe and or timely treatment. SACT training and yearly competency review is supported inhouse and through external educational opportunities (other health boards and universities).	Safety - Patient, Staff or Public	6	3	4	12	Establishment in all SACT units to be uplifted to include headroom at 26.9%.	Beard, Gina	12-Sep-22	Headroom included in last IMTP (2018) for PPH and BGH units and recruited.	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	07-Apr-22
														Apply to Charitable Funds Committee for the support of a Clinical Educator pilot scheme to support in-house SACT competency maintenance.	Beard, Gina	12-Sep-22	Job Description for Clinical Educator post at Swansea Bay under review.						

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114	Directorate Level Risk	Standard 3.1 Safe and Clinically Effective Care	USC: Radiology	Perry, Sarah	Roberts-Davies, Gail	01-Jan-16	There is a risk delay in diagnosis, not achieving 8 week diagnostic waits, increased inpatient Length of Stay (LOS) and inability to achieve cancer pathway targets. This is caused by increased demand for CT, MRI, Ultrasound and nuclear medicine which exceeds current capacity and staffing to deliver. Establishment of radiology staff and radiologists have not increased with demand. Inability to recruit to vacancies in both disciplines. This position has worsened with the pandemic and reduced cap[acity due to infection control issues This will lead to an impact/affect on delayed access to all imaging resulting in Negative impact on patient health and treatment plans. Increased stress and pressure for radiology staff. Risk location, Health Board wide.	Monthly monitoring of activity, demand. Patients / staff moved to available capacity . Weekly review of all patients on Cancer Pathway. Prioritisation of referrals based on clinical risk and discharge dependant investigations. Regular monitoring of waits. Staff working additional hours to meet demand.	Safety - Patient, Staff or Public	6	4	3	12	The role of reporting radiographers has been increased.	Evans, Amanda (Inactive User)	Completed	Eight trained reporting radiographers in post. No increase this year.	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	10-Feb-22
														Use of overtime and external reporting as required to meet demand. SBAR completed for 7 day working. On going SBAR - awaiting response.	Evans, Amanda (Inactive User)	Completed	Costs identified for working week extension to 7 days not yet funded. Welsh Audit Office review of HDUHB radiology service completed July 16. Report published June 2017, indicates that radiographers and radiologists are more productive than the welsh average Preview copy highlights: Manpower and Demand as risks. Management response is being formulated. Currently reviewing templates and cross site working to improve efficiency.						
														Working with the Programme Management office on a demand optimisation project to reduce the amount of inappropriate requests.	Evans, Amanda (Inactive User)	Completed	Process is in place and constantly monitored.						
														Workforce and on call review to ensure right people, right place, right time.	Roberts-Davies, Gail	~~30/12/2019~~ ~~30/08/2020~~ ~~31/10/2020~~ 31/10/2021	Following initial analysis it has been decided to undertake a full workforce and service review which is underway to understand the correct levels and disciplines required to deliver the service. This is being undertaken with Programme Management Office support including HR, W&OD and Medical Recruitment. Delayed due to COVID. Progress update provided to ARAC in February 2021, and a further update has been requested for August 2021.						
														Undertake a capacity and demand review (31/03/22)	Perry, Sarah	31/03/2022	Currently exploring scope through discussions with Royal Society and other Health Boards.						

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1160	Directorate Level Risk	Standard 3.3 Quality Improvement, Research and Innovation	MD: Research and Development	Rice, Dr Sam	Williams, Caroline	07-Aug-18	There is a risk of a decreasing research portfolio, both in amount as well as diversity. This is caused by a lack of research leadership across the UHB (staff able to act as Principal Investigators). This will lead to an impact/affect on our ability to meet the revised KPIs set by Health and Care Research Wales (HCRW), as well as the HDUHB planning objectives. Risk location, Health Board wide.	The situation is monitored at a monthly Research & Development (R&D) Senior Leadership Team meeting. The delivery teams on each acute site identify potential studies based on the existing PIs. Three 'research leaders' have been appointed for 1 session/week to stimulate the research culture	Workforce/OD	6	4	3	12	Clinical Director will engage with the executive medical director to influence the case for protected research time for PIs. eg. Offer of research time to current senior clinicians to augment capacity. eg. Promote use of SPA time for research.	Rice, Dr Sam	Completed	Clinical Director will prepare an outline plan in preparation for meeting on 20/09/2021 30/9/21 - Clinical Director has developed a framework for actions in preparation for the meeting which has been rearranged for 4/11/21 4/11/21 - actions being implemented	Research & Development Sub Committee	2	3	6	Treat	14-Apr-22
														Clinical director will engage with speciality leads to encourage them to add a section to their meeting to discuss R&I (as well as audit and QI)	Rice, Dr Sam	01/10/2021 14/01/2022	30/9/2021 - Clinical Director has started to engage with speciality leads and has attended a variety of meetings 14/01/2022 - A competitive process has been concluded that has led to the appointment of three new clinical leads for research (Oncology, Women's Health, and the GGH site). The arrangements will be tested over the next 6 months before deciding whether to extend to other sites and specialities						
														Increase University posts and regionalised working. eg Increase honorary or formal Senior Lecturer and chair posts. eg Follow clinical work streams e.g. oncology	Kloer, Dr Philip	~~01/11/2021~~ 14/01/2022	Research leaders being appointed mid-November. Individual assessment after that for potential for honorary posts 14.01.2022 Developments include: - A planned regional ophthalmology post will have dedicated sessions for research within Hywel Dda UHB; - A colorectal cancer surgeon has two sessions protected for research initially supported by a grant (Moondance Cancer Initiative), but with Health Board commitment to continue to support if successful; and - A research midwife with three days for developing the midwifery research portfolio, funded by R&D.						

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														The Board must help drive the R&I agenda as set out in new strategy	Kiser, Dr Philip	Completed	Meeting has been arranged for 20/09/2021 between PK, LP, SR & CW to discuss the proposed plan. 30/9/21 - Meeting unable to take place. Has been rearranged for 4th Nov. Paper going to the public board meeting on 30/9/21 to update on strategy. This risk is recorded in that report.						
														Clinicians on all sites have been invited to put in expressions of interest in new leadership roles for 1 session per week	Rice, Dr Sam	Completed	7/11/2021 - 8 applications received to date. Interviews arranged for 15th November 15/11/2021 - 3 Research Leads appointed. Meetings to be arranged with Dr Sam Rice						
1152	Directorate Level Risk		USC: Pathology	Perry, Sarah	Jones*, Dylan	08-Jun-21	There is a risk of not being able to maintain normal levels of service within the Mortuary Glangwili Hospital and Body Store Prince Philip Hospital. This is caused by 5 WTE staff absent due to retirement, resignation, sickness absence and maternity leave. This will lead to an impact/affect on the ability to perform adult postmortem examinations (Coronial/Consented) and provide adequate cover to the body stores at Glangwili and Prince Philip Hospital. This could also impact on HTA standards compliance requirements. Risk location, Glangwili General Hospital, Prince Philip Hospital.	Locum Anatomical Pathology Technician (APT) in place until end of September 2021. Mortuary Contingency Plan. Short term secondment for 8 weeks to support staffing levels, with the option to extend the length of time.	Service/Business interruption/disruption	6	4	3	12	Manage staff as per NHS Wales Managing Attendance at Work policy.	Stiens, Andrea	Completed	Progress to be added at next review. 2 of the 4 staff have now returned to work on a phased return, and the others continue to be managed as per policy	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	01-Jun-22
														Escalation of the risk to the Executives via an SBAR to Acute Bronze.	Stiens, Andrea	Completed	SBAR submitted to Bronze Acute and noted.						
														Temporary secondment of staff member from Finance.	Stiens, Andrea	Completed	Finance staff member covered the service over the summer when needed, and now has returned.						
														Temporary transfer of post mortem services to Swansea Bay University Health Board over a two week period to cover APT staff annual leave.	Stiens, Andrea	Completed	Cover was provided over the summer, and action therefore complete.						
														Vacancy created on Tempre system for a second locum Anatomical Pathology Technician (APT).	Stiens, Andrea	Completed	Second locum appointed as at May 2022 to support service while substantive APT on Maternity Leave (due to return July 2022).						
														Appoint 2x trainee APT (B4) to develop staffing resilience long term. (time scales August 22)	Jones*, Dylan	31/08/2022	To be provided at next risk review						

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200	Directorate Level Risk	Standard 3.1 Safe and Clinically Effective Care	USC: BGH	Willis, Matthew	Davies, Claire	11-Jun-15	There is a risk avoidable harm and reduced quality of patient care across the BGH site. This is caused by fragility of medical middle grade & junior posts. Funding for 11 middle grades with 7 currently in post, and vacancies on the junior rota. This will lead to an impact/affect on delays in patient discharge and poor quality, consistency and timeliness of patient care, lack of senior decision making. Reduced support to junior doctors. Risk to out of hours rota. Potential poor feedback from Deanery. Risk location, Bronglais General Hospital.	Vacancies continually advertised. zero hours NHS locums covering vacancies when available.	Quality/Complaints/Audit	8	4	3	12	Identify gaps in current on call rota far in advance to allow the rota coordinator to fill shifts in a timely manner.	Davies, Hazel	Completed	Regular meetings with medical staffing. Vacant shifts are identified four weeks in advance and discussed with the rota co-ordinator and our established medics. Escalation procedure in place if unable to fill vacant shifts.	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	29-Mar-22
														Currently filling shifts with long term internal locum staff.	Davies, Hazel	Completed	Engagement with clinical leads, ongoing recruitment.						
														Filling out of hours requirements with agency only when all other options exhausted.	Davies, Hazel	Completed	Agency staff are requested only when internal cover cannot be found.						
														Focussed attention on clinical fellow posts (which has improved the position) to enable access to training/development and improved working experience.	Davies, Hazel	Completed	A review of the clinical fellow job description has been completed to make it as attractive as possible.						
														Trial new discharge pathways to facilitate discharge and reduce pressure on junior doctors.	Davies, Hazel	Completed	Implemented Red to Green discharge pathway in July 2017.						
														Launch a new recruitment campaign in conjuction with medical recruitment and resourcing.	Davies, Hazel	Completed	The recruitment video launched the first week of March 2018 and has currently been viewed over 39000 times. Recruitment service pages for each service have also been produced for a dedicated webpage.						
														Recruit to the current vacancies at staff middle grade level (specialty doctor).	Willis, Matthew	~~02/07/2018~~ 31/10/2022	Recruitment has been more successful after liaising with an agency and 1 middle grade for diabetes is now in post, with another two onboarding. Completion date revised .						

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														Recruit to deanery vacancies to reduce need for zero hours locum doctors and additional locum shifts	Davies, Claire	Completed	Current junior vacancies stand at 4 clinical fellows (emergency medicine) and 1 F2 (medicine). Vacant shifts are being filled by zero hours locums (NHS contract) and internally. Appointed 4 clinical fellows (on boarding). Received news that we will have 15 deanery vacancies in August 2019 - F2 LAS post advertised (137 applicants) and interviews will be held 22nd May 2019.						
														Recruit to deanery vacancies August 2019	Davies, Hazel	Completed	We have successfully recruited to most of our vacancies, but due to visa issues 5 were not able to start in time for changeover. F2 LAS vacancy has been re-advertised						
														Backfill vacancies on junior rota	Davies, Hazel	Completed	We are currently using zero hours NHS locum doctors to backfill our vacancies at F2 and clinical fellow level until recruitment is successful. Although this is increasing our cost pressure, the experience of the zero hours doctors (the majority of whom are returning doctors) provides much needed support for our training doctors and ensures a smooth and safe service. Zero hours doctors are also used to backfill vacancies on the on call rota.						
														Recruit to junior vacancies	Willis, Matthew	~~05/08/2020~~ 31/10/2022	Our junior vacancies are being continuously advertised, with many applicants withdrawing this has not improved. Our zero hour NHS locum contracts are currently filling our vacancies, but this is unsustainable in the long term and leaves a high financial burden. Completion date revised						

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940	Directorate Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	Public Health: Children's Public Health	Lewis, Bethan	Hill, Lesley	14-May-20	There is a risk of increased poor health and wellbeing outcomes and increased high level safeguarding concerns of children and families in the Health Visiting Service. This is caused by by high staff vacancies and the inability to recruit into health visiting vacancies, compounded by long term sickness and maternity leave. We have a 34% deficit in staffing for the 3 counties (46% deficit in Ceredigion. As a result for the following Health Child Wales Programme (HCWP) core contacts are not being fully met. Ante-natal (28 week targeted for Generic and 24 week for universal Flying Start) 8 - 16 week Review (Clinic contact) 6 months 15 months 27 months 3.5 years This will lead to an impact/affect on missed opportunities for the identification of developmental delay and delays in appropriate referrals, adverse childhood experiences (ACES), family resilience and maternal mental ill-health, poorer health outcomes for children, reduced immunisation uptake and indicators or suspicion of abuse or neglect. Staff wellbeing with staff suffering stress, anxiety and reduced resilience resulting increased absence, the reduced capacity to host pre-reg students, specialist community public health nurses (SCPHN)students in health visiting, new members of staff, impact on recruitment and retention Risk location, Health Board wide.	Weekly meeting (Ceredigion and Pembrokeshire, monthly meetings (Carmarthenshire) with Management Team and Team Leaders to update action log and review risks. Identification of all Safeguarding Cases including children on Child Protection Register (CPR), Care and Support Plan (CASPS), and Looked after Children (LAC) All Safeguarding children have a named Health Visitor. Team Leaders cover and provide caseload support as needed Health Visitors prioritise all new births and follow ups and all children under enhanced and intensive intervention to include Safeguarding, LAC and CASPS and all movements in. Completion of holistic assessment by the Health Visitor in the first 6 weeks following birth. Health Visitors to complete or update FRAIT (Family Resilience Assessment Instrument Tool) on all families seen. Communication with Midwifery Team, identifying SIP 1 and 2 (Sharing Information in Pregnancy). 6 months universal core contact to be prioritised and delegated to RGNs where available with a delegation and competency framework. Risk Assessment Letters to be sent to all 6 months, 15 months, 27 months and 3.5 years Universal Core Contact where contact with Health Visiting Team is not available. Health Visitors to delegate to Assistant Practitioners time specific interventions with families and children under 1 years of age. Team Leaders to collate acuity and HCWP data monthly. Appointed 7 wte Health Visitors to commence October 22. Ongoing support from Workforce colleagues and rolling programme of recruitment campaign. Executive Board alerted to the Risk via QSEC 19th April and invited to attend for update in June 22. Continue utilisation of bank staff within areas of the greatest staff deficit. Support existing staff where possible and retain through regular supervision and open access to management. Implementation of 'Grow your Own model' through recruitment and training of additional RGNs.	Safety - Patient, Staff or Public	6	4	3	12	To develop an annual recruitment plan for Band 5 development roles targeting Ceredigion and Pembrokeshire due to Health Visitors shortages in line with workforce plan.	Hill, Lesley	Completed	SBAR Completed for skill mix and grow your own model to address long term recruitment challenges. Signed off by Director of Nursing. 08/09/2021 Successful recruitment campaign for SCPHN students which means a number of qualified Health Visitors available in 2022 in line with the workforce plan. Health visiting response Team in Carmarthen is assisting the Ceredigion HV team to catch up on backlog of home assessments and additional clinics. Presented to Regional Safeguarding Board, Multiagency Meeting, QESAC,CYSUR - highlighting the risks to children in Ceredigion.	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	23-May-22
														Increase the number of SCPHN student for October 2022 cohort.	Hill, Lesley	Completed	Completed						
														All health visitors working towards completing PA & PS training in line with new NMC educational standards for SCPHN workforce.	Hill, Lesley	Completed	process in place to ensure this achieved. Training booked for October to mop up outstanding staff. Training to date completed.						
														Liaison with University to implement new model for SCPHN training to commence October 2020.	Hill, Lesley	Completed	Completed.						
														Newly qualified Health Visitors appointed into vacant post, will commence 5th October 2020.	Hill, Lesley	Completed	Completed.						
														To review current service provision and risks identified against Healthy Child Wales Programme and schedule for all three counties and identification of detailed risks	Wilson, Liz	~~20/06/2022~~ 23/05/2022	Work underway and when complete will result in the closure of this risk						
														Continue to advertise all Health Visiting vacancies until appointed	Wilson, Liz	20/03/2023	Team Leaders to notify TRAC to re-advertise when vacancies are unfilled.						

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														Expansion of additional clinics in Ceredigion and Pembrokeshire	Wilson, Liz	30/06/2022	Venues to hold additional clinics to be confirmed						
														Band 5 RGN posts to be advertised prior to existing band 5 commencement on SCPHN HV course	Wilson, Liz	31/05/2022	Preceptorship of skill mix team to be supported by an intensive preceptorship and competency programme led by Professional Development Health Visitor and new RGN to shadow existing RGNs.						
														Review the use of bank staff in line with staffing caseload ratios.	Wilson, Liz	30/06/2022	mobilise existing staff to deliver the HCWP within their county						
														Introduce electronic records throughout the Health Visiting Service on a phased programme.	Wilson, Liz	31/05/2023	To prioritise areas with the highest staffing deficit.						
														Corporate Caseloads to be implemented in areas of significant staffing deficit.	Wilson, Liz	30/06/2022	Draft Standard Operational Procedure out for consultation to be signed off in the next Public Health & Wellbeing Directorate Quality, Safety and Patience Experience Group.						
														Identify funding to increase Team Leaders Posts and additional Safeguarding Specialist Post	Wilson, Liz	30/09/2022	Identified in the IMPTP						

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834	Service or Department Level Risk	Standard 3.1 Safe and Clinically Effective Care	USC: Pathology	Perry, Sarah	Jones*, Dylan	06-Feb-20	There is a risk of avoidable clinical deterioration of patients including cancer patients waiting for diagnosis and treatment. This is caused by vacancies within the small Consultant Haematologist teams covering GGH and PPH and reliance on expensive high cost agency locums. Reliance on staff who have retired and returned to cover BGH. Consultants working single handed and finding it difficult to take annual and study leave. This will lead to an impact/affect on patients having poorer outcomes from the delays in commencement of treatment, reliance on locums, increased complaints and claims and increased scrutiny from Welsh Government. Also the impact on the health and wellbeing of the remaining Consultant staff. Risk location, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital.	Full time above price cap agency locum supporting GGH service. Off framework agency locum supporting PPH one day per week. Clinical Nurse Specialists in Haematology support the caseload within their scope of competency. Actively working with medical staffing to recruit into vacant posts.	Safety - Patient, Staff or Public	6	3	4	12	Recruit to the 1.0 WTE vacant post based at GGH	Stiens, Andrea	29/06/2020 30/06/2022	Unable to recruit position, rotational advert in place. Locum currently in place.	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	01-Jun-22
														Secure charitable fund resource to purchase MGUS DAWN software package to enable CNS staff to manage / monitor MGUS patients, which will help support the Consultant caseload.	Stiens, Andrea	**Completed**	There is a significant amount of Charitable Funds within the Haematology fund to support the purchase but not the on going revenue element. 09/02/2022 - Approval received in 2020 for Charitable funds, however waiting on further costings on IT support requirements. Potential delay with the project in obtaining an interface as HDdUHB is the only HB in Wales requiring this. Action to be closed, with new action to be raised for a potential new project.						
														Complete SBAR to identify the benefits of a revenue investment in relation to procurement of MGUS DAWN software.	Stiens, Andrea	**Completed**	Total revenue required for the project is being collated. Presented to Charitable Funds Committee, action closed.						
														Review service provision post Covid to identify if any service changes introduced during the pandemic can be continued e.g. virtual/telephone consultations/ clinics.	Stiens, Andrea	**Completed**	Discussed in haematology management Meeting, and escalated to relevant management.						
														Application to Charitable funds to seek support for Clinical Haematology nurse specialist post at BGH as succession planning for existing staff member, following withdrawal of Macmillan funding.	Stiens, Andrea	**Completed**	Application submitted						
														Creating haemotology software package so the CNS can manage patients more efficiently	Jones*, Dylan	30/09/2022	Progress to be provided at next risk review						
														Service review to be undertaken, with support from the Transformation Team	Jones*, Dylan	30/09/2022	Progress to be provided at next risk review - currently, transformation team are under operational pressures and unable to undertake at present.						

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1281	Directorate Level Risk	Standard 3.1 Safe and Clinically Effective Care	Carmarthenshire:Community Nursing	Dawson, Rhian	Cameron, Sarah	05-Nov-21	There is a risk of the inability to provide a sustainable Community Nursing service. This is caused by increasing workloads and complexity, acuity and dependency of community nursing caseloads, increasing numbers of RN vacancies with challenges or recruitment and retention. This will lead to an impact/affect on the quality and safety of patient care resulting in increased incidents and complaints. The ability of services to ensure patients receive timely care. Caseload capacity may restrict timely discharge from the acute and community hospitals. Potential increase in avoidable admissions due to caseload pressures in community nursing teams. Ability of services to release staff to attend training. Delays in undertaking investigations and learning from events. Negative impact on staff wellbeing, morale and absence levels. Also community nursing services will be unable to meet the requirements of the All Wales DN Staffing Principles and Nursing Staffing Levels Section 25 Act needed to meet support the service demands. Risk location, Carmarthenshire.	All caseloads are reviewed on a daily basis in line with the reduced DN Service Specification. Community Nursing escalation Policy has been developed and recently updated. Weekly communication with Nurse Bank Office to cover bank and agency shortfalls, block booking and provision of shadow shifts where required. Support of staff through Health Board Occupational Health and Staff Psychological Wellbeing services. A daily community call has been established between teams and services to provide oversight and ensure equal distribution of resources. E-Rosters are monitored closely to ensure early identification of potential shortfalls, timely bank requests are submitted by teams. All vacancies are advertised on TRAC in a timely manner and working closely with recruitment to get positive outcomes.	Safety - Patient, Staff or Public	6	3	4	12	Complete and submit risk assessment Head of Community Nursing identifying the current risks within community nursing and requesting authorisation to continue to on contract nursing agencies (with agreed community rates) to manage the current staffing deficit.	Cameron, Sarah	Completed	11/01 - Completed, agreed to closed action in Monthly Risk Meeting.	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	07-Apr-22
														Ensure Community Nursing Escalation Policy is being followed.	Cameron, Sarah	Completed	15/02 - Ongoing, managed risk, close as an action.						
														Close monitoring of complaints and incidents to recognise trends and issues in a timely manner.	Cameron, Sarah	Completed	15/02 - Ongoing review via scrutiny meeting. 07/04 - New Datix scrutiny process up and running - agreed to close.						
														Community Heads of Nursing to participate in all national work streams in relation to All Wales DN Staffing Principles and Nurse Staffing Levels Act, in addition to highlighting nursing levels as part of the county IMTP and resource required.	Cameron, Sarah	Completed	15/02 - Ongoing. WLOC will go onto Malinko. Close as an action						
														Close monitoring of staffing development and compliance with mandatory training and PADR's.	Cameron, Sarah	Completed	15/02 - Ongoing and control measures in place. Close action.						
														Development of community metrics to measure caseload acuity and dependency to identify areas of risk and staffing shortfalls.	Cameron, Sarah	Completed	15/02 - Ongoing. Close action, further progress will be monitored via Risk Meetings						

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														Engage with All Wales DN Forum and WG to obtain scheduling tool to enable improved coordination of DN caseloads and improve efficiency and skill mix allocation.	Cameron, Sarah	~~12/01/2022~~ 09/06/2022	15/02 - Clinical Lead Nurse has contacted the Malinko Project Manager and the roll-out has started in the 3T's area. Now completed (07/04). 07/04 - Continue to work on quality indicators within Community Nursing on an All Wales basis. Looking at undertaking a pilot on WLOC which will influence staffing levels. Appointment from WG of a 3 counties Peer Nurse Advocate Band 8a for a year and Band 6 Nurse Advocate to support the development of the HCSWs which will have an impact on staffing. Putting core community nurses through the AQUIP training which is funded by WG and is progressed by June 2022. Risk is to be placed on the agenda for SOG to discuss at a 3 county level.						
														Community Nursing Escalation Process and Policies require updating to include additional business continuity management of risk due to staffing challenges as a result of COVID.	Cameron, Sarah	Completed	11/01 - Completed, agreed to closed action in Monthly Risk Meeting.						
														Monitoring the effectiveness of Malinko and auto-scheduling aiming for minimum 3 days auto scheduling to support with delegation and rescheduling of routine procedures with adequate clinical oversight.	Cameron, Sarah	Completed	15/02 - All Wales DN forum is setting the auto-scheduling at 5 days as standard. We wont be able to fully do this until all areas are on Malinko and the staffing position improves. Keep open to understand what they will agree at an All Wales level as it will link into our reporting. 07/04 - Agreed to close as links into main WLOC action.						
														Clinical skill mix, competencies of staff and acuity of caseload to be reviewed for further recruitment. Need to consider alternative recruitment opportunities for B4 assistant practitioner roles in place of registered nurses where appropriate.	Cameron, Sarah	Completed	11/01 - Completed, agreed to closed action in Monthly Risk Meeting.						
														Monitor effectiveness of daily community call between community teams following implementation of Malinko, providing report to County G&A meetings on a monthly basis.	Cameron, Sarah	Completed	11/01 - Completed, agreed to closed action in Monthly Risk Meeting.						

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														Community Nursing Services to work with HD Communications and Resourcing teams on a RN Recruitment Campaign for Community Services.	Cameron, Sarah	Completed	11/01 - Completed, agreed to closed action in Monthly Risk Meeting.						
														Clinical Lead Nurses to ensure close scrutiny is maintained of compliance with quality indicators to include reporting on patient safety incidents, workforce performance - mandatory, training and PADR compliance, patient experience and complaints.	Cameron, Sarah	Completed	11/01 - Completed, agreed to closed action in Monthly Risk Meeting.						
1377	Directorate Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	Pembrokeshire	Lorton, Elaine	Griffiths, Ceri	28-Feb-22	There is a risk There is a risk of harm to patients from ongoing and continued delay in the timely investigation and management of the 526 open datix investigations within Pembrokeshire Integrated Community Teams. This is caused by operational pressures within ICTs; increased demands to manage IT e-scheduling system, ability to provide protected time for datix investigations, poor time management, delays in team leaders prioritising investigations to be undertaken, delays in accessing patient notes from patients' homes, delays in accessing training, and lack of appropriately trained staff to undertake datix investigations and staffing resources, lack of admin support within teams This will lead to an impact/affect on patients experiencing avoidable pain, distress, increased risk of infection and a reduced quality of life. This will also impact on timely assessments, delays in the provision of appropriate equipment and nursing intervention, delays in recognising themes and specific clinical risks, complaints, risk of admission to acute hospital, increased need for more specialist TVN input due to delays in assessment. Overall increasing the potential risk of harm to patients. Risk location, Pembrokeshire.	All datix incident reports on the new system are now checked against Malinko to see if patient is known to DN service and allocated for investigation. All G3>PD incidents on DN caseload are checked against Malinko to ascertain care interventions are scheduled. Datix investigation training, prompt sheets and 7 min briefing guide has been provided to all teams. Monthly action plans for each team has been developed with total target investigations to be completed per month per team given. A process for referring 'not known' and duplicate incidents returned to QAST is now established and in place. Advice on management of outstanding datix investigations has been provided to team leaders and investigators.	Safety - Patient, Staff or Public	6	3	4	12	DNTL will commence scheduling datix investigation time into Malinko to support with time management and collection of patient notes. This will be audited monthly by Clinical Lead Nurse	Griffiths, Ceri	31/05/2022	All DNTLs made aware of requirements to have implemented this by end of May 2022.	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	25-Apr-22
														DNTLs to nominate B5 staff suitable to receive datix training and access to support with datix investigations of moisture / G1 / G2 pressure damage	Griffiths, Ceri	31/05/2022	CLN will monitor progress against this action monthly						
														DNTL to ensure that all G3> pressure damage investigations are prioritised. DNTL to complete individual risk assessment if they are unable to complete target set within action plan period and return to Clinical Lead Nurse for escalation to monthly Scrutiny and QSE meetings	Griffiths, Ceri	29/07/2022	CLN to monitor progress against this action through monthly scrutiny meetings and feedback to QSE						
														Clinical Lead Nurse to develop an SBAR with recommendations to increase 0.4wte B2 Admin support per team as per OCP to 1wte B4 Admin support within each team and share at Pembrokeshire Management Workforce meeting	Griffiths, Ceri	Completed	SBAR has been completed and submitted. Awaiting funding / finance agreement to proceed to recruitment.						
1379	Department Level Risk	Clinically Effective Care	Disability Services	Carroll, Mrs Liz	Evans, Melanie	02-Feb-22	There is a risk of ongoing high cost locum staffing potentially resulting in staff leaving at short notice. This is caused by inability to recruit substantive appointments. This will lead to an impact/affect on continuity of	Contract dates are regularly reviewed to maintain cover and ensure further arrangements are in place in good time. Recruitment processes are ongoing to secure substantive staff.	interruption/disruption	6	3	4	12	Extend Locum contracts whilst continuing to appoint into substantive positions. Adverts continue to be published via Medical Workforce.	Evans, Melanie	31/03/2023	Attempting to provide suitable accommodation to support contract extension.	Assurance Committee	1	4	4	Treat	07-Jun-22

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	Service or I	Standard 3.1 Safe and C	MHLD: Learr				care. Risk location, Health Board wide.		Service/Business					Medical Lead replacement to be identified.	Evans, Melanie	Completed	Medical Lead has been identified and has agreed to provide an extra session a fortnight.	Quality, Safety and Experience					
														Advanced Nurse Practitioner and Consultant roles to be developed to provide medical solutions. Expressions of interest to be sought via internal process.	Evans, Melanie	30/06/2022	Job Desc being reviewed for appropriateness						
1384	Service or Department Level Risk	Standard 3.3 Quality Improvement, Research and Innovation	MD: Research and Development	Phillips, Leighton	Williams, Caroline	25-Apr-22	There is a risk That there will be a significant drop in staffing This is caused by Just over 30% of staff being in fixed term contracts, and a lack of funding within Health and Care Research Wales to make all the posts substantive moving forwards. This will lead to an impact/affect on the continuity of clinical trials and research studies being delivered across the Health Board Risk location, Health Board wide.	Routine review of staffing brought to Senior Management Team meeting Some ability to support temporary posts through the capacity building account (1412) All staff in temporary posts asked to keep records of their impact	Service/Business interruption/disruption	6	3	4	12	Make HCRW aware of the issue	Williams, Caroline	Completed	HCRW informed in meeting on 28.4.2022. They have stated that going forward they will make the budget decisions in December, and will expect budget plans to be submitted in Q2	Research & Development Sub Committee	2	2	4	Treat	28-Apr-22
1367	Directorate Level Risk	S	Women and Children	Humphrey, Lisa	Humphrey, Lisa	29-Oct-21	There is a risk That women and children services estate are not fit for purpose in particular community premises that provide care for Children and Young People and the Sexual Health Service. This is caused by Old underinvested estate which does not allow for safe clinical and therapeutic delivery for children and young people. This will lead to an impact/affect on Inability to provide timely access to care or expand capacity to meet current and expected demand. Inability to provide care in a safe physical environment e.g. clinical spaces do not meet clinical specification. Does not support multidisciplinary or therapeutic interventions due to lack of above causing extended waiting times in excess of 3 years for children and young people. Difficulty recruiting the appropriate workforce due to above. Wellbeing of staff impacted due to lack of reasonable rest facilities, office space and poor clinical working environment caused by poor estate as above. Lack of defined locations for the Sexual Health Service. Risk location, Health Board wide.	?????	Safety - Patient, Staff or Public	6	4	3	12					Capital, Estates and IM&T Sub Committee	2	2	4	Tolerate	07-Apr-22

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1327	Service or Department Level Risk		USC: Pathology	Perry, Sarah	Jones*, Dylan	23-Dec-21	There is a risk there is insufficient space and resource to meet the demand for Pathology (blood Science) testing and POCT support on the Glangwili Hospital site This is caused by a multiple of factors. The laboratory space is inefficient to house modern automated equipment required to provide timely results to the hospital and surrounding area. The Blood Science laboratories are split over 2 different floors making consolidation of staff difficult and OOH working challenging. The lack of lab space and training facilities also inhibits Point of Care Team (POCT) validation, testing, repair and staff training. The reconfiguration / consolidation of services across the Health Board (for example: Maternity / Women and Childrens, Major Trauma) to Glangwili has also led to an increased workload adding pressure. This will lead to an impact/affect on potential delays in turnaround times of diagnostic results, especially outside normal working hours when the staffing establishment reduces to a lone worker covering Haematology / Blood Transfusion on 2 different floors and one lone worker for Chemistry. The increased waiting times could result in a potential risk to Heath Board reputation. Roll out of POCT devices will also be affected, which could impact on patient flow and patient management due to delays in diagnostic results at the point of contact Risk location, Glangwili General Hospital.	1. Second standby rota in operation to support Out of Hours service if workload demands are unmanageable. 2. Currently utilising 3 Gorlan offices to house some staff, and POCT currently moving. 3. Current business continuity plans allow for moving workload to another site if required. 4. Monitor workload using Pathology Dashboard	Safety - Patient, Staff or Public	6	3	4	12	Rehouse POCT into the Gorlan on a temporary basis while enabling works takes place	Jones*, Dylan	**Completed**	Action complete as POCT now in situ	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	01-Jun-22
														Complete enabling works in the Biochemistry laboratories to create one large space to house modern higher throughput analysers.	Jones*, Dylan	~~30/04/2022~~ 30/04/2023	Fortnightly project meetings held with stakeholders, and enabling works split in to three phases - estimated completion of works by April 2023						
														Implement new Haematology equipment in the new laboratory	Jones*, Dylan	30/11/2022	Work on contracts currently underway, with a view to equipment being in place by November 2022.						
														Vacate old Haematology/Coagulation laboratory	Jones*, Dylan	30/11/2022	Work on contracts currently underway, with a view to equipment being in place by November 2022.						
														Move POCT into old Haematology/Coagulation Laboratory	Jones*, Dylan	30/11/2022	Work on contracts currently underway, with a view to equipment being in place by November 2022.						
1237	Service or Department Level Risk	Standard 3.1 Safe and Clinically Effective Care	USC: Diabetes	Willis, Matthew	Davies, Claire	06-Oct-21	There is a risk There is a risk of avoidable detriment to the quality and timely provision of patient care This is caused by Sustained inability to recruit a suitably qualified diabetes consultant substantively This will lead to an impact/affect on increased reliance on locums, financial risk, poor sustainability, poor attractiveness. Reduced options to improve models of care and support good decision making and flow on site. Risk location, Bronglais General Hospital.	Long term locum consultant in post, currently undergoing CESR process to enable him to be appointed substantively Support from consultant colleagues across the health board to assist with clinics and support through CESR process Experienced middle grade doctors and clinical nurse specialists to support the consultant and patients	Safety - Patient, Staff or Public	6	3	4	12	Locum consultant to be appointed substantively	Willis, Matthew	10-May-23	Locum consultant undergoing CESR. Contract extended for further 2 years to allow him to undergo process	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	10-Mar-22
														Recruit second consultant	Willis, Matthew	~~06/01/2022~~ 31/08/2022	Recruitment ongoing with no suitable applicants to date						
														Replace Middle Grade doctor following retirement	Willis, Matthew	**Completed**	Middle Grade doctor has now been appointed and in post.						

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842	Directorate Level Risk	Standard 5.1 Timely Access	MHLD	Carroll, Mrs Liz	Carroll, Mrs Liz	02-Jan-20	There is a risk of avoidable detriment to the quality of patient care. This is caused by absence of dedicated allocation of resources to fund an effective service. This will lead to an impact/affect on children and young people with learning disabilities whose behaviours challenge their families. Early intervention would mitigate against those behaviours becoming longstanding and more difficult to manage in adulthood. Increased clinical risk of harm, injury to self/others, family/social breakdown, increased reliance on residential or out of county placements, exclusion from educational settings, long term exclusion from community activities and increased likelihood of behaviours moving into adulthood. Risk location, Health Board wide.	A Positive Behavioural Service had been funded through Integrated Care Funds for a three year period. Recent staff departures have resulted in withdrawal of the service. There is a requirement for the organisation to look at a more sustainable service for children and young people with disabilities. The service has been restricted over the past year to reflect the reduced number of staff available to provide services across the Three Counties. Educational workshops in Positive Behavioural Support have been delivered to families and professionals at foundation level to increase resilience to a wider audience. Referrals of individuals with complex difficulties or those at threat of placement breakdown have been prioritised. Individual clinical risk is been assessed at discharge which identifies whether continued involvement from other professional groups is required, for example Paediatrics, Child Health. Any transition age young people are brought to the attention of Adult services.	Quality/Complaints/Audit	8	3	4	12	The Director of Operations will pull together a cross-organisational group - Transforming Children's Services - to scope out current provision and future requirements.	Carroll, Mrs Liz	31/03/2020 31/03/2022 30/09/2022	The initial workshop has been held and regular meetings are now in place, Chaired by the Director of Operations. The wider Group will need to give consideration to the model required for this service in the future as it will be a cross-service provision. Currently there is no ringfenced budget available to support of this service. No further progress to date (31.05.22)	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	31-May-22
138	Directorate Level Risk	Standard 5.1 Timely Access	MHLD: Psychological Therapies	Carroll, Mrs Liz	Marshall, Selina	16-Oct-14	There is a risk avoidable harm to patients. This is caused by longstanding failure to recruit registered psychologists. This will lead to an impact/affect on individuals not receiving timely assessment and treatment with potential to develop worsening conditions that become more complex to treat due to the length of time that they are on the waiting list. Risk location, Health Board wide.	Cross Directorate cover to ensure that there is no inequity in the availability of services across both specialities and localities. Delivery of a wide range of interventions from the wider multidisciplinary team under the supervision of psychology and psychotherapy. Continued and varied attempts at recruitment have been successful. Additional funding has been received from Welsh Government of £485,000 during 2018/19.	Safety - Patient, Staff or Public	6	4	3	12	Waiting lists are being reviewed to identify and reassess individuals.	Carroll, Mrs Liz	Completed	Newly issued guidance around the Welsh Matrix as well as further available funding for the further enhancement of delivery of Psychological Therapies is likely to result in increased expectation and recruitment challenges for specific modems of therapy.	Operational Quality, Safety and Experience Sub Committee	1	3	3	Treat	06-May-22
														Meeting arranged with Informatics and Performance colleagues to analyse referral rates and look at trajectories as it is evident that referrals are increasing and there is limited capacity within the service to meet demand.	Carroll, Mrs Liz	Completed	The Delivery Unit are scheduling a further series of workshops to progress the Demand and Capacity work in late June/early July.						
														Where posts are identified as hard to recruit, diversity of roles are being explored at Band 4 and Band 5 level. The service are also commencing group work in order to maximise workforce skills.	Marshall, Selina	Completed	Relevant roles are being created and Job Descriptions developed. Staff development and training will be supported. Recruitment to 3 Band 4 posts has commenced but will continue until all filled substantively.3 Band4 LPMHSS practitioner posts have been recruited into with the aim of running more group therapies. commencement dates yet to be confirmed.						

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523	Directorate Level Risk		Scheduled Care: General Surgery	Hire, Stephanie	Lewis, Caroline	18-Jun-18	There is a risk maintaining a day to day service and covering the Out of Hours on call. This is caused by 2 middle grade doctor vacancies at GGH being covered by 2 clinical fellows "acting up", leaving 2 Clinical Fellow vacancies. Also as the Green hospital for elective surgery is now in Prince Philip an additional rota has been created to provide 24 hour care. This will lead to an impact/affect on the ability to provide care within the departmental budget. The ability to provide continuity of care to patients. The moral and motivation of the clinical teams involved. Risk location, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	Probity on the locum contracts being agreed to ensure continuity of service. Adherence to Health Board HR Policies in the management of cases. Substantive middle grade vacancies have been advertised and are being shortlisted currently. 3 x substantive Clinical fellow vacancies for PPH Green pathway have been advertised, interviews being held in mid-April 2022. Draft rota developed.	Service/Business interruption/disruption	6	4	3	12	04/04/2022 This consultant post has now been filled. Develop management plans for continued locum payments to cover GGH consultant off work due to employment relation issues to be specified, including time line for likely conclusion of situation.	Lewis, Caroline	Completed	Complete	Operational Quality, Safety and Experience Sub Committee	1	3	3	Treat	04-Apr-22
														Develop a management plan for continued locum payments to cover WGH consultant off work due to long term sickness, including time line for likely conclusion of situation.	Lewis, Caroline	Completed	action completed						
														04/04/2022. Complete: no vacancies at WGH currently. Develop management plans for continued locum payments to cover WGH middle grade covering a consultant off work due to employment relation issues to be specified, including time line for likely conclusion of situation.	Lewis, Caroline	Completed	Complete						
														continuing to limit spend on locum doctor cover whilst maintaining a new surgical rota in PPH to support the elective work that is being undertaken there.	Perkins, Bethan	Completed	ongoing.						
														the reliance on medical locum cover continues after the occurance of the second wave of covid. the service continues to limit overspend whilst maintaining safe services.	Perkins, Bethan	Completed	ongoing.						
														Explore option to recruit three Registered Medical Officer (RMO) posts.	Lewis, Caroline	Completed	Posts have now been advertised and will be interviewed in mid-April 2022. Draft rota developed.						
														Recruitment of 2 x substantive middle grade doctors for GGH general surgery.	Lewis, David	06-Mar-22	Posts advertised and shortlisting currently taking place.						

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1217	Directorate Level Risk	Standard 2.7 Safeguarding Children and Safeguarding Adults at Risk	Pembrokeshire	Lorton, Elaine	Hay, Sonia	25-Aug-21	There is a risk of staff being unable to identify and respond to violence against women, domestic abuse and sexual violence (VAWDASV). This is caused by failure of staff, in completing and updating their Group 1 VAWDASV e learning training in accordance with the statutory VAWDASV National Training Framework. This will lead to an impact/affect on the health and wellbeing of our patients who may suffer short to long term physical, emotional and or mental harm or even death. This could also lead to an impact on the UHB reputation by a failure to comply with our statutory duties. Risk location, Pembrokeshire.	Guidance has been issued to all individuals on how to access and complete e-learning module. All staff have been reminded of importance of completing VAWSDA module in Scrutiny and Safeguarding Training.	Safety - Patient, Staff or Public	6	2	5	10	Monitor compliance with VAWSDA e-learning at Monthly Governance and Assurance Meetings	Griffiths, Ceri	Completed	Monthly monitoring established	Operational Quality, Safety and Experience Sub Committee	1	5	5	Treat	16-May-22
														Report compliance at Community and Primary Care Delivery Group meetings	Griffiths, Ceri	Completed	Bi-monthly reporting commenced						
														Achieve over 85% compliance with VAWSDA by December 2021	Griffiths, Ceri	31/12/2021 ~~30/06/2022~~	Amended timeframes given ongoing significant operational pressures.						
1204	Service or Department Level Risk	Standard 3.1 Safe and Clinically Effective Care	Ceredigion	Skitt, Peter	Hawkes, Jina	25-Aug-21	There is a risk staff being unable to identify and respond to violence against women, domestic abuse and sexual violence (VAWDASV). This is caused by a failure by staff in completing and updating their Group 1 VAWDASV e learning training in accordance with the statutory VAWDASV National Training Framework This will lead to an impact/affect on the health and wellbeing of our patients who may suffer short to long term physical, emotional and / or mental harm or even death. This could also lead to an impact on the UHB reputation by a failure to comply with our statutory duties Risk location, Ceredigion.	Issue raised with team leaders	Safety - Patient, Staff or Public	6	2	5	10	Encourage staff to undertake the e-learning	Evans, Tracey -	Completed	Issue raised at touch point meetings. Team Leaders drilling down data to understand which staff members have not undertaken the training.	Operational Quality, Safety and Experience Sub Committee	1	5	5	Treat	19-Apr-22
														Monitor the situation and encourage staff to undertake the e-learning	Evans, Tracey -	30/09/2022	Currently 80% of staff have completed this training.						
1230	Service or Department Level Risk	Standard 3.1 Safe and Clinically Effective Care	Carmarthenshire	Dawson, Rhian	Cameron, Sarah	25-Aug-21	There is a risk staff being unable to identify and respond to violence against women, domestic abuse and sexual violence (VAWDASV). This is caused by a failure by staff in completing and updating their Group 1 VAWDASV e learning training in accordance with the statutory VAWDASV National Training Framework. This will lead to an impact/affect on the health and wellbeing of our patients who may suffer short to long term physical, emotional and or mental harm or even death. This could also lead to an impact on the UHB reputation by a failure to comply with our statutory duties. Risk location, Carmarthenshire.	Nursing Team Leaders conduct locally nursing scrutiny meetings which report to the Clinical Lead Nurses for the locality. The Clinical Lead Nurses then report on performance in the County Scrutiny Meeting.	Safety - Patient, Staff or Public	6	2	5	10	Encourage staff to undertake the e-learning and monitor progress via monthly scrutiny meeting.	Cameron, Sarah	31/12/2021 ~~04/07/2022~~	07/04 - Stats continue to improve. 04/05 - Raised as agenda item at QA SMT, Finance Business Partner to provide detailed info from cost centres. Head of Integrated Services to discuss with County Director in order to proceed.	Operational Quality, Safety and Experience Sub Committee	1	5	5	Treat	04-May-22

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1229	Service or Department Level Risk	Standard 3.1 Safe and Clinically Effective Care	Carmarthenshire:Community Hospitals	Dawson, Rhian	Cameron, Sarah	09-Aug-21	There is a risk non compliance to safe staffing principles. This is caused by insufficient Registered Nurse workforce capacity, particularly at night. This will lead to an impact/affect on safe patient care. Risk location, Llandovery Cottage Hospital.	Health Care Support Workers who are accredited by Agored Cymru for 'safe medication administration' on duty with the Registered Nurse at night. Escalation Process in place which outlines actions required in the event that the Registered Nurse where emergency circumstances occur which results in the Registered Nurse having to go 'off duty'.	Safety - Patient, Staff or Public	6	2	5	10	Urgent review by the corporate nursing team of the skill mix required that can support patient needs in Llandovery Hospital and which recognises the challenges we have had previously to recruit Registered Nurses.	Cameron, Sarah	~~09/11/2021~~ 09/06/2022	04/01/22 - Review has started with Head of Community Nursing, Nursing Programme Manager for the Health Board and the Interim Clinical Lead Nurse for Community Hospitals. 11/01 - Review is in first iteration and is being reviewed with Nursing Programme Manager. 15/02 - Review currently on-going with Chris Hayes. 07/04 - HoN creating an SBAR to utilise 2 paramedics to be the 2nd registered on a bank or permanent basis. Also looking at other staffing models. Next position statement will be presented at next QA SMT Meeting.	Operational Quality, Safety and Experience Sub Committee	1	5	5	Treat	07-Apr-22
750	Directorate Level Risk	Standard 3.1 Safe and Clinically Effective Care	USC: WGH	Cole-Williams, Janice	Johns, Helen	24-Jun-19	There is a risk unavoidable delays in the treatment of patients in Emergency Department (ED) and across Medical Specialities at WGH, with the added potential of having to close the service. This is caused by a lack of substantive middles grade and high reliance on agency locum cover, which is not always available. This will lead to an impact/affect on Patient harm or poor care outcomes, including no Senior doctor onsite to attend emergencies or Met calls over night. Delays in transfer, diagnosis and treatment, increased length of stay, limitation on surge capacity, with increased ambulance off load delays. Decreased level of supervision for all junior doctors. Pressure on WGH financial position with increased use of agency. Possible closure of services. Risk location, Withybush General Hospital.	Daily review of team strengths by rota co-ordinators and service manager unscheduled care. Issues identified escalated to GM and SDM. Recruitment program on-going to fill gaps and recruit into vacant posts. Medacs agency filling whenever possible with long term locums. Continuous monitoring of the team strengths to ensure consultant and senior support and supervision. Links with other Health Board sites (HDUHB & SBUHB) to outline current pressures and any opportunities to cross cover and to assess overall medical staffing position across HDUHB Weekly Urgent Response Group review rotas for the next six months. 1 x long term locum in place (2 left July 2020). Escalation procedures in place. Process in place to Review and recruit into all Medical Middle Grade funded posts. Continue to monitor team strengths to ensure consultant and senior support and supervision. All funded posts are with Medacs Agency for interim appointments.	Safety - Patient, Staff or Public	6	3	3	9	Complete the recruitment of 3 middle grade doctors across A&E and Medicine.	Cole-Williams, Janice	~~31/12/2019~~ ~~07/11/2020~~ ~~13/05/2021~~ 15/1 1/2021	1 Post out to advert for ED. Others offered but candidates are overseas. Delay due to potentially have to self-isolate when arriving due to health board rules.	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	15-Nov-21
1277	Directorate Level Risk	Standard 7.1 Workforce	Community Nursing	Dawson, Rhian	Cameron, Sarah	01-Oct-21	There is a risk that there is currently a high potential for adverse clinical incidents, reduced patient safety, further staff sickness and poor patient experience due to the ongoing and significant reduction in staffing and the mounting caseload pressures across the county.	Daily Reporting of sickness and absence rates. Utilisation of Community Nursing Escalation Process. Caseload reviews undertaken weekly to prioritise patients. Daily discussions around redeploying staff between clusters	Safety - Patient, Staff or Public	6	3	3	9	Request to fill with Bank/agency where appropriate	Cameron, Sarah	**Completed**	11/01 - Agreed to close as action is a duplicated, action under 1281 cover this.	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	04-May-22

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	Service or Dep	Stand	Carmarthenshire:C				This is caused by high numbers of long and short term sickness, outstanding vacancies and unfilled Maternity backfill, alongside low numbers of available bank staff. This will lead to an impact/affect on escalating workload and available Staff capacity is demonstrated through the Malinko Scheduling system that is now active in some of the teams. This is impacting on the ability of the teams to provide a safe level of patient care and is resulting in a potential reduction in the quality of patient care and experience alongside the negative impact on staff, potentially increasing sickness levels across the county. Risk location, Carmarthenshire.	~~Daily discussions around redeploying staff between clusters.~~ Requesting to backfill with bank/agency staff where possible.	Safety - Pati					Consider standing down management activities.	Cameron, Sarah	~~10/01/2022~~ 04/07/2022	06/12 - Continuing to monitor. 11/01 - Continuing to monitor as we progress through the Omicron wave. 15/02 - Still continuing to review as staffing issues still present. 07/04 - Staffing has improved, agreed at monthly meeting to remain the same for another month before de-escalating. 09/05 - Added to SOG agenda to discuss at 3 county level as risk links to #1281	Operational Quality, Safety and Experien					
														Consider cancelling study leave.	Cameron, Sarah	~~10/01/2022~~ 04/07/2022	06/12 - Continuing to monitor. 11/01 - Continuing to monitor as we progress through the Omicron wave. 15/02 - Still continuing to review as staffing issues still present. 07/04 - Staffing has improved, agreed at monthly meeting to remain the same for another month before de-escalating. 09/05 - Added to SOG agenda to discuss at 3 county level as risk links to #1281						
1365	Service or Department Level Risk	Standard 3.1 Safe and Clinically Effective Care	MHLD: Adult Mental Health Services	Carroll, Mrs Liz	Isaacs, Kay	10-Mar-22	There is a risk to patients in respect to medical clerking, treatment plans and review of care There is a requirement in respect to the Mental Health Act 1983 Code of Practice (chapter 36) as "every patient must have an allocated Responsible Clinician (RC) with the patient being informed of the identity of the RC and of any change". This same information must be provided to the nearest relative in writing. There are also certain functions under the Act that only the RC can undertake and which cannot be delegated e.g. discharge, granting leave. This is caused by a deficit in our adult mental health medical workforce staff. This will lead to an impact/affect on substantive medical arrangements at required grades on our in-patient wards and community teams being inadequate, and being non-compliant with the requirements of the MHA1983 Code of Practice. Risk location, Carmarthenshire, Ceredigion, Pembrokeshire.	Twice daily mental health bed conference to confirm medical cover arrangements for following 24 hour period Weekly meeting to agree cover arrangements in all areas where there is a deficit. This meeting is chaired by the Clinical Director in attendance are medical staff, Mental Health Act administration colleagues, senior nursing staff, clinical staff, head of service, pharmacy and advanced nurse practitioners Internal transfer of patients as required to meet their needs Continued liaison with Medical Workforce in respect of medical recruitment.	Safety - Patient, Staff or Public	6	3	3	9					Operational Quality, Safety and Experience Sub Committee	2	3	6		06-Apr-22
852	orate Level Risk	e Independence	Ceredigion	Skitt, Peter	Skitt, Peter	18-May-20	There is a risk harm to patients due to a lack of resilience within domiciliary care / care homes during the Coronavirus pandemic. Additionally, there is a long term risk to the sector due to financial and staffing capacity as a result of the pandemic.	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.	it, Staff or Public	6	3	3	9	Regular communications with Local Authority.	Hawkes, Jina	Completed	Daily touch point meetings in place	Sub Committee	2	3	6	Treat	16-May-22

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	Direct	Standard 6.1 Planning Care to Promot					This is caused by a 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. Traditional financial insecurity of the sector. This will lead to an impact/affect on patient flow from hospital as well as increased demand on services to fill the gap. Risk location, Health Board wide.		Safety - Patien					3 County Basis - develop a legal framework which will enable HDUHB to support LA and private providers deliver care in extraordinary circumstances	Skitt, Peter	Completed	3 County Service Level Agreement has been taken through the COVID 3 County Bronze group	Operational Quality, Safety and Experience					
														Working closely with the Local Authority, continuously monitor the situation.	Skitt, Peter	Completed	Situation reported into the Ceredigion Daily touchpoint meetings						
														Regional whole system escalation process to be developed	Skitt, Peter	Completed	Escalation policies have now been submitted to the 3 County Bronze COVID group						
														Regional whole system escalation process to be communicated	Skitt, Peter	Completed	Regional group to collate escalation processes to determine interdependencies						
														A regional approach to support care homes	Skitt, Peter	Completed	Partnership meetings have taken place to review fee setting						
														Consistent approach to fee setting across the 3 counties	Skitt, Peter	Completed	Fee setting is not consistent across the 3 Counties						
														Awaiting a decision from the Finance Committee in relation to the in-consistent fee setting	Skitt, Peter	Completed	Paper has been submitted to Finance Committee						
														Escalate the risk to corporate level	Skitt, Peter	Completed	The approach has been resolved locally, however needs to be escalated as a corporate approach is required						
1378	Service or Department Level Risk	1 Safe and Clinically Effective Care	Pembrokeshire	Lorton, Elaine	Svetz, Jess	15-Mar-22	There is a risk of delays in the care for patients specifically, medication reviews, prescribing medication, ward rounds, clinical support for acutely unwell patients, certifications of deaths. This is caused by a potential gap of medical input for patients in South Pembrokeshire Hospital due to the time between the notification given from AGM and developing options for a new medical workforce model and recruitment into the new model. This will lead to an impact/affect on safe and	Advanced Nurse Practitioner providing day to day support. Additional ANP in recruitment process. Able to contact Blue Team for urgent or acute advice/input Urgent and Intermediate Care GPs to provide interim medical support Recruitment to new medical workforce model Out of hours provision still in place	Safety - Patient, Staff or Public	6	3	3	9	Commence recruitment of middle grade and secure sessions of Consultant Geriatrician	Svetz, Jess	31/05/2022	Discussions commenced	ety and Experience Sub Committee	2	3	6	Treat	25-Apr-22
														Commence recruitment and induction of second ANP	Svetz, Jess	31/05/2022	Job to be advertised on TRAC						

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		Standard 3.1					This will lead to an impact/affect on safe and effective patient care, potentially leading to increase length of stay and lack of clinical/supervision support to the ANP/s. Risk location, Pembrokeshire.							Set up rota with Urgent and Intermediate Care GPs and ANP to ensure cover each day as interim arrangement	Svetz, Jess	Completed	Draft rota developed. Action completed	Operational Quality, Safe					
														Plan for induction of middle grade and develop cross covering rota with Urgent and Intermediate GPs/ANPs	Svetz, Jess	30/06/2022	Planning to commence once job planning and cross cover arrangements agreed						
111	Directorate Level Risk	Standard 3.1 Safe and Clinically Effective Care	USC: Radiology	Perry, Sarah	Roberts-Davies, Gail	01-Jan-16	There is a risk avoidable delay in diagnosis and treatment of patients, leading to a poorer quality of care. Increases in diagnostic waiting time breaches and cancer pathway breaches. This is caused by unavailability of consultants in specialised areas (MSK Paeds and Interventional). This will lead to an impact/affect on the failure to treat patients, clinical deterioration and death. Lack of availability to cover MDT meetings. Increased costs for external reporting. Inpatients may have increased length of stay due to delay in reported studies being available. Increased turnaround time for reports. Financial impacts due to high cost of external reporting and agency staff Risk location, Health Board wide.	Arrangements in place for additional reporting by existing radiology team (In lieu of Locum). Unreported studies sent to third party tele-radiology company (Everlight). Recruitment campaign commenced to target radiologists with special interest. Radiologist money utilised to employ consultant radiographer in breast. Communication with both Swansea Bay and the National Imaging Academy for additional support with joint appointments and trainee radiologist placements. Continued communication with Swansea Bay around joint appointments. Reporting radiographers working to capacity , worklists redone to accommodate. Reporting radiographers trained for appropriate studies. Use of some locums and low cost agency to fill some gaps. Establishment of Clinical interface group with primary and secondary care leads to continuously review pathways and attempt to reduce demand.	Safety - Patient, Staff or Public	6	3	3	9	Advertise for substantive and locum radiologists and recruit trainee reporting radiographers.	Evans, Amanda (Inactive User)	Completed	8 reporting radiographers now trained and in post.	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	10-Feb-22
														Increase number of reporting Radiographers.	Evans, Amanda (Inactive User)	Completed	Review to commence, with HR support, on efficiency of current staff and to evaluate the gaps. eview completed . identification of succession planning .. current staff able to fill the capacity . Robust governance identifiedand implemented						
														Monitor delay in unreported studies. Unreported studies sent to third party tele-radiology company.	Evans, Amanda (Inactive User)	Completed	Software installed to permit bulk upload of images to 3rd party reporting company. Routinely used across all sites.						
														work with the National Imaging Academy to recruit trainee radiologists	Evans, Amanda (Inactive User)	Completed	Radiology Services Manager and Clinical Director in contact with deanery to improve traiing facilities Radiologist who is trainer working in conjunction with NAID Trainees to start 1st August						
														Job description approval	Evans, Amanda (Inactive User)	Completed	Awaiting feedback from RCR Feedback recieved and Job description approved						
														Re launch the camapaign for substantive radiologists with the support of workforce	Evans, Amanda (Inactive User)	Completed	Communications team about to launch new recruitment video in Arabic						

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														Continual monitoring of radiology reporting lists to ensure no delays in turn arouund	Khan, Dr Liaquat	Completed	Working across all sites to maximise current levels of capacity						
														Review reporting radiographer capacity in light of recent retirements and vacancies of radiographers Recruit more reporting radiographers on Chest and Abdomen reporting as resilience in the system	Evans, Amanda (Inactive User)	Completed	Action completed- review has taken place.						
														Review radiology referral pathways and levels of innapropriate tests	Evans, Amanda (Inactive User)	Completed	Radiology dashboard produced with assistance from programme management office. Demand optimisation work underway The COVID-19 pandemic and the restoration of services have impacted on the ability to drive this work. However as each service is restored pathways will be reviewed and improved.						
														Undertake baseline demand and capacity to workout current and future workforce requirements.	Perry, Sarah	~~31/03/2022~~ 30/11/2022	Currently exploring scope through discussions with Royal Society and other Health Boards. Feb 22 - work has commenced on demand and capacity, and a radiology dashboard currently in development with the support of Digital Services to support this, and to quantify.						
797	Service or Department Level Risk	Standard 3.1 Safe and Clinically Effective Care	USC: Radiology	Perry, Sarah	Roberts-Davies, Gail	07-Nov-19	There is a risk of being unable to provide a full range of ultrasound services including antenatal. This is caused by retirement and resignation of current sonography staff. Low availability of sonographers UK wide including locum staff. This will lead to an impact/affect on delays in diagnosis. Inability to meet diagnostic targets and cancer pathway targets. Also an inability to meet demand in ante natal screening services. Risk location, Health Board wide.	Process for movement of staff across the health board to maintain capacity. New Leadership in the team at PPH. Additional sessions in WGH	Workforce/OD	8	3	3	9	Train two members of staff to become sonographers.	Roberts-Davies, Gail	~~31/03/2020~~ 31/03/2022	Two members of staff currently being trained. Training will be completed in 2022.	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	10-Feb-22
														Retrain staff on bank as sonographers.	Roberts-Davies, Gail	**Completed**	Staff member has embarked on second year of course						
														Develop a plan to help alleviate pressures through increasing the number of growth scan checks undertaken by midwives.	Perry, Sarah	31/12/2021	Discussions have taken place with Head of Maternity Services. Protocols and training being developed. Implementation date to be agreed.						

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														Increase capacity through converting room for ultrasound use.	Perry, Sarah	30/06/2022	Source discretionary capital.						
1395	Service or Department Level Risk		Therapies and Health Science: Occupational Therapy	Reed, Lance	Sims, Claire	04-Apr-22	There is a risk risk of adults & children who need occupational therapy waiting too long for a service or not receiving a service that will help them to maintain or improve their health & well being and live their life fully. This is caused by insufficient workforce capacity to meet the demand, due to lack of adequately funded service in some areas, exacerbated by redeployment of staff during COVID, vacancies and planned & unplanned leave. This will lead to an impact/affect on people not being able to live their lives as independently as is possible and suffering preventable and long term impacts of ill health, injury and disability. This will in turn impact on increased demands on unpaid carers as well as increase of statutory care provision. The imbalance between demand and capacity has resulted in waiting lists for community occupational therapy for children and adults in breach of the Welsh Government 14 week target. Risk location, Health Board wide.	1. Clinical prioritisation of all referrals 2. Provision of information and advice for those on waiting lists in some areas (Children's service, CNRT) 3. Additional capacity agreed in areas where people are waiting more than 14 weeks 4. Monthly monitoring and reporting of performance against 14 week target 5. Care Aims Training undertaken by some teams.	Quality/Complaints/Audit	8	3	3	9	Arrange capacity and demand training for relevant staff	Adams, Jon	30/06/2022	Update to be provided at next risk review	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	16-May-22
														Implement demand & capacity methodology, initially in areas experiencing waits over 14 weeks to support monitoring and improvements	Adams, Jon	30/09/2022	Update to be provided at next risk review						
														Work with Communications Teams to transfer universal information for children onto new Internet site	Adams, Jon	31/12/2022	Update to be provided at next risk review						
														Develop Universal offer for adult services linked with implementation of Care Aims approach	Adams, Jon	31/03/2023	Update to be provided at next risk review						
1211	Directorate Level Risk		USC: GGH	Perry, Sarah	Morgan, Olwen	18-Aug-21	There is a risk lack of compliance with Health board targets for mandatory training at GGH. This is caused by the lack of face to face training during the Covid pandemic and the recent re-establishment of face to face training being on a limited scale due to social distancing requirements (therefore increased waiting time to receive the training). The significant RN staffing deficits caused by high numbers of vacancies makes it difficult to release staff for face-to-face training, thus compounding the situation. This will lead to an impact/affect on compliance rates, performance skill sets and potentially the quality of care and service. Risk location, Glangwili General Hospital.	Mandatory training compliance figures reported to GGH Quality, Safety and Experience Committee and The Assurance Scrutiny Meeting. Staff are being supported to book onto face to face sessions as soon as they come available. Some previously 'face to face' training now done virtually via Teams thus enabling a higher release rate as staff can access from home. Training needs are risk assessed and prioritised accordingly to specific areas	Quality/Complaints/Audit	8	3	3	9	To review training needs as we emerge from Covid	Morgan, Olwen	30/09/2022	To be provided at next risk review	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	05-May-22
														Undertake a review of compliance across USC GGH with regards to training risk	Evans, Iona	30/09/2022	To be provided at next risk review.						

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1330	Service or Department Level Risk	Standard 3.1 Safe and Clinically Effective Care	Women and Children: Paediatrics and Neonates	Humphrey, Lisa	Davies, Nick	21-Dec-21	There is a risk to Paediatric acute inpatient service provision. This is caused by a significant shortfall in trainee posts (HEIW/ single lead employer positions) in the next rotation, commencing February 2022 (5 vacancies) This will lead to an impact/affect on Effective flow through the paediatric service and a need for SASG medical staff to support with SHO shortfalls, potentially placing the service at risk of business continuity in the event of sickness/ absence pressures Risk location, Glangwili General Hospital.	Recruitment process for 5 clinical fellow's (progressed at risk) has been completed and 5 appointments made- currently on boarding with only 2 likely to commence by end March 2022. New rota template (temporary for next 6 months) (reducing the numbers of SHOs over a 24 hour period) produced to further mitigate risk.	Service/Business interruption/disruption	6	3	3	9	A new rota template is required to reflect reduction from the current 12 person rota to a 10 person rota.	Davies, Nick	Completed	New rota template agreed, verified by medical staffing and existing/ remaining trainees have agreed to move over to new working pattern	Operational Quality, Safety and Experience Sub Committee	1	3	3	Treat	06-Apr-22
														Work to on-board a qualified Physician Associate (1wte) who is currently on rotation in Paeds GGH from WGH to provide additional support to the PACU area in respect of reduced SHO cover related to the rota changes.	Davies, Nick	Completed	Funding sourced internally - moving to Job Description development and recruitment process. Individual appointed and in post.						
1267	Service or Department Level Risk	Standard 3.1 Safe and Clinically Effective Care	MHLD: Older Adult Mental Health Services	Donovan, Dr Kerry	Mason, Nell.	31-Mar-21	There is a risk being unable to deliver face-to-face psychology assessment and psychotherapeutic interventions (complex high intensity & complex low intensity) necessitated for patients within older adult mental health services This is caused by the inability to recruit to WTE 4 qualified psychologist vacancies This will lead to an impact/affect on the health and wellbeing of patients subject to Part 2 of the Mental Health Measure and our ability to fulfil assessed need within care and treatment plans. Inability to provide senior and strategic psychology leadership within the Older Adult Mental Health service, including supervision and professional leadership. Inability to provide expertise, advice, supervision and support to other MDT members on psychologically informed practice and treatment modalities. Inability to pursue service development objectives to review and develop psychologically informed treatment pathways and modalities. Increased risks of acuity and suicidality and elongation of lengths of stay both within community and inpatient caseloads. Risk location, Health Board wide.	1. Interim centralised psychology referral system in place, weekly review panel (remaining psychologists with broad clinical expertise - functional/organic/neuropsychology, inclusive of two Principal Clinical Psychologists and a Consultant Clinical Psychologist). Consultation model now in place. 2. New [interim] referral form and centralised system communicated to all teams/clinicians (memo). 3. Reiteration to clinical team's re: â€œagelessâ€ access to both Local Primary Mental Health Support Services LPMHSS (common mental health problems/low intensity) and Integrated Psychological Therapies IPTS (model specific high intensity higher intensity, moderate to severe). 4. Assistant Psychologist fixed term contracts appointed with slippage to shore up service delivery and enable some continued development. 5. Dedicated Nurse Lead (time) on suicide prevention and complex cases in place to support care coordinators	Quality/Complaints/Audit	8	3	3	9	Review of Psychology Service structure, roles and responsibilities to maximise attraction of posts. Inclusive of links to universities and research programmes. NB National Shortage of qualified psychologists. (drs Gerhand, Stilweel and Greves)	Mason, Neil.	Completed	3 8a posts determined to be most suitable way forward within restructure, posts advertised within new psychology structure. No applicants first cycle, went out to advert for the second cycle and closing date 06/06/22 with no applicants.	Operational Quality, Safety and Experience Sub Committee	1	3	3	Treat	07-Jun-22
														Develop improved, targeted recruitment campaign with support from HB Recruitment Specialists. Communications with local and national university graduate programmes (placements/graduates/job fairs etc.). (Drs Gerhand, Stilwell and Greves, Head of Service and Professional Lead)	Mason, Neil.	Completed	Opportunity explored with the specialist teams but only additional element available that was not currently in place was a promotional video. This was not deemed critical by the clinical psychologists.						
														Consider need, quality and availability of locum and/or agency psychologists if problem persists long term. (Drs Gerhand, Stilwell and Greves, Head of Service and Professional Lead)	Mason, Neil.	Completed	This opportunity was explored with Kerry Donovan (Hywel Dda UHB - Professional Head - Psychology & Psychological Therapies), who advised against this action.						
														Set up workshop with Clinical Psychologists and Business Analyst to consider alternative plans if current recruitment cycle does not provide any appointments.	Mason, Neil.	18/05/2022	Neil Mason indicated and agreed action with Clinical Psychologists and Business Analyst. Ongoing workshops on a monthly basis, Workforce Development is engaged.						

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1066	Service or Department Level Risk	Standard 7.1 Workforce	Scheduled Care: Ophthalmology	Hire, Stephanie	Buckingham, Carly	01-Apr-21	There is a risk that the Ophthalmology service will not be able to provide the level of outpatient clinics, IVT service, pre-operative assessment and RACE activity required. This is caused by the lack of nursing staff and health care support workers available as the service provided has increased and requires more staffing input, whilst the nursing establishment has not been reviewed to accommodate the service growth. This will lead to an impact/affect on disruption of the services being provided; inability to comply with The Nursing Staffing Levels (Wales); inability to cover planned and unplanned leave, risking cancellation of appointments and treatments. Risk location, Health Board wide.	WGH - Seeking support from colleagues at general OPD and DSU almost on a daily basis to cover regular clinic activity and staff absence (due to leave or sickness) NRC - Offering staff overtime during the week to help cover regular clinical activity Nurse injectors - Doctors upskilled to help cover for nurse injector absence/leave across all sites Across the Board - Implementation of telephone pre-op and telephone pre-op updates to better use nursing resources available - Mobilising staff between sites to help cover the clinical activity as required. - Review of activity changes and support we can request from units who have benefited from those changes.	Workforce/OD	6	3	3	9	To participate in the imminent nurse staffing review in line with the Health Board's review of all services to compare establishment in the services with the All Wales Nurse Staffing Act recommendations.	Barreiro, Marta	~~01/07/2021~~ ~~20/09/2021~~ ~~31/12/2021~~ ~~30/06/2022~~ 31/10/2022	Initial contact made, review deemed necessary and started. Feedback from Head of Nursing is that this work will take several months. Update (March 2022) - work towards this continues. Update (May) - difficulty in carrying this work due to the lack of clear standards and lack of time to invest in this work.	Quality, Safety and Experience Assurance Committee	1	3	3	Treat	28-Sep-21
														To submit SBAR requesting an increase in establishment in service covering Pembrokeshire area, including an uplift which does not currently exist.	Barreiro, Marta	~~01/07/2021~~ ~~12/07/2021~~ ~~31/10/2021~~ ~~31/05/2022~~ 31/10/2022	SBAR completed with costing details from Finance. As of September 2021 SBAR with General Manager for review, but this has been delayed due to operational pressures. Update: SBAR included in IMTP process for consideration Update: no move with SBAR via IMTP, exploring alternative options.						
														Submit requirements for staffing to allow 5 day/week pre-op in GGH, in line with service needs and with the current activity levels.	Barreiro, Marta	**Completed**	Submitted. Awaiting outcome.						
														Additional nurses to take up advanced positions.	Barreiro, Marta	~~31/01/2022~~ ~~31/05/2022~~ 31/10/2022	Recruitment of 1.6 WTE has been made. 1 Nurse already employed by HB, increasing hours. Optometrist taking up role with start in January 2022, and Orthoptist is likely to start November 2021. Update as of March 2022 - severe recruitment delays for varied reasons. Overall, 0.6 WTE stared, 0.2 WTE to start in April, plus 0.6 WTE currently undergoing re-registration process and unable to start training until this has been completed. 0.4 WTE available to advertise due to reduction in working hours of a current staff member, and reduction in offered hours to a new starter. Update: 0.4 WTE of IVT Practitioner out for advert. Appointed into 0.4 WTE of Band 7 Glaucoma Practitioners, which still leaves a vacancy of 2.3 to recruit into, but the current glaucoma clinics do not support employing more than two people for one day a week.						

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1387	Service or Department Level Risk		USC: Pathology	Perry, Sarah	Jones*, Dylan	23-Feb-22	There is a risk of the OOH Blood Service being non-compliant with staff competency requirements This is caused by 1.Departments not compliant with requirement to provide evidence of staff competence (ISO 15189:2012, BSQR (2005), UKTLC, Pathology TED Policy) 2.Low staffing levels with less priority given to training and competence 3.Potential gaps in staff knowledge and skills unknown / not recorded 4.Large number of competencies for staff to complete to evidence on going competence This will lead to an impact/affect on 1.Avoidable detriment to the quality of patient care 2.Poor inspection outcomes, loss of accreditation, restriction on function of the Blood Sciences service; 3.Lower staff morale 4.Increase in turnaround times, errors and/or incidents 5.Avoidable detriment to business objectives Risk location, Health Board wide.	Annual inspection cycle by UKAS raising findings of non-compliance. Action plans sent out to staff by Quality Manager with defined dates for completion of competences. Progress monitored fortnightly Training and competence matrix is a standing agenda item at TED Subgroup. Responsibility for individuals joining the OOH rota rests with the Site Lead. TPBHB601 Training program - Blood sciences BMS, specialist BMS and Senior BMS in place for all new staff detailing training and competence requirements TPBHB610 Training program - Out-of-Hours Working (Blood Sciences) and CRBHB604 Staff competence record - Out-of-Hours Working (Blood Sciences) in place which have to be completed before staff commence out of hours working Competence matrix in place and training plans set up in Q-Pulse for all grades of staff Additional monitoring of completion of competence assessment action plans on a fortnightly basis until 100% compliance achieved.	Safety - Patient, Staff or Public	6	3	3	9	Write SBAR to reduce the frequency of blood transfusion (BTR) assessments	Albery, Hannah	31/05/2022	To be provided at next risk review	Operational Quality, Safety and Experience Sub Committee	3	1	3	Treat	01-Jun-22
														Revise competence assessment format in line with Swansea Bay UHB	Albery, Hannah	30/06/2022	To be provided at next risk review						
														Undertake capacity planning for all sites	Albery, Hannah	30/06/2022	To be provided at next risk review						
														Update competence matrix (MFPAT683)	Albery, Hannah	31/05/2022	To be provided at next risk review						
														Update training and competence plans in Q-Pulse	Albery, Hannah	31/05/2022	To be provided at next risk review						
														Carry out a gap analysis of completion of training programmes for all staff	Albery, Hannah	31/05/2022	To be provided at next risk review						
1109	Service or Department Level Risk	Safe and Clinically Effective Care	P,C,LTC: Primary Care	Bond, Rhian	Swinfield, Anna	24-May-21	There is a risk that there could be days in Managed Practices where there is no GP on site. This is caused by limited locum availability, challenging recruitment to substantive posts This will lead to an impact/affect on direct delivery of General Medical Services to patients. Risk location, Meddygfa Gelli-Onn/Ash Grove Medical Centre, Llanelli, Meddygfa Minafon,	Trying to recruit more salaried GPs into the Managed Practice Workforce. Use of regular locums. Diversification of staffing to MDT model.	Safety - Patient, Staff or Public	6	3	3	9	Continue with recruitments for salaried GP vacancies. Liaise with local VTS to promote managed practices to trainees as a career option on qualifying.	Swinfield, Anna	31/03/2022 31/08/2022	Update Apr 2022: We had successfully recruited a GP in our Tenby practice, but unfortunately the GP has since left. We intend to rerun the GP recruitment advert. We have recruitment ads out for Advanced Practitioners.	Operational Quality, Safety and Experience Sub Committee	2	1	2	Treat	13-Apr-22

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	Se	Standard 3.1 Sa					Kidwelly, Meddygfa'r Sarn, Pontyates, The Surgery, Tenby.							Advanced Medical Rota planning to cover difficult to fill slots such as school holidays. Medical rotas are particularly difficult to fill over school holiday periods and the GP Clinical Leads had to step-in to ensure basic cover was in place on occasion.	Howell-Williams, Vicki	~~31/03/2023~~ 30/09/2022	Update Apr 2022: Medical rotas are booked in advance, but these arrangements can sometimes fall through if those locums are partners in other GP Practices and are required to provide cover there at short notice. Update May 2022: SMT continue to review rotas on a weekly basis. Specific to Tenby in relation to the change of clinical system, in the autumn training will be offered / provided to locums to ensure ongoing cover. Locum cover is an increasing challenge across all 4 Managed Practices.	Operational Quality, Safety a					
986	Service or Department Level Risk	Standard 3.1 Safe and Clinically Effective Care	P,C,LTC: Primary Care	Bond, Rhian	Swinfield, Anna	23-Sep-20	There is a risk that services in managed practices will be reduced. This is caused by staff sickness or quarantining due to Covid-19. This is a combination of sickness other than Covid and Covid infection/symptomatic. This will lead to an impact/affect on patients being unable to access services in a timely manner. Risk location, Meddygfa Minafon - (Kidwelly, Trimsaran & Ferryside), Meddygfa'r Sarn, Pontyates, The Surgery, Tenby.	Reviewing existing working arrangements; Reviewing potential to work across Managed Practices to try to cover staffing gaps; Management team providing operational support if needed, weekly meetings	Safety - Patient, Staff or Public	6	3	3	9	Agreed monthly meetings with Practice Managers and HR to support monitoring of LT sickness, audit check of ESR to check compliance.	Swinfield, Anna	~~31/03/2022~~ 30/09/2022	Update Apr 2022: There continues to be high levels of Covid in the community, and we are experiencing high levels of short-term sickness, which is exacerbating the impact of the long-term sickness, particularly in Minafon. Recruitment and pre-employment checks are underway. Managing Attendance at Work training has been put in place for all Practice Managers and audit have shown good compliance.	Operational Quality, Safety and Experience Sub Committee	1	1	1	Treat	13-Apr-22
118	Directorate Level Risk		USC: Cardiology	Perry, Sarah	Smith, Paul	02-Nov-15	There is a risk of patient harm arising from prolonged waits in-patient permanent cardiac pacing, especially at WGH and PPH. There is also a potential for harm for out-patients due to occasional/fluctuating out-patient pacing demand. This is caused by absence of a Pacing implantation service at WGH and PPH, further compounded by bed pressures and transportation issues which impede patient transfer to GGH for implantation. Additionally, there are periods of no-cross cover for Cardiologist Pacing implantation on the GGH site due to inadequate Pacing job planning capacity, further impacted by Cardiologist of the Week rota, annual leave and sickness. Swansea Bay (SBUHB) often have inadequate capacity to support delivery of the LTA service in place.	Emergency in-patients are doubly listed with SBUHB to ensure that they access the first available pacemaker slot. BGH pacing list x 1 weekly developed at BGH in 2019. GGH and BGH Consultants undertake additional pacing sessions as and when access to theatres and staffing allow (outside of job plan). Daily site update of all patients awaiting in-patient pacing (in-house or SBUHB) with escalation to Cardiology SDM and onwards to SBUHB as appropriate. SBAR outlining and evidencing the benefits of increasing in-house pacing capacity in 2019/20 as part of a broader plan to repatriate the pacing LTA from SBUHB submitted to Executive Board on 16/08/2019 - not progressed due to impact of COVID-19.	Safety - Patient, Staff or Public	6	2	4	8	Increase Hywel Dda inpatient pacing capacity by repatriating SBUHB pacing LTA.	Smith, Paul	~~30/09/2020~~ 30/12/2021	Historic Pacing SBAR approved by Executive Team in Sep '19 supporting repatriation of Pacing (LTA) from SBUHB - this plan to phase repatriation from Spring 2020 was suspended by COVID throughout 2020. Development of local Pacing is a key priority within the ARCH Cardiology Programme in 2021/22. Indicative investment for Pacing highlighted in IMTP - 2019 SBAR currently being updated and scheduled for completion in December 2021 in support of IMTP.	erational Quality, Safety and Experience Sub Committee	2	4	8	Treat	09-Nov-21

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							This will lead to an impact/affect on the increased clinical risk associated with prolonged in-patient waits for cardiac pacing. This is also associated with increased disruption to scheduled services to support ad hoc urgent pacing and associated risks of having to recover patients in CCU procedure room, which is not designated for this purpose. There are also risks related to poorer post-implant recovery. Risk location, Health Board wide.							Maintain engagement with ARCH 'pacing workstream' regarding potential LTA repatriation.	Smith, Paul	~~30/09/2020~~ 30/12/2021	Historic Pacing SBAR approved by Executive Team in Sep '19 supporting repatriation of Pacing (LTA) from SBUHB - this plan to phase repatriation from Spring 2020 was suspended by COVID throughout 2020. Development of local Pacing is a key priority within the ARCH Cardiology Programme in 2021/22. Indicative investment for Pacing highlighted in IMTP - 2019 SBAR currently being updated and scheduled for completion in December 2021 in support of IMTP.	Ope					
														Development of Cardio-Respiratory Day Case Investigation & Intervention Suite in GGH Site	Smith, Paul	31/03/2022	Scoping in progress to identify appropriate space for development within Priory Day Hospital foot-print						
														Resolution of barriers to reliable ambulance transport for conveyance of in-patients to GGH for pacing implantation	Smith, Paul	31/03/2022	Cardiology SDM to scope opportunities with NEPTS / Central Transport Team.						
1227	Service or Department Level Risk	Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	Carmarthenshire:Palliative Care	Dawson, Rhian	Cameron, Sarah	07-Sep-21	There is a risk of harm to both Health Board staff and patients within the community due to the currently processes and mechanism in place that manage the storage, cleansing and transportation of specialist palliative care equipment. This is caused by unsatisfactory processes in place to manage and monitor to ensure that equipment and devices are maintained, cleaned and calibrated in accordance with manufacturers' guidelines and the relevant EN (European) Standards. This includes storage decommissioning and disposal. This will lead to an impact/affect on ensuring the safe and effective procurement, use and disposal of medical equipment, devices and diagnostic systems. Risk location, Ty Bryngwyn, Ty Cymorth.	SPC Therapy team completing cleaning tasks and identifying if equipment is faulty or needs repair. Larger items (Riser Recliner Chairs) are transported by an external company Just Wales. SPC Therapy team now liaise Wider SPCT and with 3rd parties for procurement of equipment and where applicable seek guidance from NWSSP and HDUHB Medical Devices Group. Risk assessment completed by H&S officer for safe moving and handling of equipment by staff.	Safety - Patient, Staff or Public	6	2	4	8	Centralise storage of SPC Team Equipment at CICES or by another provider.	Cameron, Sarah	04/11/2021 04/07/2022	15/02 - Service Support Delivery Manager is currently reviewing new NHS Framework agreement for equipment with the County Director to form an approach. 07/04 - Meeting booked in with County Director on 26/04/22 to discuss. 09/05 - Meeting held and progressing actions.	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	04-May-22
														Servicing and Repairs undertaken at CICES or by another provider.	Cameron, Sarah	09/11/2021 04/07/2022	15/02 - Service Support Delivery Manager is currently reviewing new NHS Framework agreement for equipment with the County Director to form an approach. 07/04 - Meeting booked in with County Director on 26/04/22 to discuss. 09/05 - Meeting held and progressing actions.						

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														Transportation (Collections & Deliveries) undertaken by CICES or by another provider. Same day or next day delivery required. Decontamination of equipment on return from service user by CICES or by another provider.	Cameron, Sarah	09/11/2021 04/07/2022	15/02 - Service Support Delivery Manager is currently reviewing new NHS Framework agreement for equipment with the County Director to form an approach. 07/04 - Meeting booked in with County Director on 26/04/22 to discuss. 09/05 - Meeting held and progressing actions.						
														Purchasing of new equipment to be agreed as to most appropriate process either Palliative Care Charitable Funds or equipment procured through CICES or by another provider.	Cameron, Sarah	09/11/2021 04/07/2022	15/02 - Service Support Delivery Manager is currently reviewing new NHS Framework agreement for equipment with the County Director to form an approach. 07/04 - Meeting booked in with County Director on 26/04/22 to discuss. 09/05 - Meeting held and progressing actions.						

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1305	Directorate Level Risk		Cancer Services	Humphrey, Lisa	Bennett, Debra	07-Dec-21	There is a risk that Hywel Dda is reliant on oncology service via Swansea Bay. This is caused by recruitment pressures and national shortage of oncologist. This will lead to an impact/affect on compromised patient care and treatment, possible delays and safe management of the treatment. Risk location, Health Board wide.	Service Level Agreement with Swansea Bay UHB in place for provision of visiting oncology sessions. Governance document for non medical management of Oncology Swansea Bay process and medical staffing in place. Hywel Dda non medical staff to support patients.	Safety - Patient, Staff or Public	6	2	4	8	Develop a new strategy with SBUHB and ARCH. Monitoring process for all areas of the services.	Bennett, Debra Bennett, Debra	30/12/2022 30/12/2022	New action to be updated at next review. Regular checking process underway.	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	07-Apr-22
906	Directorate Level Risk	Standard 3.1 Safe and Clinically Effective Care	Carmarthenshire:Community Nursing	Dawson, Rhian	Cameron, Sarah	13-Jul-20	There is a risk to patients in Carmarthenshire who require reviews and interventions and complex assessments by the Heart failure Nurses and the Diabetic Specialist Nurses. This is caused by a lack of capacity in the teams. The registered nurses are undertaking tasks and interventions which could be undertaken by Health Care Support Workers, thereby freeing up capacity to respond to those with complex needs in a timely manner. This will lead to an impact/affect on patients being delayed in accessing the support required. They may also remain in the acute hospitals for an extended period whilst awaiting availability of community specialist nurses. Risk location, Carmarthenshire.	Heart failure nurses review their caseloads and prioritise patients according to need. Diabetic Specialist nurses review their caseloads and prioritise according to need. One GP cluster is providing funding for 1 whole time equivalent HCSW to support the specialist nurses but this is not available in the other 2 clusters.	Safety - Patient, Staff or Public	6	2	4	8	To appoint into the funded post of 1 whole time equivalent HCSW to support the specialist nurses for 2 years, to evaluate the impact of the HCSW on releasing capacity with a view to support ongoing funding following the pilot and to share evaluation with the remaining 2 clusters.	Cameron, Sarah	02/11/2020 09/06/2022	Head of Nursing is progressing a submission for the post from the Regional Investment Fund, this is not likely to be agreed before 01.04.22. Head of Nursing to flag with finance business partners to continue the posts at risk. Risk and Assurance Manager has confirmed Cardiology SDM is progressing a formal risk on the Cardiology Risk Register. 07/04 - Funding has not been secured via the Regional Investment Fund, Head of Community Nursing looking at other areas of funding.	Operational Quality, Safety and Experience Sub Committee	2	4	8	Treat	07-Apr-22
1292	Directorate Level Risk	n Prevention and Control (IPC) and Decontamination	Pembrokeshire	Lorton, Elaine	Griffiths, Ceri	25-Nov-21	There is a risk that Pembrokeshire System-wide Services would be unable to maintain business continuity in the event of an infection prevention and control outbreak situations (COVID / Influenza / Enteric infections etc)and experience significant service disruptions. This is caused by community nursing teams, domiciliary care providers and care homes experiencing significant staffing challenges as a result of increased sickness absence, self-isolation or requirements for staff to be deployed into non patient facing roles resulting in limited resilience to meet service demands. Wider impacts on care homes due to IP&C regulations and limitations on admissions to care homes during any outbreak will also impact on the Pembrokeshire system wide services to deliver and maintain patient services.	National and local IP&C guidance is in place across Pembrokeshire and includes specific guidance and risk assessment tools for social distancing, use of PPE, screening/testing, managing absence and return to work, signage and use of posters are well established and regularly updated by NHS Wales and Welsh Government. All health and social care staff are encouraged to uptake all mandatory and voluntary vaccinations including annual flu vaccinations and COVID vaccinations(inc boosters). A daily Pembrokeshire wide system sit rep call has been established to enable oversight and early identification of any potential IP&C outbreaks / risks which may impact on services to deliver and support timely and effective patient care. An e-scheduling system (Malinko) has been implemented across community nursing teams in Pembrokeshire allowing oversight and opportunity for redistribution of clinical activity in	Safety - Patient, Staff or Public	6	2	4	8	A review of social distancing within offices and clinical settings will be undertaken following the recent update of social distancing guidelines by WG and any actions completed within the agreed time frames. A 3 month review of IP&C and COVID infections will be undertaken in March 2022. Any additional actions identified following this review will be agreed and implemented in April 2022	Griffiths, Ceri Griffiths, Ceri	Completed Completed	To be discussed at next CMT Governance and Assurance meeting in December 2021. Completed. Monthly IP&C audits continue and reported / reviewed through QSE processes	ional Quality, Safety and Experience Sub Committee	2	3	6	Treat	25-Apr-22

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		Standard 2.4 Infection					and maintain patient services. This will lead to an impact/affect on the delivery of safe and effective quality patient care resulting in potential harm to patient due to delays in timeliness of patient visits and ability to respond to care needs. Delays in accessing care in the community may result in reduced patient flow from acute and community hospitals resulting in delayed discharge, increased numbers of avoidable admissions and additional pressure on community nursing services. Increased pressures on staff to manage service needs could lead to reduced staff wellbeing and increased stress and anxiety resulting in increased staff absence. Risk location, Pembrokeshire.	oversight and opportunity for reallocation of clinical activity in event of increased demand and reduced capacity. This system along with the development of a single point of access ensures early identification of potential delays in patient care and opportunity to manage all activity being directed to community services. Community Nursing Escalation Plans and business continuity plans have been reviewed in line with increasing operational pressures and updated to reflect the learning gained following the COVID 19 Pandemic.						Review current IP&C practices once new WG and HDUHB guidance on management of COVID has been agreed. Any changes required to be reviewed and implemented.	Griffiths, Ceri	29/07/2022	WG guidance under review by HDUHB	Operat					
742	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	E&F: Fire	Elliott, Rob	Evans, Paul	14-Mar-19	There is a risk to staff that in the event of a fire the photocopier, printer and open plan kitchen and various combustible materials are all within the escape route. This is caused by the location of the photocopier and printer within the escape route, the use of extension leads due to lack of electrical sockets, microwave, fridge and facilities for making beverages, one means of escape and the roof ceiling is not of a required standard. This will lead to an impact/affect on staff in the event of a fire as they would be unable to evacuate the building. Risk location, Glangwili General Hospital.	Microwave and toaster removed. (A1.1, A1.2) All unnecessary items/paper covering walls removed. (A2.4) Discussion with Hotel Services re: door to the courtyard to be locked out of hours. (A1.6) Confirmation that all staff are in date with ESR requirements. (A4.2)	Safety - Patient, Staff or Public	6	2	4	8	Review needed of additional sockets required: review undertake and quote submitted.	Evans, Paul	23/09/2019 31/12/2019 31/03/2022	Capital bid submitted to Capital (discretionary) Group. This work will form part of the roof replacement scheme when completed.	Health and Safety Assurance Committee	2	3	6	Treat	31-May-22
														Review security arrangements as smoking materials found outside of the office.	Humphreys, Helen	**Completed**	Agreed area secured from 9pm each night as within general hospital lock up.						
														High risk item (printer) to be unplugged and disconnected.	Humphreys, Helen	**Completed**	Printer removed						
														Program to be develop staff fire training.	Humphreys, Helen	**Completed**	Staff have booked themselves onto fire training - Request information from ESR team to confirm 100% compliance.						
														Install fire doors within the office space to FD30S specification.	Evans, Paul	**Completed**	Fire doors are not required in this area.						
														Ensure suitable and sufficient escape route for staff	Humphreys, Helen	**Completed**	Doorway created in the bottom office to provide an additional means of escape						

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														The roof, ceiling should ideally be upgraded to a 60 minutes fire rated standard to protect the adjacent wards opposite on the GF/FF levels. Capital bid required.	Evans, Paul	31/03/2021 31/03/2022	This will be completed as part of the phase 2 fire works at GGH as part of GGH enforcement letter managed by Jason Woods.						
														Provide suitable emergency lighting.	Evans, Paul	05/07/2019 31/12/2019 31/03/2022	Quotes now received for this circa £1,500 of capital is required. Awaiting capital allocation for 2020/21 to proceed. This work will form part of the roof replacement scheme when undertaken.						
837	Service or Department Level Risk	Standard 3.3 Quality Improvement, Research and Innovation	USC: Pathology	Perry, Sarah	Jones*, Dylan	31-Oct-18	There is a risk of loss of reputation, increased scrutiny by Welsh Government as a result of not meeting certain Organization for Standardization (ISO) 15189 quality standards. This is caused by the lack of Consultant Immunologist input into clinical advice and interpretation of the results produced within the scope of immunology tests analysed within the Health Board. This will lead to an impact/affect on the perception of a poorer quality service than that provided by accredited services and the potential loss of income. Risk location, Health Board wide.	The Health Board operates within the recommendations of the All Wales Immunology Scientific Services Advisory Groups (SSAG). Analyses can be referred to Immunology laboratory within Cardiff and Vale for further analysis or specialist testing as required.	Quality/Complaints/Audit	8	4	2	8	Secure sign off of the Mid and West Wales Regional Cellular pathology, Diagnostic Immunology and Microbiology strategic outline case.	Stiens, Andrea	**Completed**	SOC was submitted to Welsh Government for scrutiny in May 2019. The project has responded to initial scrutiny questions and has undertaken a gateway review exercise.	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	01-Jun-22
														Establish regional workstream as part of the ARCH Pathology programme	Jones*, Dylan	31/05/2022	Workstreams have been established as part of the ARCH pathology programme. The Laboratory Medicine workstream (which includes immunology) has yet to meet, however a blood sciences workshop was convened on 29th April 2022.						

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199	Directorate Level Risk	Standard 3.1 Safe and Clinically Effective Care	USC: BGH	Willis, Matthew	Davies, Claire	01-Apr-15	There is a risk avoidable detriment to the quality and timely provision of patient care. This is caused by sustained inability to recruit consultants. 5 out of 9 consultant posts are substantively filled in Unscheduled Care (USC), 2 others by Middle Grade (MG)acting up. Links directly to clinical strategy for BGH to establish clinical services and make recruitment attractive. This will lead to an impact/affect on increased reliance on locums, financial risk, poor sustainability, poor attractiveness to potential candidates. Reduced options to improve models of care and support good decision making and flow on site. Impact on non ward work. Risk location, Bronglais General Hospital.	Engagement with HDUHB & Mid Wales Healthcare Collaborative (MWHCC) clinical strategy development forums. Human Resources Leave and Retirement policies followed. Recruitment to posts is on going, specifically in respiratory, stroke and diabetes/ endocrinology with no suitable applicants to date. COTE consultant and MAU consultant now appointed substantively.	Safety - Patient, Staff or Public	6	2	4	8	IMTP service planning underway.	Davies, Hazel	Completed	Strategy document in draft form. Regular strategy meetings for all senior staff	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	10-Mar-22
														Develop Strategy decisions (surgery, cardiology, respiratory, COTE).	Davies, Hazel	Completed	Successfully appointed 5 x consultants to join Bronglais. 1 x MAU (locum contract) March 2019 1 x COTE (locum contract)Dec 2018, but AAC date September 2020 to be recruited substantively 1 x Cardiology (locum contract)started October 2018, undergoing CESR process 1 x Diabetes (locum contract)started November 2018, undergoing CESR process 1 x Respiratory (locum contract) March 2019 A locum consultant for gastroenterology has been appointed who will have an introductory post as middle grade before working towards his article 14 with the aim of a substantive appointment.						
														Develop internal process to identify current middle grade doctors to act up as consultants and support them with obtaining article 14.	Davies, Hazel	Completed	Two current middle grade physicians are "acting up" as locum consultants.						
														Recruitment on going though more radical options under consideration. Develop a workforce strategy to underpin the clinical strategy for BGH.	Davies, Hazel	Completed	BGH jobs advertised early 2017 but no response. Additional Care Of the Elderly consultant to be recruited at BGH with job planning the others.						
														Work with finance to reduce high cost agency spend.	Davies, Hazel	Completed	We no longer have any high cost agency locum consultants after successfully recruiting into the diabetes post. Unfortunately we have been unable to recruit substantively for a gastro consultant and we are looking into alternatives, such as an IBD specialist nurse to support the service, however we may have to revisit agency workers to maintain patient safety and quality.						

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														Remove the risk of single practice consultants	Willis, Matthew	19/06/2020 31/03/2022	IMTP includes a plan to invest in two more consultant posts in Bronglais - a second consultant in diabetes/endocrinology and a second consultant in Respiratory. Recruitment to these posts remains a challenge with no suitable applications to date. Completed date revised accordingly						
														Appoint substantively to our consultant vacancies	Willis, Matthew	30/09/2020 31/10/2022	COTE consultant and MAU consultant now appointed substantively. Locum consultant in cardiology and diabetes going through the CESR process with a view to appoint substantively once accreditation completed. Other vacancies (stroke/diabetes/respiratory/gastroenterology) remain unfilled. Completed date revised due to ongoing recruitment challenge						
928	Directorate Level Risk	Standard 3.1 Safe and Clinically Effective Care	USC: Cardiology	Perry, Sarah	Smith, Paul	31-Jul-20	There is a risk patients having delayed new and follow-up consultations. This is caused by significant backlog in demand on account of significant reduced capacity for Cardiology new and follow-up activity during the COVID Pandemic peaks, as well as reduced capacity whist the service recovers from the Pandemic. This will lead to an impact/affect on potential increased mortality and morbidity for patients who are not managed in a timely manner. Risk location, Health Board wide.	Health Board Facebook post advising existing cardiology patients of arrangements in place re contacting all 4 HDUHB Cardiac Rehabilitation services. Establishment of Health Board Cardiology helpline. Standard letter sent to all Covid-19 cancelled Cardiology follow-up patients encouraging contact via Cardiology helpline if worsening symptoms. Triage of news to urgent and routine. Review of follow-up patients by a Cardiology Consultant. Facility for Primary Care escalation to Cardiologists. Community Cardiology (ANP/APP) support for virtual Cardiology Clinics. Cardiologist Telephone/virtual Clinics. Face to face (socially distanced/PPE enabled) Cardiologist Consultations for urgent patients. Weekly Review of referral pathways and virtual Cardiologist GP advice/electronic referrals. Weekly clinically led review of patient numbers. Community venues used where possible.	Safety - Patient, Staff or Public	6	2	4	8	Explore virtual clinics and technology to support service.	Perry, Sarah	Completed	Onc Clinician who is shielding is already using a virtual clinic. Exploring with IT to increase virtual clinics for other consultants.	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	09-Nov-21
														Use of non-hospital sites for access to service.	Perry, Sarah	Completed	Using non-hospital site for diagnostics and hoping to include outpatient appointments by end of September 2020.						
														Implementation of additional 'follow-up' capacity as per Cardiology Recovery Plan.	Smith, Paul	31/03/2022	Recovery plan funding approved. 1.0 WTE Consultant Cardiologist currently focusing on new patient referrals and follow-up backlog.						

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105	Directorate Level Risk		USC: Cardiology	Perry, Sarah	Smith, Paul	03-May-17	There is a risk significant patient harm due to long waiting times for respiratory diagnostics. This is caused by lack of funding for substantive respiratory physiologist staff in respiratory diagnostics and recruitment difficulties in sleep sciences. Current substantive workforce HB-wide: 2.5 WTE; Estimated substantive workforce required HB-wide: 9 WTE. Additionally, the current HB work-force model is inconsistent with the workforce currently being trained in that respiratory physiologists are trained in Sleep and Respiratory Diagnostics and seek opportunities where they can practice both. This is further exacerbated by a national shortage (worse than Cardiac Physiologists). This will lead to an impact/affect on increased length of stay/inappropriate treatment/poorer outcomes for in-patients. Failure to meet RTT targets for out-patients, failure to diagnose in a timely way resulting poorer outcomes for out-patients, inefficient working in support of respiratory activity. Risk location, Health Board wide.	Respiratory diagnostics workforce currently funded: GGH 1 WTE; PPH approx 0.5 WTE; WGH 0 WTE; BGH 1 WTE. The current limited service available is provided by 3 locums and 1 STP student delivering the service in WGH, BGH, GGH. GGH: 0.05/0.1 WTE locum to maintain Cardiopulmonary Exercise Testing (CPEx) service. Due to insufficient funded substantive posts service prioritisation to OP Pulmonary Function Test (PFT), pulse oximetry, 6-min walk and CPEx only. No capacity available for flight assessment, Exhaled Nitric Oxide (ENO) and Spirometry for clinic. We are working towards a workforce plan. We are developing the support roles and apprentice roles which would also require funding.	Safety - Patient, Staff or Public	6	4	2	8	Review service design to ensure maximum efficiency.	Smith, Paul	31/08/2020 30/11/2021	Considering cross site working to facilitate recruitment into WGH and BGH, and provide additional support for services at GGH. Review of service model remains outstanding, with progress delayed due to Covid-19. Unable to support cross-site working due to geography and low staffing levels. Cardio-physiology service leads, Cardiology SDM, Respiratory SDM and Respiratory Clinical Lead scheduled to meet in September/October '21 to review progress and update plan.	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	09-Nov-21
1053	Service or Department Level Risk	Standard 3.1 Safe and Clinically Effective Care	Ceredigion	Skitt, Peter	Hawkes, Jina	08-Mar-21	There is a risk there is no timely access to a medical consultant in palliative medicine in Ceredigion. This is caused by unexpected long term absence of the single palliative care consultant who covers both community and BGH. This will lead to an impact/affect on patient care (particularly complex symptom assessment and management) and timely planning, potentially causing additional distress to both the patient and their family. MDT decision making and access to specialist medical advice in a timely manner which could potentially influence inappropriate care planning and increase unnecessary time in hospital. Additional stress and anxiety placed upon the CNS Palliative Care team whilst they operate without a key member of the team. Risk location, Bronglais General Hospital, Ceredigion.	Collaborative working is established between Ceredigion and Pembrokeshire consultants, where consultants have covered during periods of defined absence, however due to the possibility of an excessive and prolonged period this approach is non-sustainable. Locum support has been sort, but has been unsuccessful to date. The health board has successfully piloted external consultancy cover. Middle Grade Doctor to commence in April 2022 Awaiting full Attain report to be published The health board has successfully piloted external consultancy cover.	Safety - Patient, Staff or Public	6	2	4	8	Undertake a full and detailed review of the full palliative care service to ensure a sustainable future delivery model.	Hawkes, Jina	Completed	Attain has been commissioned to undertake review of service. The first phase of the review has been drafted and presented to the Director of Primary, Community and Long term Care	Quality, Safety and Experience Assurance Committee	1	4	4	Treat	16-May-22
														Continue to seek locum cover.	Hawkes, Jina	Completed	No locum cover was secured. The Palliative Care Consultant has now returned to post, however the episode has demonstrated the fragility of the service.						
														Review medical workforce in HDUHB to explore the opportunity of utilizing alternative consultant cover.	Paterson, Jill	Completed	Risk raised with Director of Primary, Community and Long term Care. The Palliative Care Consultant has now returned to post, however the episode has demonstrated the fragility of the service.						
														Continue to work with external consultants to determine a sustainable model for future delivery	Hawkes, Jina	Completed	Attain are currently organising workshops with the wider stakeholders.						
														Sign off of the Palliative Care Strategy by Execs	Hawkes, Jina	Completed	Supporting papers have been submitted. Strategy has been signed off						

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														Paper submitted requesting additional medical support for clinician	Hawkes, Jina	Completed	Paper included in Ceredigion Integrated Medium Term Plan						
														Recruitment of a Palliative Care Consultant	Hawkes, Jina	30/06/2022	Recruitment process underway						
1375	Service or Department Level Risk		MHLD: Older Adult Mental Health Services	O'Connor, Dr Graham	Carroll, Mrs Liz	04-Apr-22	There is a risk of insufficient older adult mental health psychiatrist capacity to effect care and treatment for a vulnerable, complex and higher risk (Secondary Specialist) older adult mental health patient population. This is caused by a combination of long-standing (over a decade) inability to recruit to substantive NHS Medical posts, therefore a reliance on internal acting up arrangements, sickness absence, , and recent requests for unpaid leave on compassionate grounds, from the older adult mental health medical workforce. This will lead to an impact/affect on -Timely accessibility of senior psychiatric/medical clinical decision making -Timely accessibility urgent psychiatric assessment, including MHA detentions and reviews -Timely prescribing of psychiatric medication -Timely accessibility psychiatric diagnosis and treatment plans -Medical waiting list breaches -Reputational damage to the Service and Health Board -Patient/carer experience and complaint rates -Numbers of near-miss and/or serious untoward incidents -General workforce confidence and morale -Remaining medical workforce burden of workload -Safe and effective business continuity and patient flow -Recruitment and retention of medical workforce and trainees Risk location, Bronglais General Hospital, Canolfan Bro Cerwyn St Nons and St Caradogs, Ceredigion, Glangwili General Hospital, Prince Philip Hospital.	1. Skill, experience and flexibility of remaining medical workforce to support and cross cover each other, supplemented by improved capabilities with remote working offered opportunity to formalise some addition capacity. 2. Interim contingency plan agreed and in place until 17th June 2022: Pembrokeshire South Speciality Doctor is acting-up NHS Locum Consultant for North Pembs 11.04.22 - 17.06.22,NB this control ends from this date, therefore solutions are reliant on recruitment but the situation will need to be reviewed in advance of this date regardless. There is another option, sub-optimal, that can then be considered in the worst case scenario i.e. no recruitment. Matrix Cross Cover from remaining Medical Workforce. .	Safety - Patient, Staff or Public	6	4	2	8	1. Obtain clarity around timeframes urgent absence end-point to feed into short-term or medium term planning (Occupational Health Appointment w/c 25.04.22)	O'Connor, Dr Graham	05-Jan-22	New action in progress.	Operational Quality, Safety and Experience Sub Committee	2	2	4		21-Apr-22
														2. Request Locum Agency for two Consultant Psychiatrist posts, Ceredigion & North Pembrokeshire	O'Connor, Dr Graham	05-Jan-22	New Action in progress.						
														3. Advertise [TRAC/NHS JOBS] NHS Locum Consultant Psychiatrist positions for Ceredigion and North Pembrokeshire.	O'Connor, Dr Graham	05-Jan-22	New action in progress						
														4. Liaise with the Royal College of Psychiatrists for JD approvals before moving rapidly to recruitment.	O'Connor, Dr Graham	05-Jan-22	New action in progress.						
														5. Once Royal College approved JD's (usually takes 3 weeks), Advertise [TRAC/NHS JOBS] Substantive/NHS Consultant Psychiatrist positions for Ceredigion and North Pembrokeshire.	O'Connor, Dr Graham	30/05/2022	New action in progress.						
														6. Map and track (matrix spreadsheet) Clinical Fellow positions to both recurrent and slippage posts to (approx... 6.0 WTE) to qualified medical presence assessment and retreatment and medical care, enabling consultant remote working.	O'Connor, Dr Graham	05-Jan-22	New action in progress.						

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1314	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	MHLD: Learning Disability Services	Carroll, Mrs Liz	Evans, Melanie	03-Oct-16	There is a risk of avoidable harm to staff or visitors, and of avoidable deterioration of the structure of the building internally and externally. This is caused by by the gradual deterioration of the external and internal condition of the building. Water penetration of the building has affected entire wall elevations and is penetrating into internal walls and office spaces. This will lead to an impact/affect on • the health and wellbeing of staff and visitors exposed to mould and damp conditions. Service is experiencing increased sickness absence due to respiratory issues; eye, throat and sinus problems. • the ability to ensure business continuity due to: o Condemned and sealed office and clinical spaces reducing capacity of the team to function / access the building. o Reduced availability of network data and electrical points due to being isolated and shut off further restricting access to electrical systems by staff. o Reduced availability of office furniture due to being condemned and removed. o Continuity of care for clients who attend the building for clinics and appointments. Risk location, Penlan (MHLD).	1. Closure of 11 condemned office/ clinical rooms. Electrical points isolated and shut down in affected areas. 2. Immediate development of a room usage plan. • Staff moved to alternative rooms within the building. • Time limits of room usage clearly marked on doors of affected spaces where appropriate (as advised by Estates Team). • Improved ventilation of office spaces during office hours. • Remote access tokens ordered for staff to enable remote working on a rota basis. • Minimise client interventions within the building. Increased home visits and relocation of clinics where possible. 3. Secondary Covid Workforce Plan • Majority of staff now working from home on a rota basis • Only essential, and risk assessed visits to Penlan by clients and others. • Use of MSTeams and Attend Anywhere to conduct meetings and clinics wherever possible. 4. Enhanced monitoring of sickness absence reasons with automatic referral to Occupational Health if potential/actual risk of environmental cause. 5. Estates have completed external works on the building and put in place interim safety measures in affected spaces.	Safety - Patient, Staff or Public	6	2	4	8	Considerable Estate work has been completed in Penlan. The impact of this on the environment for both staff and patients needs to be re-visited.	Evans, Melanie	30/06/2022	New action	Health and Safety Assurance Committee	1	4	4	Tolerate	07-Jun-22
119	Directorate Level Risk		USC: Cardiology	Perry, Sarah	Smith, Paul	21-Apr-17	There is a risk of significant avoidable patient harm due to long waiting times for cardiac diagnostics. This is caused by This is caused by a historic lack of substantive cardio-physiology funding/capacity in pacing and non-invasive diagnostics (ECHO and ambulatory ECG analysis), as well as lack of funded substantive administrative staff to support the steady increased activity levels at some sites. This is compounded by the availability of specialist cardiac workforce and capacity to train new appointees. This will lead to an impact/affect on increased length of stay/inappropriate treatment with poorer outcomes for cardiology in-patients. Failure to meet Referral to Treatment (RTT) targets for outpatients, failure to diagnose in a timely way resulting poorer outcomes for out-patients, inefficient working in support of cardiology activity. Risk location, Health Board wide.	Service capacity is supported by locum staff and overtime activity. Weekly adjustment to planned outpatient activity to balance the risk in the three main sub-specialties (ECHO, Pacing follow-up/ implant and non-invasive diagnostics). At least monthly meeting between Cardiology SDM and cardio-physiology service leads to review Health Board wide demand/ capacity and consider sharing of resourced/ re-allocation of activity. ARCH Cardiophysiology workstream identifying workforce solutions Utilising Community venue in Llanelli for ambulatory ECG monitoring. Allows greater throughput of patients whilst reducing the risk of Covid-19 transmission. Triage all referrals (inpatient and outpatient) to prioritise those with greatest clinical need/risk to be seen as early as possible, with consideration of Covid-19 risk assessment. Suspended one-stop services for Cardiology investigations, unless required urgently by Cardiologist. Allows for greater capacity to book outpatient tests and maintain inpatient services. Cardio-physiology departments undertaking regular environmental risk assessments and complying with universal/Covid ICP (infection, control and prevention) measures.	Safety - Patient, Staff or Public	6	2	4	8	BGH: Additional cost to support the service with a locum/ overtime echo cardiographer whilst recruiting into 1WTE Cardio-physiologist (echo) and whilst training an echo cardiographer onsite using a higher apprentice model.	Smith, Paul	Completed	3 x trainees in post. Locum support continues. Trainee Band 6/7 Cardio-physiologist interview to be planned. Agreed to close action based on meeting held with SDM on 18/01/2022 18/01/2022 - agreed for risk action to be removed	Operational Quality, Safety and Experience Sub Committee	1	4	4	Treat	17-Mar-22
														WGH: Recruit to 1WTE Band 7 cardio-physiologist vacancy.	Smith, Paul	Completed	Completed- vacancy removed.						
														Undertake 'Demand/ Capacity' exercise to identify service efficiencies/ resource requirements.	Smith, Paul	~~30/08/2020~~ ~~30/11/2021~~ ~~31/01/2022~~ 31/03/2022	Indicative investment requirement of £755K p/a identified in IMTP. Completion of 'Demand/ Capacity' exercise imminent in support of IMTP.						
														Develop improved process for robust triaging of echocardiography requests from Primary Care.	Smith, Paul	Completed	ECHO triage now completed on all 4 sites.						

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														Optimise use of NTproBNP test in Primary and Secondary Care as an alternative to use of ECHO as first line diagnostic to exclude Heart failure in shortness of breath.	Smith, Paul	Completed	Due to the new corporate risk written on Heart Failure Pathway Transformation, this action is no longer applicable to this particular risk. Options to optimise NTproBNP currently being scoped as part of the Heart Failure Pathway Transformation Project.						
														Linked to IMTP plan/investment requirement, development of 5 year Cardiac Physiology Workforce Plan to support succession planning and sustainability of service	Smith, Paul	~~31/03/2022~~ 31/03/2025	HDUHB Cardiac Physiology Managers engaging with HEIW and All Wales Cardiac Physiology Manager Forum with respect to Wales-wide workforce planning. Cardiac Physiology is also a key workstream within the '21/'22 ARCH Cardiology Programme.						
														Opportunities for developing short-term/intermediate cardiology diagnostic capacity	Smith, Paul	~~31/03/2022~~ 30/06/2022	Locum Cardiac Physiology locum activity optimised. Payment of double-time payment to in-house staff. ECHO in-source included in Cardiology Recovery Plan, however update from market is currently limited. As at March 22, funding is secured for the current financial year, however for FY 22/23 additional sources of funding required in order to continue developing short-term and intermediate diagnostic capacity.						
														Support delivery of ECHO Training from the ARCH Workstream (accelerated training programme and use of other workforce to help with ECHOgrams)	James, Nerys	31/12/2022	Feb 22 - Courses have commenced with the Universities and training underway on 50% of the sites. Course is 18 months in duration						

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1383	Service or Department Level Risk		Scheduled Care: Endoscopy	Hire, Stephanie	Buckingham, Carly	28-Apr-22	There is a risk Two of the endoscopy units: BGH and WGH are experiencing chronic and acute staffing issues due to vacancies and Long Term Sickness. This is caused by Both of the units have rolling recruitment which is not yielded much success. This is being caused by remote location, possible lack of career progression, on-call commitment and long-term sickness. This will lead to an impact/affect on The service provision could be affected in reduced number of lists, which will impact on USC pathway, RTT pathway and JAG accreditation. It could also impact on the morale of existing team members covering existing lists with additional pressures caused by vacancies and the LTS. Risk location, .	Cross-cover between all units, however difficult because of locations. Agency sought on framework and requested for off-framework. Backfill circulated weekly by Waiting List team. All P1 patients prioritised and dated across sites within 10 days. Both units are reviewing rotas 4-6 weeks in advance and flexing lists depending on staffing availability. Reviewing relocation of staffing.	Safety - Patient, Staff or Public		2	4	8					Quality, Safety and Experience Assurance Committee	1	4	4		28-Apr-22

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1007	Service or Department Level Risk	Standard 2.1 Managing Risk and Promoting Health and Safety	E&F: Directorate Team	Elliott, Rob	Williams, Heather	04-Nov-20	There is a risk porters and hotel services staff not being able to appropriately assist with outbursts of behavioural or clinical violence and aggression in acute or complex settings under increased pressures of Covid. This is caused by the large number of new hotel services and porters recruited that have not received appropriate training per the V&A passport scheme. Large numbers of porters are recruited and may be requested to assist with outbursts of behavioural or clinical violence and aggression. The health board has obligations to provide safe health care and comply with appropriate Information, Instruction, Supervision and Training for staff. There is currently limited capacity for training of correct Restrictive Physical Intervention (RPI) techniques and protocols being introduced. This will lead to an impact/affect on safety of patients and staff in ward and department settings. Safety of participants in RPI, leading to the likelihood of increased sickness. Increased likelihood of harm and adverse incidents including litigation or reputational harm. The health board staff and patients, reputation and finances are potentially compromised due to a lack of training and resilience due to likelihood of sickness and increased demand including confused or violent patients in acute or complex settings. Risk location, Health Board wide.	Training courses have restarted and porter staff are undertaking the training. Completion of all staff training anticipated for completion in December 21 All relevant staff will be booked on asap. Due to reduced capacity available in the training sessions , it is taking longer to complete all the sessions and therefore the date has been amended . GGH 70% in compliance PPH 100% in compliance WGH 56% in compliance BGH 100% in compliance On the larger sites it is not necessary to train all staff , clinical waste and mail room porters do not require this training . Adequate shift coverage is currently being maintained and all other staff have been booked onto courses before March 2022	Safety - Patient, Staff or Public	6	2	3	6	consideration to extend and obtain training to facilitate large numbers of staff in Covid complaint manner including internal delivery or external agencies.	Wood, Rachel	Completed	Closed. Action no longer relevant. Face to face training has resumed.	Health and Safety Assurance Committee	2	3	6	Treat	26-Jan-22
														All relevant portering staff to receive face to face V&A training.	Williams, Heather	30/09/2021	Face to face training has resumed (reduced to 6 people per training sessions due to social distancing guidelines), with front line staff having already been trained, or are booked in for a training session in the near future.						
1298	Directorate Level Risk	Standard 7.1 Workforce	Pembrokeshire	Lorton, Elaine	Griffiths, Ceri	26-Nov-21	There is a risk There is a risk that community nursing services will be unprepared for the extension of the NSWLA into District Nursing and compliance with the act will not be met. This is caused by challenges with recruitment and retention of registered nursing workforce, increasing caseload demands due to aging population, increasing complexity, acuity and dependency of community nursing caseloads. This will lead to an impact/affect on Pembrokeshire community nursing services being unable to meet the legal requirements of the NSWLA when it is extended into district nursing. Insufficient staffing will limit the sustainability of community services, resulting in delays for patients in accessing services. A lack of adequate and sufficient staffing would impact on the quality, safety, effectiveness and timeliness of patient care, resulting in increased patient incidents, reduced patient experience,	Processes are in place to ensure compliance with the bi-annual Interim District Nursing Staffing Principles submissions Community Heads of Nursing participate in all national work streams in relation to All Wales DN Staffing Principles and Nurse Staffing Levels Act, in addition to highlighting nursing levels as part of the County IMTP and resources required. Community District Nursing Service Specification and Community Nursing Escalation Policies have been developed and are regularly reviewed and updated to meet the requirements of the services and teams. E-scheduling system (Malinko) has been implemented across community nursing teams in Pembrokeshire allowing oversight and opportunity for redistribution of clinical activity in event of increased demand and reduced capacity. Community Nursing caseloads are regularly and closely scrutinised in line with the e-scheduling system and DN Service Specification. Clinical Lead Nurses ensure close scrutiny is maintained of compliance with quality indicators to include reporting on patient	Safety - Patient, Staff or Public	6	2	3	6	A review of skill mix across DN teams will be completed by March 2022 to ensure staffing levels and skill mix is equitable across all teams	Griffiths, Ceri	31/05/2022	Review to commence in December 2021. TNA review completed and awaiting final report and recommendations. Updated review required following recent recruitment and date for report deferred.	Operational Quality, Safety and Experience Sub Committee	2	3	6	Treat	17-Mar-22
														The Community Nursing Service Specification will be reviewed and amended by March 2022 to ensure that the service criteria is fit for purpose, meets the requirements of the patient population and health board and is in line with the statutory guidance of the NSWLA.	Griffiths, Ceri	31/05/2022	Draft service specification has been completed - issued for comments 25th April 2022.						

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							reduced staff well-being with reduced retention and increased absence. Risk location, Pembrokeshire.	safety incidents, workforce performance - mandatory training and PADR compliance, patient experience and complaints. E-Rosters are monitored closely to ensure early identification of potential staffing shortfalls, timely bank requests are submitted by teams and regular communication with Nurse Bank office to cover bank and agency shortfalls has been established The role of Community Practice and Professional Development Nurses has been established to work with the Community HoN to establish professional development pathways, lead/facilitate practice education, clinical skills and develop induction and competency frameworks for new and existing staff. New roles to support and compliment nursing teams as well as mitigate the challenge of RN recruitment have been developed including Assistant Practitioners in both community hospitals and community teams, Administrators and Rehabilitation workers. The remit of roles and opportunities for additional development are monitored regularly. Community Nursing Services work with HD Communications and Resourcing teams as required for RN Recruitment Campaigns for Community Services Recruitment processes are monitored at monthly governance and workforce meetings to identify any delays or concerns in a timely manner A recent OCP has included a review of existing and required nurse staffing levels to meet the recommendations of the NSWLA / Interim Principles and the requirements of community nursing services.						Review potential opportunity to enhance proposed admin roles to support DN Teams and to release RN hours	Griffiths, Ceri	Completed	Await evaluation report from pilot site. SBAR developed and awaiting review through Pembs County Management Team. JD completed and sent for job evaluation. Actions complete and awaiting finance / funding to recruit into posts.						
														Undertake review of all local Community Escalation plans and policies	Griffiths, Ceri	Completed	Review commenced and completed						
														All senior community nurses to be offered opportunity to access / apply for leadership and management programmes including STAR, MSC and PNA training and for overall uptake to be increased.	Griffiths, Ceri	31/03/2023	Quarterly review in place to ensure that any actions, opportunities to access training and sufficient community allocated places are made available						
														Utilise WG Peer Nurse Advocate Funding to develop the role of the Band 7 DN Team Leader, supporting in developing skills around A-EQUIP clinical supervision, and improved management of teams and caseloads	Griffiths, Ceri	31/03/2023	Monthly Senior Peer Nurse Meetings established to monitor progress						
														Service Leads and HONs to liaise with Workforce and Organisational Development to undertake workforce modelling, identifying challenges for potential retirements and opportunities to minimise impact on services	Griffiths, Ceri	31/08/2022	Actions to be reviewed through Pembs County Workforce meetings						
														Increase uptake of SPQ students in both DN and Community Services in preparation for development of future B6 / B7 roles	Griffiths, Ceri	31/03/2023	Monitor through Community Professional and Practice Development Nurse reports and CMT meetings						
462	Service or Department Level Risk		ecialist Services (Catering/Laundry)	Elliott, Rob	Jones, Peter	04-Mar-16	There is a risk non compliance with Food Hygiene, Temperature Regulations, the All Wales Menu Framework (AWMF), inadequate nutrition for patients and failure to demonstrate 'due diligence'. This is caused by insufficient supervision in three main production kitchens and an inadequate number of staff, particularly chefs. This will lead to an impact/affect on safe food delivery to patients, an inability to meet patients' nutritional requirements resulting in an increased	Progress has been made in respect of the AWMF with existing resources at PPH, GGH and BGH.	Safety - Patient, Staff or Public	6	2	3	6	A proposal and consultation document have been submitted to enable full compliance in this regard. Awaiting Executive Approval.	Baines, Mr Tim (Inactive User)	Completed	Executive approval was received in July 2017. Consultation commenced in August 2017. Anticipated completion in December 2017. The completion date has now been extended to April 2018 due to a delay in staff appointment to manage the risk.	ety and Experience Sub Committee	2	3	6		21-Mar-22

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			E&F: Sp				~~nutritional requirements resulting in an increased~~ adverse impact of malnutrition during hospital stay, possible delayed recovery, reduced function and increased dependence, increased length of stay and increased re-admissions. Risk location, Withybush General Hospital.							Recruit and subsequently train applicant. Adverts now placed for supervisory staff in WGH.	Baines, Mr Tim (Inactive User)	Completed	Awaiting the interview process to commence.Interviews	Operational Quality, Saf					
														Post for a cook ay WGH to be re advertised.	Ricketts, Matthew	Completed	Second approval granted post out to advert.						
														Recruit to vacant post.	Ricketts, Matthew	Completed	Issue Resolved.						
														Third supervisor commenced work Nov 18		Completed	Band 4 no longer required to undertake supervisory duties						
														Recruit to the vacant cook's position following termination of the post holder.	Ricketts, Matthew	Completed	Continuing process has begun to fill the vacant position. On-going due to staff continually leaving.						
														Staffing levels to be reviewed.	Baines, Mr Tim (Inactive User)	Completed	Existing staffing levels adequate.						
														Band 4 post to be recruited to permanently now previous as left the department	Ricketts, Matthew	Completed	Approval to be sought to fill post						
														additional staff at WGH due to Covid 19 to be used to introduce AW Menu	Ricketts, Matthew	~~17/07/2020~~ 17/07/2020	Plan being preared						
														To recruit additional cooking staff externally as Covid staff recruited have left or due to in October	Ricketts, Matthew	30/09/2020	Approval to recruit to be submitted						
														bid submitted for additional cook	Ricketts, Matthew	Completed	bid turned down						

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														considering buying in of items required to comply with AW Menu	Ricketts, Matthew	30/10/2020	suppliers being contacted and other sites						
136	Directorate Level Risk	Standard 7.1 Workforce	MHLD	Carroll, Mrs Liz	Amner, Karen	16-Oct-14	There is a risk avoidable harm to patients. This is caused by the difficulty in recruiting medical staff to particular geographical areas, namely Ceredigion and Pembrokeshire. The current age profile of the Consultant workforce will result in a number of retirements within the next five years. Presently the substantive Consultant workforce is 49%. This will lead to an impact/affect on the use of agency/locum doctors resulting in lack of continuity of care, delayed decision making, reduction in the availability of Section 12 approved doctors, increased clinical risk and deteriorating waiting times in scheduled services. For out of hours services use of temporary staff necessitating the collapse of rotas to cover 4 DGHs with reduced medical cover at short notice. Removal of core training posts impacts on consultant recruitment. Risk location, Health Board wide.	Strong links with Deanery and Universities for trainees and graduates to enhance training experience. Annual survey and audit of trainees' experience. Enhanced recruitment approach in place with support of the W&OD recruitment team. A well established Medical Staff Committee (MSC) to monitor workforce organisational demands and raise any resulting professional issues. This has direct links to the Directorate Business, Planning and Performance Assurance Group. Directorate have adopted a comprehensive job planning process. Exit interviews are undertaken to identify themes. There is a weekly on-call supervision slot facilitated by a Consultant. Medical Staff supporting the current on call rota which requires cover for the 4 General Hospitals as well as overarching consultant cover. Lead appraiser roles in place to support additional appraiser training. Workforce medical representative has and will continue to attend MSC to discuss issues raised. The Mental Health Legislation Assurance Committee have identified delays in receipt of medical reports for both Hospital Managers Hearings and Mental Health Review Tribunals which could cause unnecessary length of stay in inpatient settings. Mental Health Act Department will monitor number of incidents to ensure a reduction. There are an increasing number of ANPs being appointed across the service.	Workforce/OD	6	2	3	6	Review all rotas in line with audit findings.	Lloyd, Dr Warren (Inactive User)	Completed	Audit complete and fed back to Medical Staff committee and rotas being reviewed in line with audit findings.	Operational Quality, Safety and Experience Sub Committee	2	3	6	Tolerate	05-Apr-22
														A targeted medical recruitment campaign has been launched. In addition to this there will be a national recruitment campaign for psychiatry.	Lloyd, Dr Warren (Inactive User)	Completed	Welsh Government have now commenced a national recruitment campaign for psychiatry.						
														Full implementation of unscheduled care across all four acute hospital sites.	Carroll, Mrs Liz	Completed	The CMHT and CRHT in Ceredigion have now begun the process of combining resources.						
														The Welsh Government transformation fund has allowed the Directorate to create two additional Pharmacy posts which will include non medical prescribing as either essential or to be gained through training in order to support medical workforce.	Carroll, Mrs Liz	Completed	One post has now been filled. Second post has been recruited to but staff member will not complete diploma until Summer 2020. They will be joining the relevant team meetings in the intervening period.						
														Development of advance practice opportunities where possible. Physicians associate opportunities are being progressed between the Directorate and the learning and Development Department.	Carroll, Mrs Liz	Completed	A Job Description has been developed for a Consultant Nurse with responsibility for developing the wider non-medical workforce to undertake roles to compliment the medical workforce and ensure they undertake those roles and responsibilities within their remit. This post is now out to advert with interview date for 30th January 2020.						

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														COVID-19 Black, Asian and Ethnic Minories risk assessment implications to be understood due to a significant proportion of the Directorate medical workforce meeting this criteria. Situation compounded by a significant number of MH&LD doctors who have either received shielding letters or Occupational Health advice to undertaken non-face to face duties and or work from home.	Carroll, Mrs Liz	Completed	BAME position within medical staffing compliment understood and arrangements in place to support staff in line with current guidelines.						
														Risk 136 to be reviewed in collaboration with Associate Medical Director MH&LD in light of enhanced out of hours provision.	Carroll, Mrs Liz	30/06/2022	Meeting arranged with Medical Leads and Heads of Service to formalise operational risks prior to updating Directorate Risk Register.						
220	Directorate Level Risk		E&F: Fire	Elliott, Rob	Evans, Paul	01-Sep-14	There is a risk avoidable harm to patients, staff and visitors due to staff being unaware of their roles and responsibilities in the event of a fire incident. Also avoidable non-compliance with legislation. This is caused by whilst recent figures show that improvements in attendance for fire training have improved. Now at circa 70% for the HB, there are still concerns that staff may not be fully aware of how to operate evacuation aids appropriately. This will lead to an impact/affect on possible enforcement and Health and Safety Executive (HSE) prosecution in the event of a serious incident occurring. The risk of external enforcement and prosecution remains on this item. This risk assessment however is purely based on the risk of injury to individuals, staff and public. Compliance with HTM-05 guidance documentation for fire safety within the healthcare sector and the Regulatory Reform Order. Risk location, Health Board wide.	New fire safety team in place to now deliver training at each acute site. New TNA for fire in place April 2019 to standardise fire safety training content (soon to be reviewed) A new fire policy has been implemented with a revised Training Need Analysis (TNA) for training. Eeasier and more understandable training categories to make staff attending sessions much easier. Training prospectuses now been fully updated and are available online for staff.	Safety - Patient, Staff or Public	6	2	3	6	Target for training for this group of staff should be in excess of 80% annually, so the HB are almost meeting this target percentage.	Evans, Paul	Completed	MS Teams training programme now being rolled out across the HB for staff to attend. Commencing in August. Weekly sessions will be available for L2 staff to attend. This has been introduced since Covid-19 to address the backlog of training. We will be reviewing this in Dec to see how effective the programme has been.	Health and Safety Assurance Committee	2	2	4	Treat	31-May-22
														A new target has been set at >80% attendence by the end of Nov 2019, this will be dependent upon staff attending training. New fire team in place with adequate capacity to deliver training demand. Regular updates on training performance are being issued to ensure that the target is achieved.	Evans, Paul	29/11/2019	TNA approved for 2019 and new fire team in place with dates for training identified. Global communications have been issued on this with regular reminders.						
														It is necessary to undertake a review of a selection of inpatient wards to assess the adequacy of learning for fire evacuation aids equipment, this will be undertaken in conjunction with the MH teams and the work that is scheduled for the T&F group to look a the bariatric evacuation situation.	Lloyd, Gareth	Completed	This is being discussed at the forthcoming meetings that have now been arranged with MH teams to establish a way of how to test and measure the levels of efficiency and leaning for the use of our evacuation aids.						

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														review of evacuation training is required with MH teams across the HB, to ensure that staff are receiving the correct level of training. T&F group required.	Evans, Paul	21/12/2020	Discussions on this have taken place to agree on a formal action plan. Fire safety training TNA is also being reviewed and the HB will be reverting back to e-learning for non-inpatient staff for up to 2 years. Due to Covid-19 issues, only e-learning module will be used for fire training, this aims to get 80% attendance by Dec 2020.						
760	Service or Department Level Risk	Standard 7.1 Workforce	MD: Medical Education and Knowledge	Evans, John	Noble, Jayne	17-Jul-19	There is a risk to service provision if HEIW de-commission training posts. This is caused by reduction of junior doctor numbers impacting on the ability to provide a supportive teaching environment due to an insufficient critical mass of juniors. This will lead to an impact/affect on the ability to sufficiently populate junior doctor rotas, as a consequence of having posts de-commissioned, other training posts could be lost. Risk location, 22 Wellfield Road (MHLD), Bronglais General Hospital, Brynmair Clinic (MHLD), Canolfan Bro Cerwyn St Nons and St Caradogs, Glangwili General Hospital, Gorwelion (MHLD), Hafan Hedd (MHLD), Haverfordia House - MHLD Joint Service, Penlan (MHLD), Prince Philip Hospital, Swn-y-Gwynt Day Hospital (MHLD), Ty Gwili (MHLD), Withybush General Hospital.	Notice period given by HEIW for posts that are to be de-commissioned to allow Health Boards to plan.	Service/Business interruption/disruption	6	2	3	6	Close engagement with HEIW to fully contribute to any Specialty training reviews that affect junior doctor posts in Hywel Dda UHB	Noble, Jayne	**Completed**	Commissioning Visit confirmed review of Psychiatry training will be undertaken, but no firm plans in place. HEIW confirmed there are no current plans to decommission any training posts. As part of a wider process of interaction and communication, an informal mid-year meeting between the Health Board and HEIW will be established to provide an opportunity to discuss issues and forthcoming initiatives in more detail.	People, Organisational Development and Culture Committee	1	3	3		14-Mar-22
														Close working with HEIW through Commissioning Process to monitor any plans to de-commission posts	Noble, Jayne	~~03/06/2020~~ 11/03/2020	Delays to Commissioning process due to COVID. Await 2021 Commissioning Process information from HEIW. Two posts in Core Surgery de-commissioned for August 2021 in WGH. Service notified						
1084	Service or Department Level Risk	Standard 7.1 Workforce	Scheduled Care: General Surgery	Hire, Stephanie	Lewis, Caroline	13-Jul-20	There is a risk to the sustainability of the surgical out of hours rota in PPH. This is caused by the rota being reliant on Locum doctors. This will lead to an impact/affect on the Surgical Green Pathway in PPH and the capacity to safely treat the elective patients. Cost implication from being reliant on locum cover. Risk location, Prince Philip Hospital.	a locum consultant is managing the rota on a daily basis to ensure that there is sufficient cover in advance and that any gaps are filled.	Workforce/OD	8	2	3	6	Request agreement for 3 RMO posts to be advertised for PPH.	Lewis, Caroline	31/08/2021	SBAR will be written to Bronze by end of August 2021 to request 3 RMO posts. 09/02/2022 - RMO posts currently in shortlisting stage of recruitment with interviews to be held before the end of February 2022.	People, Organisational Development and Culture Committee	1	3	3	Treat	09-Feb-22
609	r Department Level Risk	e and Clinically Effective Care	lth Science: Speech and Language	Reed, Lance	Thomas, Alison	26-Oct-18	There is a risk laryngectomy patients not having timely access to SLT valve change clinic, leading to prolonged period of tracheal aspiration, chest infection,dehydration and compromised ability to communicate. This is caused by head and neck being a small specialist service which is vulnerable to staff absence	Training of additional SLTs from within the SLT team in surgical voice restoration (SRV)has taken place. Patients are taught to use 'plug' to enable safer oral intake, until voice prosthesis changed. ENT consultant can provide urgent cover for SVR if there is no SLT available. The SLT department is currently comissioning some band 8a specialist Head and neck Cancer time from Swansea Bay to oversee service whilst HDUHB clinical and service leads are on	- Patient, Staff or Public	6	2	3	6	Train 3 additional SLTs in SVR. This involves in house training and the completion of a Masters module. this is ongoing.	Thomas, Alison	~~20/12/2019~~ 13/04/2022	Two additional therapists have started in house training and one therapist is applying for McMillan funding to complete Masters Module. This is ongoing.	y, Safety and Experience Sub Committee	1	3	3	Treat	13-Apr-22

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	Service o	Standard 3.1 Saf	Therapies and Hea				absence. This will lead to an impact/affect on the health, well-being and quality of life. Risk location, Health Board wide.	oversee service whilst HBUHB clinical and service leads are on maternity leave.	Safety					Upgrade 1wte band 5 to 1wte band 6 within budget	Large, Philippa	Completed	Money identified within budget. Upgrading to band 6 completed	Operational Quality					
1289	Service or Department Level Risk		MHLD: Substance Misuse	Carroll, Mrs Liz	Richards, Matthew	04-Oct-21	There is a risk to the delivery of the specialist prescribing service due to the lack of suitable prescribers and clinical governance structures within the CDAT Specialist Opiate Prescribing service. This is caused by • Retirement of sessional GPs with a specialist interest in substance misuse • GP surgeries pulling out of the substance misuse enhanced arrangement • Evolution of the prescribing model within CDAT and the introduction of rapid access prescribing • Transition from medical to non-medical prescribers and the need to train appropriate staff • Lack of a robust structure to support non-medical prescribers within CDAT • Lack of cover for sickness/annual leave or staff changes This will lead to an impact/affect on the delivery of a comprehensive service, possible delays in treatment and having appropriate prescribers. This could also lead to a lack of support and staff working beyond their competencies. Risk location, Health Board wide.	1. Non-medical prescriber in place in each County providing cover as specialist GPs retire and further staff are training as prescribers. 2. Specialist GP in Ceredigion has increased the number of sessions he provides although he has indicated he is going to retire in May 2022. 3. Service users in Pembrokeshire, service users who were prescribed by enhanced surgeries have been absorbed into to CDAT specialist clinics. These are being provided by CDAT non-medical prescriber. 4. CDAT Service Consultant providing limited clinical governance arrangements.	Safety - Patient, Staff or Public	6	2	3	6	Work with APB and finance colleagues to secure funding and recruitment	Richards, Matthew	~~31/03/2022~~ 30/06/2022	To be updated at next risk review We have secured funding for an ANP and a further NMP role in Ceredigion from the APB. We have also submitted a bid for extra resource to the APB to fund the prescribing model.	Operational Quality, Safety and Experience Sub Committee	1	2	2	Tolerate	11-Apr-22
														Develop Advanced Nurse Prescriber role and Clinical Governance Structure	Richards, Matthew	Completed	To be updated at next risk review						
														Continue the existing training programme to develop non-medical prescribers within the service to provide adequate prescribing cover for the service •Identify staff to undertake prescribing qualification (September 2021 intake) •Ensure finances are in place to progress staff as they qualify •Ensure capacity isn't affected by the development of specialist roles (backfill)	Richards, Matthew	31/08/2022	To be updated at next risk review						
														Work alongside the ABP to ensure continuity of prescribing service and the enhanced prescribing model particularly in Carmarthenshire	Richards, Matthew	31/12/2022	To be updated at next risk review						
137	Service or Department Level Risk	Standard 7.1 Workforce	MHLD: Learning Disability Services	Carroll, Mrs Liz	Evans, Melanie	01-Sep-16	There is a risk avoidable detriment to the quality of patient care. This is caused by an ageing learning disability registered workforce that will lead to vacancies that are difficult to fill. There is limited locally based learning disability registered nurse and psychology training to Doctorate level. This will lead to an impact/affect on potential increase in adverse incidents within services due to the increased vacancies and absences. Lack of continuity of care for patients and delayed decision making which increase clinical risk and waiting times. Inability to sustain all services in	Open University (OU) commenced a four year part time degree in September 2020 for RNLD which encourages HCSWs to undertake their degree closer to home. There are currently 3 HCSWs who are being supported to work towards attaining registration within Learning Disability services under the Grow Your Own Nurse scheme with the OU. Due to qualify in September 2024; February 2025 and January 2026. Process in place for retire and return for suitable applicants. Continue to raise the profile of Hywel Dda Health Board Learning Disabilities services nationally through attending and contributing to national conferences.	Workforce/OD	8	1	4	4	Explore with Corporate Nursing Team the workforce demands and the number of available university places to meet this.	Carroll, Mrs Liz	Completed	Corporate Nursing Team assisting in the negotiation of 2 year nurse training programme for HCSWs who have completed Level 4. Currently 3 HCSWs completing year 1 and 2 completing year 2. Directorate have met with University of South Wales to develop a career pathway for HCSWs to become registered LD nurses.	ty, Safety and Experience Sub Committee	1	4	4	Tolerate	07-Jun-22

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							their current configuration. Risk location, Health Board wide.	Contingency plan in place should establishments decline. Registered nurses in non-clinical roles will be approached to undertake clinical work. Directorate have met with University of South Wales to develop a career pathway for HCSWs to become registered LD nurses as a four year part time degree. Swansea University will commence a four year part time degree for RNLD in September 2021 enabling local HCSWs to undertake their training closer to home. Secondment opportunities have been offered to RMN and RGN nurses for nursing posts which have proved difficult to recruit to. Band 5 development roles have been introduced into the community teams.						Further HCSW training will be commissioned at Level 4 to enable a shortened registered nurse training programme on an annual basis from 2017.	Carroll, Mrs Liz	Completed	Directorate have met with University of South Wales to develop a career pathway for HCSWs to become registered LD nurses.	Operational Quality					
														Additional bank hours within current workforce are now available following substantial Directorate recruitment initiative. LD Lead Nurse linked with Workforce & OD to explore alternative recruitment measures.	Carroll, Mrs Liz	Completed	Learning Disabilities registered nurses are included in the corporate student nurse recruitment campaign that takes place within the Health Board.						
														An SBAR regarding the age profile of registered LD nurses to be submitted to the March meeting of the Business, Planning and Performance Assurance Group with a view to removal of the risk if this is an improved position.	Carroll, Mrs Liz	Completed	An SBAR regarding the age profile of registered LD nurses to be submitted to the March meeting of the Business, Planning and Performance Assurance Group with a view to removal of the risk if this is an improved position.						
														Service linking with Professional Lead to agree a plan of action for the immediate future. This will include placing all new referrals on hold, diagnosing safely where possible and concentrating on complex and high risk cases.	Donovan, Dr Kerry	30/09/2022	New action						
														The process for newly qualified nurses to engage in Streamlining has been reviewed and strengthened to ensure throughput.	Quinlan, Caitriona	30/09/2022	All NQN's need to engage in the streamlining process and are unable to apply for jobs on Trac. NQN's are asked to rank their preferences around posts in Learning Disability Service. Service Lead is working with HB Streamlining Lead to ensure opportunities are progressed.						
														Support HCSW to undertake qualified training opportunities.	O'Connor, Eleanor	30/09/2022	New action						
														Development of practitioner roles within Community Team Learning Disabilities	O'Connor, Eleanor	30/09/2022	New action						

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														Development of Professional Lead roles to enable clinical supervision of qualified practitioners within LD.	Evans, Melanie	30/09/2022	New action						
1142	Service or Department Level Risk	Standard 2.9 Medical Devices, Equipment and Diagnostic Systems	MD: Research and Development	Phillips, Leighton	Hopkins, Mr Chris	01-Jun-21	There is a risk the resources aligned to the newly established TriTech Institute from the Research and Development and Clinical Engineering departments not being sustained. This is caused by Tritech being a joint venture between both departments with competing priorities. This will lead to an impact/affect on the delivery of research studies and service evaluations not being delivered in a timely manner. Risk location, Health Board wide.	A new team of researchers and scientists has now been established to support the TriTech Institute function. Discussions have now concluded between the Executive Director of Therapies & Health Sciences, the Executive Director of Operations and the Executive Medical Director.	Business objectives/projects	6	2	2	4	Job description to be developed for additional resource to support TriTech team.	Hopkins, Mr Chris	**Completed**	Job description developed.	Research & Development Sub Committee	1	4	4	Treat	31-Mar-22
														Job description developed for additional resource within TriTech team. Job description developed & approval provided from Director of Therapies and Health Science. Awaiting recruitment process.	Hopkins, Mr Chris	18/03/2022	Awaiting recruitment.						

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1055	Service or Department Level Risk	Standard 7.1 Workforce	MD: Medical Education and Knowledge	Evans, John	Noble, Jayne	11-Mar-21	There is a risk that Non UK Graduates will not be adequately prepared to take up their first Foundation post. This is caused by lack of experience of working in the UK due to unpreparedness of UK systems and processes. This will lead to an impact/affect on impact on patient safety in their first weeks taking up posts. Risk location, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	Shadowing period in place for 4 working days, the same for UK Graduates.	Safety - Patient, Staff or Public	6	2	2	4	Increased numbers of non-UK trained F1s across the Health Board who have not sat the PSA exam. Work with Pharmacy to put a programme in place across all four DGHs during August ahead of the first sitting on 7th Septemer. SIFT funding set aside to fund the teaching	Noble, Jayne	Completed	Training has taken place, awaiting results	People, Organisational Development and Culture Committee	1	2	2		14-Mar-22
														Agreement with Service to review any PSA fails to ascertain whether the individual can prescribe, pending on result of exam. Close working with Educational Supervisor and Foundation Programme Director to make this decision	Noble, Jayne	30/09/2021	Awaiting result of PSA exam						